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MODERNIZING MIDWIFERY:
MANAGING CHILDBIRTH IN ONTARIO AND THE BRITISH ISLES, 1900–1950

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THESIS/DISSERTATION
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Abstract

This dissertation considers the differences, as well as the similarities, between midwifery and childbirth practices in Ontario and in Britain in the first half of the twentieth century. Addressing the modernization of medical practices on either side of the Atlantic, the periodization of this project reflects the increasing concerns about maternal and infant morbidity and mortality alongside medical and political attempts to ensure the involvement of trained medical professionals during pregnancy and childbirth. In Britain, the establishment of the 1902 Midwives Act regulated midwifery so that only midwives approved by the Central Midwives' Board were allowed to practice. British midwives helped to improve maternal and infant health and welfare by making childbirth a co-operative, medically-managed event in conjunction with physicians. The medical training of midwives and physician support meant that British midwives thus participated in, and contributed to, advances in obstetrics through their access to obstetrical medicine and technology. In contrast, physicians in Ontario worked to exclude midwives from participation in the modernization of birth management, emphasizing a physician-exclusive concept of "medicalization". Under Ontario legislation, only physicians were legally allowed to act as primary attendants during childbirth, and nurses and midwives were prohibited from practicing midwifery. Nurses and midwives in Ontario, unlike their counterparts in Britain, were excluded from developments in obstetrics. This study challenges the medical profession's claims that the exclusion of midwives in Ontario was necessary for maternal safety or the medicalization of childbirth. The British alternative, where midwives were seen as

partners rather than obstacles, illustrates that medicalization in the interest of maternal and infant safety could be integrated, effectively and efficiently, with the work of midwives. By ensuring that midwives were trained medical professionals with access to obstetrical medicine and technology, greater numbers of British women had widespread access to affordable medical attention during childbirth, at an earlier date, than was possible for Ontario mothers having to deal with the physician-centred model. Comparative maternal and infant mortality statistics for the first half of the twentieth century indicate which was the more effective approach in saving mothers and babies.

For my father, Dr. James Cross (1937–2006)

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I would also like to thank the many librarians and archivists who have provided their assistance. Their knowledge and expertise helped me to navigate the collections and strengthened my research. They also shared my joy at surprising discoveries: an unopened box of chloroform capsules, fabric swatches for nurses' uniforms, and pre-cut patterns for 'breast slings'. Chatting with the archivist about the potential efficacy of 75-year-old chloroform remains one of the highlights of my research trips.

There are many friends and colleagues who have supported me throughout this project. In particular, I would like to thank Alistair Edgar, Anthony Gus Hampton,

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1 **“LIKE THE STUDY OF SNAKES IN ICELAND”: UNLICENSED MIDWIFERY AND THE MEDICALIZATION OF BIRTH**

In 1904 the English journal *Nursing Notes and Midwives' Chronicle* published a series of articles on “Foreign Midwives and Their Work,” which outlined midwifery regulations and practices in countries across Europe and around the world. Before addressing midwifery in each Canadian province, the author offered the following commentary: “We will now turn to a short summary of the present state of Colonial midwifery, merely noting in passing that an investigation of the subject shows that, like the study of snakes in Iceland, there are next to *none*.”¹ From a legislative perspective this assessment of midwifery was strikingly accurate for Ontario. In 1897, with much physician support, the Ontario Liberal government of Arthur Sturgis Hardy criminalized midwifery.² While unlicensed midwives did continue to practice in the province, their work could not be officially recognized. Beginning in the early nineteenth century and gaining prominence during the interwar years, an active campaign, by the Ontario Medical Association and the provincial Department of Public Health, promoted physician-attended birth as the only safe option for expectant mothers.³ Nevertheless,

¹ J. Wilson, “A Postscript to ‘Foreign Midwives and Their Work,’” *Nursing Notes* (April, 1904), 55.

² *The Ontario Medical Act, Revised Statutes of Ontario, 1897*, c. 176, s. 49.

³ Although local health boards of health were established in response to infectious disease beginning in 1832, these boards were disbanded following the infection and offered no continuity of effort. The long-term commitment to public health was established with the Ontario Department of Public Health as part of the *Public Health Act* (1882). This Act was inspired in part by a similar response to public health in the United Kingdom and the *Public Health Act* for England and Wales (1875). The

hospital births were not predominant until the late 1930s and both unregistered midwives and unsupervised nurses assisted parturient women in their homes.

This study is a transnational examination of patterns in obstetrical practices and perinatal care in Ontario and the United Kingdom during the first half of the twentieth century. The regulation and practice of certified midwives in the United Kingdom, and the involvement of unregistered midwives and nurses working without physician supervision in Ontario, are especially emphasized. The purpose of this study is to compare approaches to medicalization—the process by which medical practice and technology became standard in childbirth practices—and analyse the impact on parturient women. Although the models were very different, authorities in both regions were attempting to medicalize childbirth by ensuring that professional medical care and access to cutting-edge obstetrical medications and procedures were uniformly available to parturient women. As a result of the active medical campaign against midwives in Ontario, which also precluded nurses from practicing midwifery or administering obstetrical drugs, the medicalization of obstetrical practices occurred fully under the authority of physicians. I argue that physician-controlled medicalization was less effective for two key reasons. First, and ironically, it did not eliminate midwifery so much as it eliminated the proper medical training of midwives. Second, and intrinsically related, the absence of medical training and recognized midwifery in the province also

establishment of public health departments in Ontario has been covered in both primary and secondary literature: J.J. Heagerty, “The Development of Public health in Canada,” *Canadian Medical Association Journal* 25, 2 (February, 1934): 53–59; Heather Anne MacDougall, *Activists and advocates: Toronto's health department, 1883–1983* (Toronto: Dundurn Press, 1990).

impeded obstetrical advancements that would have benefitted parturient women. Since nurses and unregistered midwives attended many births in Ontario without a supervising physician, their exclusion from medicalized practices meant many parturient women could not access the newest developments in perinatal care. In contrast, midwives in Britain were entirely involved in the process of medicalization as they were considered key agents in ensuring that professional medical care and medical advancements were widely available. Obstetrical technology in the United Kingdom—the material aspect of medicalization—was not only adopted by midwives, but was also developed, with their influence, to suit their specific needs. Consequently, expectant mothers in the United Kingdom had access to professional care and pharmaceutical and technological advancements earlier than their Ontario counterparts. The benefit of this access to medical supervision and intervention was reflected in the maternal mortality rates: in 1926, Ontario had a maternal mortality rate of 5.6/1,000 births, while in England and Wales the rate was significantly lower at 4.1/1,000 births and in Saorstát Éireann⁴ the maternal mortality rate was 4.9/1,000 births.⁵ Medical professionals in

⁴ In the early twentieth century literature referred to the modern Republic of Ireland as 'Ireland'; however, following the Irish War of Independence, English literature used their new constitutional term 'Irish Free State'. The 'Irish Free State' was reformed under new constitution in 1937, and became the 'Republic of Ireland' in 1949. In Ireland, the new country was referred to as Saorstát Éireann—or Saorstat Eireann in some publications—or Éire. For the purpose of consistency, I will use Saorstát Éireann when referring to Ireland after 1921 unless quoting a document using the English name. Irish authors have written on the legislative history and controversial naming of the country: Mary E. Daly, "The Irish Free State/Éire/Republic of Ireland/ Ireland: 'A Country by Any Other Name'?", *Journal of British Studies* 46 (January 2007): 72–90; Alan O'Day, *Longman Handbook of Modern Irish History Since 1800* (London: Routledge, 2014).

Ontario acknowledged the lower mortality rates in Britain but refused to acknowledge that any credit should be given to midwives.⁶ Studies conducted in Ontario and Canada, including key publications such as *Need Our Mothers Die?*, underscore the benefits of a transnational approach to the history of midwifery. These publications demonstrate that physicians and health authorities in Ontario were looking to the British Isles when considering solutions to lower the morbidity and mortality rates, and a transnational approach complements that research.

The periodization of this project, 1897–1950, reflects the increasing concerns about maternal and infant morbidity and mortality and medical and political attempts to ensure pregnancy and birth was supervised by trained medical professionals. In 1897, Lady Aberdeen, wife of the Governor General of Canada, established the Victorian Order of Nurses (VON) of Canada with numerous branches in Ontario. From the outset, the VON emphasized the importance of maternal and infant care and endeavoured to provide pre and postnatal care to all mothers. Although the regulation of nurses and midwives was very different in the British Isles, at the turn of the century there was a similar emphasis on providing mothers access to pre and postnatal care. In 1902, a mere five years after the establishment of the VON, the first *Midwives Act* for England and Wales was passed. The 1902 Act was followed by the *Midwives Scotland Act* (1915) and the *Midwives Ireland Act* (1918). The Acts provided regulations that established

⁵ *Need our mothers die?: a study made by a special committee of the division on maternal and child hygiene* (Council House, Ottawa: Canadian Welfare Council, December 1935), 11, 15.

⁶ Grant Fleming, "The Future of Maternal Welfare." *Canadian Medical Association Journal* 29, 2 (August, 1933): 162.

professional midwifery and official training standards for midwives and enabled qualified, and later trained, women—both with and without prior nursing training—to obtain a licence to practice midwifery. Although, throughout the first half of the twentieth century, midwifery in England remained a gendered profession subject to professional hierarchies, the professionalization of midwifery in the British Isles did give women the right to legally practice an autonomous medical profession with the associated access to relevant medical technology. As later chapters will show, physicians sought their inclusion in medicalization as a benefit, not a hindrance, to their own practice. This project looks at the establishment of professional midwifery in Britain—with its expansion from the *Midwives' Act* for England and Wales to a series of Acts that covered not only the British Isles but also corners of the Empire far away from England such as India and Hong Kong—and the subsequent effect on the development of obstetrics and establishment of medicalized childbirth by ensuring supervision by medical professionals with access to the latest medications, apparatuses, and techniques. These developments in the early twentieth century show the divergent trajectory of midwifery practice and women's professional work in medicine, as well as establishing the distinctions in these areas between the British Isles and Ontario.

In contrast to the British approach to midwifery and modern obstetrics, midwives in Ontario—and to a lesser extent nurses—were actively excluded from developments in medicalization. In Ontario, the changes to the *Medical Act* made under the Liberal government of Arthur Sturgis Hardy made the work of midwives illegal and women found to be practicing midwifery could be charged with practicing medicine

without a licence. This approach to midwifery and midwives was encouraged by Ontario physicians and later the Department of Health as a means of ensuring physician dominance over childbirth as part of a broader ambition to establish a strong medical profession with physicians as the primary professionals. The exclusion of midwives and nurse-midwives from the Ontario health system, although arguably detrimental to parturient women, was done in the name of maternal and infant safety and was promoted as a means of establishing a modern medical service in the province. The promotion of physician-dominated birth in Ontario has been seen as a means of establishing a medicalized model of childbirth and motherhood in keeping with the advancements in obstetrics and gynaecology in the first half of the twentieth century. Contemporary physicians and historians of women's health and childbirth in Canada have all argued that this path towards physician dominance in Ontario represents a model of forced medicalization of childbirth—regardless of whether these means were efficient or practical.⁷

While no provincial legislation granted midwives the professional and medical authority they received in the United Kingdom, this model of medicalization was not consistent across Canada: other provinces followed different paths in the demise of midwifery and promotion of medicalized, physician-dominated, childbirth. The

⁷ Seminal works such as Mitchinson's *Giving Birth in Canada* and Comacchio's *Nations are Built of Babies* speak of the medicalization of childbirth as physician-dominated, and use physicians' access to obstetrical medication and apparatuses as proof of their leading role in medicalization. Cynthia Comacchio, *Nations are Built of Babies: Saving Ontario's Mothers and Children, 1900–1940* (Montreal & Kingston: McGill-Queen's University Press, 1993); Wendy Mitchinson, *Giving Birth in Canada: 1900–1950* (Toronto: University of Toronto Press, 2002).

persistence of midwives, either as illegal or legislated attendants, varied greatly depending on location and provincial legislation. These differences, along with the fact the health departments were established as local and provincial authorities—and the 1882 Public Health Act for Ontario was provincial rather than federal—means that a national study is not viable as it is not possible to effectively tell one history of the medicalization of obstetrics in Canada. Elements of this study examine federal organisations and publications, but the primary focus in Canada is on the regulation and practice of midwifery—meaning both the specific profession and act of attending a woman during childbirth—in Ontario.

At the start of the century there was a new emphasis on scientifically guided medical care during pregnancy and birth. By the middle of the century, numerous medical, political, and social changes meant that birthing practices had changed notably in both Ontario and Britain. In Ontario, the transition to hospital-based, physician-attended births, which began in the 1920s, increased rapidly during the 1940s. Although home births, including midwife-assisted births and nurse-assisted births, predominated in Ontario until the late 1930s, by 1950 less than ten per cent of births took place in the home and nearly all mothers had access to physician care.⁸ In Ontario, there was no resurgence of midwifery until the 1980s. On the other side of the Atlantic, the implementation of the *National Health Services Act* in 1948 also brought many changes to medical care. Midwives remained a fundamental part of maternity services in Britain with secure professional status, but the changes to healthcare at this time, along with

⁸ “Percentages of Live Births Hospitalized, by Province, 1931–61,” *Canada Year Book, 1963–64*, 229.

comparable changes in Ontario, make 1950 a logical end point for this comparative study of midwifery and maternity services.⁹ At present no such comparative study exists. This project considers the medicalization of childbirth and professionalization of medicine in both Ontario and the British Isles. In Ontario, nurses achieved professional status through training, but their exclusion from pharmaceutical developments and medical procedure means they were largely excluded from medicalization. In contrast, midwives in the British Isles were part of both professionalization and medicalization. Considering these distinctions, I address the medicalization of childbirth in both locations, and offer an alternative to the extant historical interpretations of the process of medicalization in Ontario.

The historical literature indicates that the exclusion of midwifery and the shift to hospital-based births in Ontario was done in the interests of maternal and infant safety, the standard argument being that medicalization—defined as physician-dominated medicalization—of childbirth saved lives. Yet, significantly, the literature also acknowledges that physician-attended hospital-based births were not safer than births attended by experienced midwives.¹⁰ Although trained midwives could have played a significant role in the desired medicalization, physicians in Ontario contended that

⁹ While this project is primarily studying England and Wales I have chosen the British Isles as my focus as I do also discuss both Scotland and Ireland/Saorstát Éireann. Furthermore, the influence of the Central Midwives' Board stretched to further corners of the Empire. Midwives were trained, and passed British qualifying exams, at schools outside of the British Isles, including eight in India and one in Hong Kong: TNA, Ministry of Health, Grants for the training of midwives, health visitors and nurses: transfer of Administration from board of education, MH 55/235.

¹⁰ Existing studies have shown that throughout the 1920s and 1930s maternal mortality rates in Ontario were higher in hospitals than in the home and midwives had enviably low maternal mortality rates: Mitchinson, *Giving Birth in Canada: 1900–1950*, 91.

physician-led birth was the best option, and sought to make this their exclusive domain by legally marginalizing midwives. Why physicians in Ontario argued for medical supervision and intervention during childbirth but actively delayed its implementation by excluding midwives from the process is the fundamental question considered here.

My work challenges this view of medicalization in relation to midwifery and childbirth in Ontario in the first half of the twentieth century, and suggests that there was an alternative model already in practice and that physicians in Ontario were aware of viable alternatives. In both primary sources and the Canadian historiography of childbirth, the process of medicalization is usually taken to mean “physician control,” but this is too narrow a focus. Equating medicalization with physician control overlooks alternative models to medical care. The impracticality of the model of medicalization promoted in Ontario suggests that some alternative could have been highly beneficial. Despite their illegality in Ontario, and the probable lack of official training for all but the nurses who acted as midwives “ex-officio,” midwives are an “absent presence” that, notwithstanding the challenge of evidence, must be taken into account. These women provided a continuity of care that was the only feasible option for most mothers who found a physician’s fees unaffordable. Allowing for the training of midwives, and including nurses in technical medical advancements, would have allowed for a, more rapid, comprehensive medicalization of parturient care—which is ostensibly what Ontario physicians wanted. By comparing the exclusion of midwifery in Ontario to the professionalization and promotion of midwifery in Britain I offer an alternative view of medically-managed birth and the associated gendered development of medical

professions. I argue that the inclusion of midwifery in the medical profession hastened the medicalization of birth as midwives had access to and influenced the development of obstetrical techniques and technologies. Nurses and illegal midwives in Ontario were excluded from the development and use of medical technologies such as analgesia and anaesthesia apparatuses. In contrast, midwives in England were crucial to their development and distribution. Consequently, women in England were able to have assistance during labour from such technologies and medical advancements long before such practices were commonplace on the other side of the Atlantic where they were only available if parturient women were under a physician's care—which most were not.

The tenets of the scientific motherhood movement help to explain the process of medicalization in both Ontario and Britain: their basic philosophies were influential in both locations in spite of their divergent responses to the concerns and ideology of scientific motherhood. The scientific motherhood movement has its roots in the nineteenth century and came into prominence in the early twentieth century.¹¹ Merging ideals of maternal feminism, which emphasised the value of the woman's role as a mother, with the increasingly scientific and technologically driven field of medicine, scientific motherhood operated on "the belief that women need assistance in raising

¹¹ Several historians of medicine have written on the influences of scientific motherhood in the early twentieth century: Franca Iacovetta and Mariana Valverde (editors), *Gender Conflicts: New Essays in Women's History* (Toronto: University of Toronto Press, 1992); Katherine Arnup, *Education for Motherhood: Advice for Mothers in Twentieth-Century Canada* (Toronto: University of Toronto Press Incorporated, 1994); Rima D. Apple, "Constructing Mothers: Scientific Motherhood in the Nineteenth and Twentieth Centuries," *Social History of Medicine* 8, 2 (1995): 161–178; Apple, *Perfect Motherhood: Science and Childrearing in America* (New Brunswick, NJ: Rutgers University Press, 2006).

their families healthfully and they expected that this assistance would be in the form of medical and scientific expertise.”¹² In Ontario the obvious embrace of scientific motherhood can be seen in the early promotion of physician-authored or approved advice literature and physician-dominated childbirth. These publications also promoted ideas of nation-building, which increased in prominence after the casualties of the First World War.¹³ As I will show in chapters five and six, in the early decades of the twentieth century provincial publications in Ontario and federal publications in Canada explicitly stated the need for physician monitored pregnancy, childbirth, and childrearing. The literature for expectant and new mothers was written with the dual assumption that women had a primary role and responsibility to be mothers, but that they were simultaneously incapable of being a good mother without the supervision of a family physician.¹⁴ Comparing this literature to relevant publications from the British Isles shows that the same messages about childcare and medical supervision can be delivered without an emphasis on physician dominance and the need for mothers to seek a physician’s guidance and defer to their authority. The comparison will also show how the literature available to mothers in Ontario reinforced this narrative through

¹² Apple, *Perfect Motherhood*, 22.

¹³ In Ontario, the most prominent, and prolific, supporter of the scientific motherhood movement and maternal feminism was Dr. Helen MacMurphy (1862–1953). Her numerous publications on pregnancy and motherhood, *The Little Blue Books* series, will be discussed in Chapter 6.

¹⁴ Dianne Dodd has written about the connections between maternal feminism and advice to mothers in MacMurphy’s *The Little Blue Books* series. Dianne Dodd, “Advice to Parents: The Blue Books, Helen MacMurphy, MD, and the Federal Department of Health, 1920–34” *Canadian Bulletin Of Medical History* 8 (1991): 203–230; Dianne Dodd, “Helen MacMurphy: Popular Midwifery and Maternity Services for Canadian Pioneer Women,” in Dianne Dodd and Deborah Gorham (eds.), *Caring and Curing: Historical Perspectives on Women and Healing in Canada* (Ottawa: University of Ottawa Press, 1994), 135–161.

language intended to make the mother fearful of the child's health and her own competence.

The North American emphasis on physicians as central to the necessary process of medicalization and the idea that mothers needed assistance was expressed through physician supervision in Ontario. In Britain, the same belief in necessary assistance was in place and the literature reflects these beliefs, but it was expressed through class dynamics and assumptions about the medical situation of families in varying socio-economic communities. Moral reform was present and relevant in Ontario, but was not the impetus behind campaigns in favour of medicalized birth.¹⁵ Furthermore, in Britain there was considerable overlap and moral reformers saw the promotion of medically-managed pregnancy and birth as a means to achieving their goals. Organizations such as the National Birthday Trust Fund (NBTF) were key players in making medical care and technology available to mothers regardless of their economic station. Established in 1928 as a philanthropic organization initially dedicated to reducing maternal mortality, the Trust worked closely with both British physicians and the Central Midwives Board to develop safe and effective obstetrical analgesics and bring trained midwives and advanced medical technology to expectant mothers.¹⁶ Their emphasis on obstetrical technology helped reinforce the midwife's position as a medically trained individual

¹⁵ Existing historiography on social reform includes: Beier, *For Their Own Good: The Transformation of English Working-class Health Culture, 1880–1970* (Columbus: Ohio State University Press, 2008); Linda Kealey (ed.), *A Not Unreasonable Claim: Women and Reform in Canada, 1880s–1920* (Toronto: The Women's Press, 1979); Mariana Valverde, *The Age of Light, Soap, and Water: Moral Reform in English Canada, 1885–1925* (Toronto: McClelland and Stewart, 1991)

¹⁶ A. Susan Williams, *Women & Childbirth in the Twentieth Century: A History of the National Birthday Trust Fund* (Thrupp, Gloucestershire: Sutton Publishing Limited, 1997).

responsible for administering medical care and services. Thus supervised motherhood and medicalization were promoted without the North American emphasis on physician involvement.

The existing historiography on midwifery and the development of obstetrics has not looked at the development of practices and policies in a transatlantic perspective. Canadian historians have emphasised that many Canadian physicians were trained in the United Kingdom and shown the influence of British policies, but these discussions have addressed limited influence rather than a transnational study. The majority of existing studies have been either national or regional in focus, with a few exceptions, such as Cheryl Krasnick Warsh's transnational study: *Prescribed Norms: Women and Health in Canada and the United States Since 1800* (2010).¹⁷ While Warsh's book provides a good overview on the key issues that influence women's health in the nineteenth and twentieth centuries, the broad nature of the topic prevents her from delving into the political and professional influences on the rise of obstetrics and subsequent demise of midwifery in Canada. Warsh does acknowledge the similarities and differences between regional developments in the United States and Canada, often studying these countries in parallel and demonstrating the comparative influence of region regardless of nation. She does not, and indeed cannot in this study, fully compare the differences in professional programs and subsequent effect on the lives of parturient women.

¹⁷ Cheryl Krasnick Warsh, *Prescribed Norms: Women and Health in Canada and the United States Since 1800* (Toronto: University of Toronto Press, 2010).

My project builds on this historiography on midwifery and the development of obstetrics and offers a revised view by situating these developments in a transnational context and challenging existing theories regarding the medicalization of birth in Ontario. It also adds to the literature on midwifery and childbirth in Britain by providing new approaches to the understanding of the development of midwifery as an autonomous, if still hierarchical, branch of the medical profession. This comparison is an expansion of contemporary discourse about medical practice and legislation in other countries. Authorities in Ontario researched the regulations and mortality rates in Britain and cited this research in academic arguments and established the premise for a transnational comparison of medical practices. While there are studies on maternal and infant welfare campaigns in Britain and the subsequent organizations and technologies that emerged from these campaigns, little has been written on the early establishment of professional midwifery and its correlations to the medicalization of pregnancy and birth.¹⁸ Similarly, historians on both sides of the Atlantic have produced studies that show the development of obstetrical and gynaecological science and technologies, but these are focused on the developments as they relate to medical advancement and do not address the gendered and professional connections that exist between medical technologies and the structure and influence of the medical profession. My project considers all of these elements and establishes the connections between professional

¹⁸ In 1981 Betty Cowell and David Wainwright offered a 100-year history of the Royal College of Midwives, which did address some of the milestones in the history of professional midwifery. This work, however, offers an overview rather than an in-depth historical study. Betty Cowell, and David Wainwright, *Behind the Blue Door: The History of the Royal College of Midwives, 1881–1981* (London: Ballière and Tindall 1981).

and scientific advancements in conjunction with views on midwifery and gender in the medical profession. Permitting midwives to work hastened the process of medicalization and by no means undercut the professional dominance of physicians.

There are several works in the Canadian historiography on midwifery and childbirth in the twentieth century that are particularly noteworthy for their contributions to this field: C. Lesley Biggs', "The Case of the Missing Midwives" (1983); Cynthia Comacchio's, *Nations are Built of Babies* (1993); Wendy Mitchinson's, *Giving Birth in Canada* (2002); Jo Oppenheimer, "Childbirth in Ontario" (1983). While these works establish the theory that physician dominated childbirth was synonymous with the medicalization of childbirth in Ontario, all challenge the physician dominated belief that midwifery was detrimental for mothers and babies. These works also all point out that there were efforts to professionalize midwifery in the early twentieth century, but that these efforts were all rejected by physicians. They do not, however, question whether medicalization occurred *because* of physician dominance or *in spite* of it.

Biggs and Oppenheimer were two of the earliest historians to write about the exclusion of midwifery in Canada and draw connections between this exclusion and the broader themes of gender and professional hierarchies. As Biggs establishes in her article, the demise of midwifery in Canada was not a gradual process; it was the result of an active campaign by physicians seeking dominance over the medical profession.¹⁹ In the late nineteenth century there was an attempt to pass the Haycock Bill, which would have allowed licensed midwives to practice in Ontario, but this Bill was strongly

¹⁹ C. Lesley Biggs, "The Case of the Missing Midwives: A History of Midwifery in Ontario from 1795–1900," *Ontario History* 75 (1983): 21–35.

defeated by opposition from physicians and the government.²⁰ Further evidence of the active exclusion of midwifery in Ontario can be seen in the attempts by women's groups to instate midwifery options in the province, only to be met by opposition from the medical profession. In the late nineteenth century Lady Aberdeen wished to include trained midwives as part of the services offered by the Victorian Order of Nurses, but she was quickly forced to abandon this idea due to opposition from physicians—the same opposition as defeated the Haycock Bill. Similar problems arose in the twentieth century when other groups attempted to promote midwifery. When Dr. Frederick Truby King, organizer of the New Zealand Plunket Society, established the Mothercraft Society in Canada physician opposition meant he was unable to promote midwifery services in keeping with the practices in New Zealand and England.²¹ Although the Mothercraft Society was founded in Toronto in 1931 by New Zealander Mrs. Irving Robertson, the medical profession opposed Dr. King's approach.²² These examples clearly demonstrate that the exclusion of midwifery in Ontario was the result of an active campaign.

Oppenheimer's article, originally published in the same special issue of *Ontario History* as Biggs' "The Case of the Missing Midwives," focuses on the rise of hospital births rather than the demise of midwifery, but, like Biggs and others, demonstrates

²⁰ Biggs, "The Case of the Missing Midwives," 29.

²¹ Suzann Buckley, "Ladies or Midwives? Efforts to Reduce Infant and Maternal Mortality," in *A Not Unreasonable Claim: Women and Reform in Canada, 1880s–1920s*, ed. Linda Kealey (Toronto: the Women's Educational Press, 1979), 131–149; Biggs, "The Case of the Missing Midwives" (1983); Cynthia Comacchio, *Nations are Built of Babies: Saving Ontario's Mothers and Children, 1900–1940* (Montreal & Kingston: McGill-Queen's University Press, 1993); Linda Bryder, *A Voice for Mothers: The Plunket Society and Infant Welfare, 1907–2000* (Auckland: Auckland University Press, 2003).

²² Bryder, *A Voice for Mothers*, 130.

that the increase in hospital deliveries was the result of active campaign by obstetricians, and later charitable organizations concerned with maternal health, who promoted hospital births and physician attended births.²³ While charities in the British Isles supported the inclusion of midwives, Canadian organizations towed the line and only endorsed physician attended, hospital based, birth. Historians studying the transition to hospital based confinements have emphasised that, apart from whether care was provided by a physician, for many years hospitals were not the safest place for a woman to give birth. While there was a steady increase in hospital births in the first half of the twentieth century, it was not until after the Second World War that the safety of hospital births matched that of home births.²⁴ Connecting hospital births to risks for mothers and associated infections is an important element of this project as the need to protect the health and welfare of mothers and infants was used by Ontario physicians and health reformers as a reason why physician dominated childbirth was imperative. This model of physician-centred medicalization argued that, during their confinement, women and newborns should receive this care in hospital. Yet, as these and other studies have shown, hospitals were no safer—and were in fact more dangerous—for mothers than home births, a category which includes midwife assisted

²³ Jo Oppenheimer, "Childbirth in Ontario: The Transition from Home to Hospital in the Early Twentieth Century," *Ontario History* 75 (1983): 36–60.

²⁴ Oppenheimer, "Childbirth in Ontario" (1983); Comacchio, *Nations are Built of Babies* (1993); David Gagan and Rosemary Gagan, *For Patients of Moderate Means: A Social History of the Voluntary Public General Hospital in Canada, 1880–1950* (Montreal & Kingston: McGill-Queen's University Press, 2002); Wendy Mitchinson, *Giving Birth in Canada: 1900–1950* (Toronto: University of Toronto Press, 2002).

births, nurse assisted births, and physician assisted births.²⁵ Physician dominated medicalization impeded the advancement of medically managed birth and this delay did not improve maternal and infant safety. Furthermore, evidence suggests that such correlations between hospital births and increased maternal dangers were prevalent in the United States where medicalization was similarly dominated by physicians.²⁶

Historiography on midwifery in the United States has, with a couple of notable exceptions, shown a similar trajectory regarding the rise of physician attended births as is seen in Canada. In her ground-breaking 1986 publication, *Brought to Bed: Childbearing in America, 1750–1950*, Judith Leavitt addresses the rise of hospital births in America using a similar model of medicalization as is seen in the literature on physician births in Canada: the, likely male, physician is the authority over medical practice and the physician encourages the shift from home births—a woman’s domain—to hospital births—a physician’s domain.²⁷ Leavitt traces the rise of hospital births, and

²⁵ Although, legally, physician assisted births were the only officially sanctioned form of childbirth in Ontario, regardless of location, there is evidence that lay-midwives and visiting nurses did attend women in childbirth without the supervision of a physician.

²⁶ Judith Walzer Leavitt, *Brought to Bed: Childbearing in America, 1750–1950* (New York: Oxford University Press, 1986).

²⁷ Although initially published in 1986, *Brought to Bed* remains a pertinent text on the history of childbearing. In 2016, Oxford University Press published a “30th Anniversary Edition” with a new preface from Leavitt on both the original inspirations for the text and the book’s place within the new historiography on medical history and gender history. There have been many changes to the historiography since the original 1986 publication, but the text remains relevant. In a more recent publication Leavitt discusses the role of the father in childbirth, which she sees as an “omission” from *Brought to Bed*, but the approach and arguments in the original text remain relevant. Judith Walzer Leavitt, *Brought to Bed: Childbearing in America, 1750–1950*, 30th Anniversary Edition (New York: Oxford University Press, 2016), xiii–xxv; *Make Room for Daddy: The Journey from Waiting Room to Birthing Room* (Chapel Hill: University of North Carolina Press, 2009).

physician attended births, in America as being part of an active campaign towards physician dominance as part of the scientific motherhood movement. Although Leavitt illustrates that mothers were active agents in childbirth practices, there is evidence that the shift towards medically managed birth was the result of policy rather than agency.

The historical literature on African American midwives shows that it is doubtful that African American women chose to move to physician attended, hospital based, births as an active campaign by physicians limited the work of African American midwifery.²⁸ The midwife and mother were considered incapable of handling pregnancy and birth. This emphasis on the physician as the competent and capable caregiver was a central aspect of the scientific motherhood movement. In both Canada and the United States, supporters of this movement advocated for physician controlled pregnancy and childrearing as the best method for ensuring the health and welfare of mothers and children.²⁹ While the scientific motherhood movement did argue for the inclusion of modern medical techniques and practices in the assistance of women during childbirth these advancements were supposed to be firmly in the hands of physicians and the

²⁸ Gertrude Jacinta Fraser, *African American Midwifery in the South: Dialogues of Birth, Race, and Memory* (Cambridge, Massachusetts: Harvard University Press, 1998).

²⁹ Many historians have written extensively on the history of the scientific motherhood movement in both the United States and Canada: Barbara Ehrenreich, and Deidre English, *For Her Own Good: 150 Years of the Experts' Advice to Women* (New York: Anchor Books, 1989); Katherine Arnup, Andrée Lévesque and Ruth Roach Pierson, *Delivering Motherhood: Maternal Ideologies and Practices in the 19th and 20th Centuries* (London: Routledge, 1990); Katherine Arnup, *Education for Motherhood: Advice for Mothers in Twentieth-Century Canada* (Toronto: University of Toronto Press Incorporated, 1994); Rima D. Apple, "Constructing Mothers: Scientific Motherhood in the Nineteenth and Twentieth Centuries," *Social History of Medicine* 8, 2 (1995): 161–178; Rima D. Apple, *Perfect Motherhood: Science and Childrearing in America* (New Brunswick, NJ: Rutgers University Press, 2006).

North American movement did not allow for the inclusion of nurses or midwives as primary care providers. As this project will show, this aspect of the scientific motherhood movement is strikingly different from the evidence from the United Kingdom. Since midwives were included in—and even furthered—advancements in obstetrics and promoted medically managed birth, the tenets of the scientific motherhood movement were available to more women. On both sides of the Atlantic midwives were more affordable, and more readily available—if unofficial in Ontario—than physicians.

Many aspects of the history of midwifery in the United States are very similar to the Canadian example, a similarity that is especially clear when looking at the persistence of midwifery in relation to region and culture. There is, however, one aspect of the American history that is notably different than the history of midwifery in Ontario. While Ontario offered no professional midwifery training in the first half of the twentieth century—nor indeed until the last decade of the twentieth century—the United States established nurse-midwifery programs in 1925 that offered nurses specialized training in obstetrics and maternity care. These nurse-midwifery programmes were considered an answer to the “midwife problem,” and offered another level of specialized maternity care that was not available in Ontario.³⁰ Although nurse-midwives in the United States lacked the professional autonomy and standing of British midwives, they were offered a level of medical training and status that was

³⁰ Helen Varney Burst, “The history of nurse-midwifery/midwifery education,” *Journal of Midwifery and Women’s Health* 50, 2 (March, 2005): 129–137; Laura E. Ettinger, *Nurse-Midwifery: The Birth of a New American Profession* (Columbus: Ohio State University Press, 2006).

unavailable for nurses in Canada—including those who worked in outpost situations where they were required to act as midwives when it was impossible for a physician to attend the birth.

Although nurse-midwifery is one of the developments that marks the differences between midwifery in the United States and midwifery in Canada, the impetus behind the American developments point to some of the similarities between Canada and the United States. The “midwife problem” in the United States that necessitated the development of nurse-midwifery programmes was the persistence of midwifery in certain communities, especially Southern Black communities where midwifery prevailed in spite of a lack of professional training or standards. Nurse-midwifery was seen as a compromise that enabled parturient women to have access to qualified maternity nurses without actually passing legislation or establishing training programmes to allow the professionalization of midwives. As a result, it also introduced medically managed birth earlier than would have been the case if physician attended birth was the only sanctioned option.³¹

In both the United States and Canada the persistence of midwifery in the twentieth century was isolated to certain communities, defined by “race,” region, or religion. “Race” is particularly important to the persistence of midwifery in the United States: Black women continued to use midwives even when white women had largely transferred their care in pregnancy and childbirth to physicians. In 1939 midwives in the United States attended only 3 per cent of the births of white mothers, but attended a

³¹ Varney Burst, “The history of nurse-midwifery/midwifery education,” 129.

full 50 per cent of the births of Black mothers.³² These numbers suggest the high persistence of midwifery, both trained and untrained, in Black communities, especially in Southern Black communities.³³ Trained midwifery also predominated in Japanese-American communities, where trained Japanese midwives—*sanba*—moved to the United States and continued to practice.³⁴ In *Japanese American Midwives: Culture, Community, and Health Politics, 1880–1950* (2005), Susan Smith outlines the establishment of Japanese midwives in the United States based on the experiences of some of these women. The *sanba* were fully trained, as Japan regulated midwifery in the late nineteenth century. As was the case in the British Isles, midwifery was an established but not entirely autonomous profession in Japan as physicians maintained medical authority over midwives.³⁵ Nevertheless, the training of midwives in Japan, which incidentally occurred many years before the regulation of nursing in Japan, did establish midwives as licensed, and respected, medical professionals.³⁶

Regional variations were crucial exceptions to the norm of maternity care in the United States. “Race” delineated the persistence of Black—untrained—midwives in the Southern states and Japanese—trained—midwives on the West coast, but the training and practice of midwives in Wisconsin was a regional variation: Wisconsin midwives

³² Susan L. Smith, *Japanese American Midwives: culture, community, and health politics, 1880–1950* (Urbana: University of Illinois Press, 2005), 41.

³³ Pegge L. Bell, “Making Do with the Midwife: Arkansas’s Mammie O. Hale in the 1940s,” *Nursing History Review* 1 (1993): 155–169; Susan L. Smith, “White nurses, Black midwives, and public health in Mississippi, 1920–1950,” *Nursing History Review* 2 (1994): 29–49.

³⁴ Smith, *Japanese American Midwives*.

³⁵ Smith, *Japanese American Midwives*, 18.

³⁶ Smith, *Japanese American Midwives*, 47–51.

were professionally trained in the late nineteenth century. In her 1995 publication *Catching Babies: The Professionalization of Childbirth, 1870–1920*, Charlotte Borst addresses the work of trained midwives in Wisconsin at the turn of the century. In both urban and rural Wisconsin, licensed and trained midwives attended more births than physicians. Their work predominated until the 1930s when the rise in institutionalized healthcare—which also occurred in Ontario in the 1930s—meant that few midwives registered for licenses and birth transitioned to a hospital based, physician attended, event.³⁷ On one level, the Wisconsin training and licensing of midwives at the turn of the century appears to mirror the certification of midwives in Britain. Borst is very clear, however, that the training of these midwives was never intended to establish professional midwifery or give midwives autonomy or regulatory control over their practice.³⁸ The fact that Wisconsin transitioned to institutionalized birth at the same time as most American States saw a rise in hospital births shows that the earlier training of midwives was a temporary, regional, exception. Their case highlights variations across the country, but does not challenge the trajectory of physician led medicalization in the United States.

Such racial, regional, and cultural differences were also prevalent in Canadian midwifery services—and among their clients. While regulated midwifery in the twentieth century persisted only in Nova Scotia and Québec, there are communities across Canada where women continued to use midwives—most of whom had not

³⁷ Charlotte G. Borst, *Catching Babies: The Professionalization of Childbirth, 1870–1920* (Cambridge Massachusetts: Harvard University Press, 1995).

³⁸ Borst, *Catching babies*, 3, 8.

received formal training—for assistance during pregnancy and childbirth. Midwives were prevalent even after the rise of physician-attended birth among Mennonite families, mostly in Ontario and Manitoba, outpost and Aboriginal communities in the North, and in outpost Newfoundland—even after Newfoundland joined Confederation in 1949. The historiography on the rare examples of the persistence of midwifery in Canada has almost exclusively focused on these communities.³⁹ With the exception of nurses in outpost Red Cross hospitals, who had nursing training if not specific obstetrical training, the majority of midwives who continued to work in Canada in the twentieth century were untrained and not even legally permitted to work as midwives. These women were thus inherently excluded from advancements in obstetrics and perinatal care.

These studies of fringe groups of midwives in Canada reveal how starkly different the situation was for midwives and midwifery in Canada during these years from that of

³⁹ A number of Canadian historians have written on the persistence of midwifery in isolated pockets of Canada and within certain communities: Cecilia Benoit, *Midwives in Passage: The Modernisation of Maternity Care* (St. John's Newfoundland: Institute of Social and Economic Research, 1991); Judith Bender Zelmanovits, "Midwife Preferred': Maternity Care in Outpost Nursing Stations in Northern Canada, 1945–1988," in *Women, Health, and Nation*, edited by Georgina Feldberg, Molly Ladd-Taylor, Alison Li, and Kathryn McPherson (Montreal & Kingston: McGill-Queen's University Press, 2003), 161–188; Dena Carroll and Cecilia Benoit, "Aboriginal Midwifery in Canada: Merging Traditional Practices and Modern Science," in *Reconceiving Midwifery*, edited by Ivy Lynn Bourgeault, Cecilia Benoit and Robbie Davis-Floyd (Montreal & Kingston: McGill-Queen's University Press, 2004), 236–286; Marlene Epp, "Midwife-Healers in Canadian Mennonite Immigrant Communities: Women who 'made things right,'" *Histoire Sociale/Social History* 40 (November 2007): 323–344; Marlene Epp, "Catching Babies and Delivering the Dead: Midwives and Undertakers in Mennonite Settlement Communities," in *Caregiving on the Periphery: Historical Perspectives on Nursing and Midwifery in Canada*, edited by Myra Rutherdale (Montreal & Kingston: McGill-Queen's University Press, 2010), 61–83.

the British Isles. Nurses who worked in outpost hospitals in Northern communities, usually administered by the Red Cross, did not actually receive any obstetrical training above that of general nurses as the official policy was that a physician would supervise all incidences of childbirth.⁴⁰ This policy was in place despite the fact that in many cases it was impossible for a physician to arrive in time for the delivery. Even in these isolated communities where physician-assisted birth was impossible the approach of health authorities in Ontario was to argue for the benefits of physician-assisted birth and official policy prevented nurses from acting as midwives—even though their jobs necessitated it.

The Canadian historiography has, with these few exceptions for isolated and specific communities, focused on the exclusion of midwifery based on the purported benefits of physician-attended birth. When taking a transnational approach, however, it is possible to see that the historiography on midwifery and nursing in Britain, along with the historiography on the development of obstetrical science and technology, begins to reveal that medicalization is a process with multiple avenues and outcomes. The medicalization of birth in Ontario was physician-dominated, but that is not because improved medical care, professionalized medicine, or obstetrical drugs and technology, need to be the exclusive realm of physicians. Recognising the various models of medicalized care provides part of the foundation for my argument that medicalized childbirth happened more rapidly in the British Isles than it did in Ontario precisely

⁴⁰ Prior to 1967, when Dalhousie University began offering midwifery training as part of the training for outpost nurses, nurses with training in midwifery from countries such as England and Australia were considered desirable for work in outpost communities. Zelmanovits, "Midwife Preferred," 166.

because of the promotion of midwifery in the United Kingdom and the establishment of midwives as licensed professionals. Reconsidering the process of medicalization is in keeping with emerging trends in the history of motherhood, which argues that women were neither victims of a dominant medical profession nor free agents.⁴¹ Identifying the medicalization of obstetrics helps illustrate how both mothers' choices and medical dominance influenced childbirth practices.

There is no historical study extant that addresses professional midwifery in relation to medicalization in Britain. Furthermore, there are few works that address midwifery on a national level in either England and Wales or Britain as a whole. In part because of substantive differences between London and the rest of the British Isles—as well as regionally within England, Wales, Scotland, and Ireland—histories of childbirth have generally focused on specific aspects or regional areas. Lycinda McCray Beier provides such a regional focus with her article and monograph on childbirth and healthcare in Northern communities, specifically in Lancashire.⁴² Like Susan Williams' work on the National Birthday Trust Fund, Beier's work focuses on correlations between early twentieth century health policies and socioeconomic status.⁴³ Many British maternal health policies in the first half of the twentieth century were concerned with

⁴¹ Janet Greenlees and Linda Bryder (eds), *Western Maternity and Medicine, 1880–1990* (London: Pickering and Chatto, 2013).

⁴² Lucinda McCray Beier, "Expertise and Control: Childbearing in Three Twentieth-Century Working-Class Lancashire Communities," *Bulletin of the History of Medicine* 78,2 (Summer 2004): 379–409; Beier, *For Their Own Good: The Transformation of English Working-class Health Culture, 1880–1970* (Columbus: Ohio State University Press, 2008).

⁴³ Susan A. Williams, *Women & Childbirth in the Twentieth Century: A History of the National Birthday Trust Fund, 1928–93* (Thrupp, Gloucestershire: Sutton Publishing Limited, 1997).

improving health and hygiene levels amongst working-class citizens. Beier argues, quite effectively, that the professionalization of midwifery was in part an attempt to replace untrained handywomen with trained midwives of a higher socioeconomic standing.⁴⁴ The National Birthday Trust Fund is another prime example of a middle-class foundation that attempted to change health practices of working-class citizens, often with little or no understanding of their economic or housing constraints.⁴⁵ While some of the resulting practices were misguided, the overall effect was to increase the level of medical care during pregnancy and birth by influencing legislation and practice.

To some degree such socioeconomic concerns also prevailed in Ontario. Health and social policies, especially those guided by the moral reform movement, were designed to reflect and instil middle-class values.⁴⁶ On both sides of the Atlantic, until well into the twentieth century, hospitals were associated with poverty.⁴⁷ Such associations mean that the move to hospital based births, and physician-led medicalization practices in Ontario, also required an overhaul of the operations and perceptions of hospitals. Nevertheless, in spite of the way practices and policies in Ontario may have echoed socioeconomic concerns in Britain, the situation was different on the other side of the Atlantic. The government regulated poverty to a greater extent in the United Kingdom than in Ontario. As an aspect of this regulation, the poor law in the United Kingdom further increased the level of stigmatization. It was not until 1929

⁴⁴ Beier, *For Their Own Good*, 86, 279–80.

⁴⁵ Williams, *Women & Children in the Twentieth Century*, 39.

⁴⁶ Valverde, *The Age of Light, Soap, and Water*; James Struthers, *Limits of Affluence: Welfare in Ontario, 1920–1970* (Toronto: University of Toronto Press, 1994).

⁴⁷ Gagan and Gagan, *For Patients of Moderate Means*.

that workhouse institutions in England and Wales became public hospitals.⁴⁸ The state framework for poverty in England and Wales meant poverty was treated as a fact of life rather than a social problem in need of collective remedy.⁴⁹ Given that both sides of the Atlantic had these socioeconomic concerns, albeit with a different emphasis, it is unsurprising that many works on maternal and infant healthcare focus on the socioeconomic element.

Another economic difference between Britain and Ontario that helps to explain the distinct approaches to maternity care, both at the time and by present-day historians, is health insurance. In 1911, less than a decade after the introduction of the *Midwives Act* (England and Wales), the *National Insurance Act* for England and Wales was introduced, which insured “all persons of the age of sixteen or over, including married women, who are engaged in any employment under a contract of service.”⁵⁰ While not as comprehensive as the 1948 *National Health Services Act*, this Act changed maternity services in two key ways: it reduced economic competition and made professional services more readily available. In Ontario physicians sought professional control of childbirth for reasons that were predominantly connected to economic security: without obstetrical cases physicians were less likely to have a steady income. In England and Wales national insurance made medical care more accessible, which in turn

⁴⁸ Beier, *For Their Own Good*, 132.

⁴⁹ Peter Wood, *Poverty and the Workhouse in Victorian Britain* (Bath: Alan Sutton Publishing, 1991).

⁵⁰ R.W. Harris, *National Health Insurance in Great Britain, 1911–1946* (London: George Allen and Unwin Ltd, 1946), 17.

reduced the economic concerns of physicians.⁵¹ The long and unpredictable hours of perinatal care made obstetrics less appealing to physicians who were not dependent on the income.

Physicians benefitted from the *National Insurance Act*, and this economic concern can partially explain why physicians in the United Kingdom did not seek complete dominance of obstetrical practice. Equally important to medical care, the Act offered maternity benefits to insured women:

Provided always that the mother shall decide whether she shall be attended by a duly qualified medical practitioner or by a duly certified midwife, and shall have free choice in the selection of such practitioner or midwife, but if in the case of a midwife being selected, a duly qualified medical practitioner is subsequently summoned in pursuance of the rules made under the Midwives Act, 1902, the prescribed fee shall, subject to regulations made by the insurance commissioners, be recoverable as part of the maternity benefit.⁵²

The maternity benefits offered by the Act, which provided forty shillings to an insured woman or wife of an insured man, made professional attendance, whether by physician or certified midwife, more readily available.⁵³ The language of the Act ensured midwives were promoted as licensed professionals, while the insurance also helped discourage the use of untrained handywomen. Women in Ontario did often receive benefits from private insurance companies such as the Metropolitan Life Insurance Company, but these benefits were not as widespread as national insurance in Britain, and their costs to private families made them generally unavailable to the working class. Consequently, many women were unable to afford physician supervised pregnancy and birth and were

⁵¹ Alice Reid, "Birth Attendants and Midwifery Practice in Early Twentieth-Century Derbyshire," *Social History of Medicine* Vol. 25, No. 2 (2012): 381.

⁵² *The National Insurance Act 1911*, Part 1, Section 18, "Maternity Benefits."

⁵³ Harris, *National Health Insurance in Great Britain*, 164.

thus excluded from medicalized care. While the *National Insurance Act* paid the same amount for a midwife or physicians, physicians were usually more expensive than licensed midwives and uninsured women in Ontario would have been more likely to afford a certified midwife than a physician.

In the study of access to medical care, issues of regulation and professional standing also come into play. Many works on maternal and infant health in Britain focus on professionalization in and of itself. The majority of works highlighting the importance of socioeconomic status primarily discuss localized concerns; however, the authors discussing issues of professionalization tend to address the problem at a national level—although many of these studies focus on England and Wales rather than the entire British Isles. Physicians in Ontario were equally concerned with professionalization, but focused exclusively on the physician in connected discussions of medicalization. In British literature, works on the professionalization of midwifery consider midwifery as part of a broader process of the professionalization of medicine, which began in Britain in the mid-nineteenth century. Such works predominantly examine the process of professionalization as well as the immediate goals for the established medical profession.⁵⁴ Identifying the role of midwifery within this broader professional structure

⁵⁴ Notable works on the professionalization of medicine in Britain and Europe as a whole include: Jean Donnison, *Midwives and Medical Men: A History of Inter-Professional Rivalries and Women's Rights* (London: Heinemann Educational Books Ltd, 1977); George Weisz, "The Emergence of Medical Specialization in the Nineteenth Century," *Bulletin of the History of Medicine* 77, 3 (Fall 2003): 536–574; Vincent De Brouwere, "The Comparative Study of Maternal Mortality over Time: The Role of the Professionalisation of Childbirth," *Social History of Medicine*, 20 (2007): 541–62; MJD Roberts, "The Politics of Professionalization: MPs, Medical Men, and the 1858 Medical Act," *Medical History*, 53 (2009): 37–56; Heather Stanley, "Sairey Gamps, Feminine Nurses and Greedy

reveals both the midwife's status as a medical professional and some of the professional hierarchies at play, and how these hierarchies influenced childbirth practices.

Exploring issues of power and regulation, especially in relation to nurses and midwives, reveals some of the nuances of the structure of the medical profession and highlights external factors that influence decision-making and official policy. As such, the research looks primarily at the records of midwives and nursing organizations to reveal not only the policies that governed their practice, but also their responses to such policies. These organizations include the Victorian Order of Nurses and Child and Maternal Health Division in Ontario; the Central Midwives' Board and National Birthday Trust Fund in the United Kingdom; and the Central Midwives Board and records of An Bord Altranais in Saorstát Éireann.⁵⁵ The records from these nursing and midwifery organizations include publications directed to nurses and midwives, as well as correspondence about the practice and regulation of nursing and midwifery. The research also considers nursing journals including *The Canadian Nurse*, *Nursing Notes and Midwives Chronicle*, and *Irish Nursing News*, which contain articles written by nurses and physicians. Comparing nursing journals to medical journals written by and for physicians, such as the *Canadian Medical Association Journal* and *British Medical Journal*, illustrates the distinctions in how similar topics were presented to different

Monopolists: Discourses of Gender and Professional Identity in the *Lancet* and the *British Medical Journal*," *Canadian Bulletin of Medical History* 29, 1 (2012): 49–69.

⁵⁵ Libraries and Archives Canada (LAC), Victorian Order of Nurses for Canada Fonds, R2915-0-7-E; LAC, Child and Maternal Health Division, RG 29 Vol 991–993; The National Archives UK (TNA), Records of the Central Midwives Board, DV1–DV13; Wellcome Library, National Birthday Trust Fund, SA/NBT/H.1–H.6; University College Dublin Archives, Archives of An Bord Altranais, Central Midwives Board, P220/38, P220/207–209, P220/216, P220/222.

groups of medical professionals. As the study of these journals illustrates some of the ways nurses in Ontario were excluded from medicalization.

In order to highlight the role that midwives and nurses played in the medicalization of childbirth—or how they were excluded from the process—this transnational comparison takes a ‘bottom-up’ approach to reflect as many voices as possible. While this approach considers the practice of nurses and midwives, and the experiences of expectant and new mothers, the records provide only limited insight to the experience of Indigenous women, immigrants, and women of colour as these women are largely excluded from the source material.⁵⁶ Despite these limitations, such an approach illustrates how official policy influenced the medical care available to the largest sector of the population. This framework is in keeping with the methodology used in existing historiography, especially such seminal works as Leavitt’s *Brought to Bed* (1986), Mitchinson’s *Giving Birth in Canada* (2002), and the edited collection *Reconceiving Midwifery* (2004), which study the agency of parturient women in a physician-dominated medical system.

While the primary framework used is a ‘bottom-up’ approach, in both Ontario and Britain there are some individuals in positions of authority or an elevated socioeconomic status whose contributions to this process cannot be ignored. In Ontario,

⁵⁶ While the records of the Victorian Order of Nurses and Child and Maternal Health Division exclude the experiences of Indigenous women, other studies have addressed medical practice in First Nations communities in Canada: Patricia Jansen, “Race, Culture, and the Colonization of Childbirth in Northern Canada,” *Social History of Medicine* 10, 3 (December 1997): 383–400; Mary-ellen Kelm and Lorna Townsend, *In the Days of Our Grandmothers: A Reader in Aboriginal Women's History in Canada* (Toronto: University of Toronto Press, 2006); Maureen Lux, *Medicine that Walks: Disease, Medicine, and Canadian Plains Native People, 1880–1940* (Toronto: University of Toronto Press, 2001).

physician and health reformer Dr. Helen MacMurchy was extremely influential in the medicalization of birthing practices. She led studies on the causes of maternal mortality and published extensively on how to improve maternal and infant care. Lady Aberdeen (Ishbel Hamilton-Gordon), was equally influential as she founded the Victorian Order of Nurses for Canada. As Chapter Two will show, the Victorian Order Nurses offered professional care and medical guidance—albeit without the professional autonomy of UK midwives—to a significant percentage of expectant mothers and were central to the model of medicalized childbirth in Ontario.

In Britain, midwives held a unique position and offered medicalized care and professional status without occupying the authoritative positions that would set them apart from a ‘bottom-up’ approach. Nevertheless, trained physicians and women of high socioeconomic standing were also influential, much as they were in Ontario. Countess Lucy Baldwin, wife of Prime Minister Stanley Baldwin, changed British maternal care much as how Lady Aberdeen inspired changes in Ontario. The distinction, however, is that while Lady Aberdeen and the VON provided nursing care to parturient women and established social practices, Countess Baldwin also influenced the development and dissemination of obstetrical technology—ensuring midwives a place in medicalized birthing practices. As founder of the National Birthday Trust Fund, Baldwin was closely involved with projects to make analgesia and anaesthesia available to midwives and parturient women. Her involvement was such that one of the early gas-air inhalers was

later named after her in honour of her efforts.⁵⁷ In addition to Countess Baldwin's influence, many notable physicians in Britain, such as Comyns Berkeley, supported professionalized midwifery and their endorsement helped to establish midwives as central to the medicalization of childbirth.

One individual, however, deserves particular attention as she is a link between maternal healthcare in Britain and Ontario: Dame Dr. Janet Campbell. A British physician and senior medical officer in the Ministry of Health (1919–1934), Campbell was especially concerned with correlations between medical training and medical care, particularly in areas related to maternal and infant health. Campbell did support trained midwives, but was emphatic about the need for rigorous education—particularly given their access to pharmaceuticals. The establishment of an effective midwifery service would balance medicalization with mothers' preferences. "The mother often prefers an old ill-qualified midwife simply because she is kindly and motherly and understanding, but there is no reason why the modern midwife should not have all of these qualities in addition to her greater professional competence."⁵⁸ Her balanced approach partly explains why she was a respected physician who published extensively on obstetrics and maternal and infant health.⁵⁹ Her work was so well-known that a 1934 newspaper

⁵⁷ Wellcome Library, National Birthday Trust Fund, Lucy Baldwin Nitrous Oxide and Oxygen Machine, SA/NBT/H.2/8.

⁵⁸ Campbell, *The Training of Midwives* (Ministry of Health, London, Published by His Majesty's Stationery Office, 1923), 20.

⁵⁹ Some of Campbell's publications include: Janet Campbell, *Notes on the Arrangements for Teaching Obstetrics and Gynaecology in the Medical Schools* Ministry of Health, London, Published by his Majesty's stationery office, 1923; Campbell, *The Training of Midwives* Ministry of Health, London, Published by His Majesty's Stationery Office, 1923; Campbell, *Maternal Mortality* Ministry of Health, London: Published by His Majesty's

article in the *Evening News*, London, described Campbell as “the ‘Fairy Godmother’ of thousands of children to whose welfare she has devoted many years of her life.”⁶⁰

Campbell’s work, however, was not limited to the United Kingdom. Not only did medical professionals in Ontario read her publications, Campbell also visited Canada where she was involved in maternal health care. The Canadian response to her visit was highly favourable as it was felt that she could help enact positive change:

It is already evident that this visit is strengthening the efforts of the local health authorities to unite varied community interests in a common effort to overcome the needless hazards of maternity. It is expected that the visit of this public health leader will have a permanent constructive value.⁶¹

Health officials in Ontario and Canada maintained this relationship with Dame Janet Campbell for many years. Furthermore, strong support for Dame Janet Campbell was such that it persisted in spite of the fact the department of health felt slighted when Campbell was in North America on a previous, personal, trip but unable to visit Ottawa.

In 1920, shortly after taking the post as senior medical officer in the Ministry of Health, Campbell went on a personal visit to Canada and the United States. While there she was invited by the Helen MacMurchy on behalf of the department of health to visit Ottawa:

Stationery Office, 1924; Reports on Public Health and Medical Subjects, No. 68. High Maternal Mortality in Certain Areas. Reports by Dame Janet Campbell, DBE, MD, MS. Isabella D Cameron, MD, and Dilys M. Jones, MB. Ministry of Health London Published by His Majesty's Stationery Office (1932).

⁶⁰ TNA, Ministry of Health, Ministry of Health and predecessors: Selected Senior Officials' Personal Files. Name and Appointment: Dame Janet Mary Campbell DBE, Senior Medical Officer, Ministry of Health, 1919, Chief Woman Adviser, Board of Education, MH 107/22.

⁶¹ “Prenatal Letter Series,” LAC, Child and Maternal Health Division RG 29 Vol 991 File 499.3.2 pt 1.

This Department, having no official intimation of a contemplated visit of Dr. Campbell to Canada, assumed, at the outset, that her activities here were entirely of a personal and private character, but, in order that no possibility of a misunderstanding could exist, letters and telegrams were forwarded to her, welcoming her to Canada; extending an invitation to Ottawa; offering all possible assistance; and forwarding a special invitation to be present and address the Dominion-wide Conference on Child Welfare, arranged by the Federal Department of Health, Canada, and held in Ottawa on October 19th and 20th. To these requests Dr. Campbell replied that her time was extremely limited and that she was only visiting a few towns in Canada and the United States.⁶²

In spite of the personal nature of this trip, Canadian officials took offence at her decision not to attend the conference. Campbell's inability to change plans to attend the conference was considered a "neglect of Ottawa" by Colonel Clark and the department of health.⁶³ Eventually this misunderstanding was rectified and, through repeated explanations from the Ministry of Health, the Department of Health in Ottawa recognized that this was not a personal offence. Their reaction, however, does help to highlight the respect held for Campbell both within Britain and internationally. Indeed, Campbell's international reputation, in place throughout most of her career, was such that she was "loaned" to Australia for six months in 1929 (while still working for the Ministry of Health) to conduct a study on maternal and child welfare in Australia.⁶⁴ Yet,

⁶² TNA, Ministry of Health, Ministry of Health and predecessors: Selected Senior Officials' Personal Files. Name and Appointment: Dame Janet Mary Campbell DBE, Senior Medical Officer, Ministry of Health, 1919, Chief Woman Adviser, Board of Education, MH 107/22.

⁶³ TNA, Ministry of Health, Ministry of Health and predecessors: Selected Senior Officials' Personal Files. Name and Appointment: Dame Janet Mary Campbell DBE, Senior Medical Officer, Ministry of Health, 1919, Chief Woman Adviser, Board of Education, MH 107/22.

⁶⁴ TNA, Ministry of Health, Ministry of Health and predecessors: Selected Senior Officials' Personal Files. Name and Appointment: Dame Janet Mary Campbell DBE, Senior Medical Officer, Ministry of Health, 1919, Chief Woman Adviser, Board of Education, MH 107/22.

irrespective of her international renown, Campbell's work in both the United Kingdom and Canada helps to reveal how the transnational aspect of this project is not arbitrary. The connections between Canada and Britain were not merely a product of the Empire; there was an exchange of knowledge—and individuals—across the Atlantic that meant that developments in Ontario were made with full knowledge of alternatives occurring in Britain.

In sum, this project compares midwifery in Britain and Ontario and highlights how the process of medicalization in Ontario, which dictated that physicians were to be the only legislated professionals to attend parturient women, was delayed because of the untenable aspects of this structure: when obstetrics were entirely the domain of the physician the use of obstetrical science and technology was limited by the number of births still supervised, if unofficially, by nurses and untrained midwives. The study of medicalization in Britain shows the midwife's central role in ensuring parturient women had access to trained professionals and obstetrical advancements. Work on professionalization in Britain, however, highlights how certified midwifery was established late compared to other European countries and how midwives had less professional status in Britain than in most of Europe.⁶⁵ In the late nineteenth century,

⁶⁵ Comparing British studies on professionalization to other European histories of midwifery further highlights how England lagged behind the rest of Europe in the promotion of midwives and establishment of professional midwifery. In particular, studies from Sweden show how midwives directly contributed to the reduction in maternal mortality rates: Stephan Curtis, "Midwives and their Role in the Reduction of Direct Obstetric Deaths in the late Nineteenth Century: The Sundscall Region of Sweden (1860–1890)," *Medical History* 49 (2005): 321–50; Ulf Högberg, "The Decline in Maternal Mortality in Sweden: The Role of Community Midwifery," *American Journal of Public Health*, 94 (2004).

midwives in England and Wales faced more competition from physicians than was the case in much of Europe.⁶⁶ The significance of such competition will be addressed in chapter three with an examination of British midwives' participation in the International Confederation of Midwives, which analyses the differences in midwifery across Europe. Britain was also a European anomaly as, unlike the rest of Europe, it established regulation for midwives only after the establishment of midwifery schools. In other countries regulation predated formal training for midwives by as much as a century.⁶⁷ Recognizing that the work of midwives in Britain was comparatively restricted but still resulted in key contributions in medically managed birth highlights the lack of status of midwives in Ontario and the exclusion of Ontario nurses from many obstetrical advancements. This transnational comparison shows that the medicalized model of perinatal care was enhanced by the inclusion of midwives. The exclusion of midwives in Ontario delayed the introduction of obstetrical advancements as physician controlled medicalization prevented nurses and untrained midwives—the primary attendants during birth—from accessing current practices and technologies.

⁶⁶ De Brouwere, "The Comparative Study of Maternal Mortality over Time," 548.

⁶⁷ De Brouwere, "The Comparative Study of Maternal Mortality over Time," 545.

2 “MINE WAS A VON BABY”: THE ROLE OF THE VISITING NURSE IN MATERNITY CARE

In Ontario, visiting nurses, staffed by organisations such as the Victorian Order of Nurses (VON), the Red Cross, and St. Elizabeth Visiting Nurses—of which the Victorian Order of Nurses was by far the largest—formed an integral part of health care services in the first half of the twentieth century. Nurses from these organisations were integrated in the public health practices in Ontario, and physicians viewed their involvement as beneficial. This chapter explores the role of visiting nurses, with emphasis on the VON, in the establishment of maternal care, the prevalence of home confinements, and reductions in the maternal mortality rate. Visiting nurses in Ontario were not trained midwives; nor were they permitted to act as such. Nevertheless, as this chapter will show, there were many commonalities between the work of visiting nurses in Ontario and that of certified midwives in Britain. As with other aspects of maternal care in both Ontario and Britain, there was a marked shift in policy and procedure during the interwar years. In Ontario, the physician-led process of medicalization, and the exclusion of nurses from many advancements in obstetrical medication and technology, combined with the emerging preference for hospital confinements changed the work of visiting nurses and gave them more professional authority but reduced their ability to work autonomously. While I will argue that home births remained a vital part of Ontario health practices throughout the first half of the twentieth century, I will also look at the shifting nursing and birthing practices during

this period. By examining the increasing tensions surrounding childbirth practices through the lens of nursing services, I will identify how birthing options were presented to women and address how socioeconomics influenced women's preferences during pregnancy and childbirth.

In 1897, two years after the defeat of the *Haycock Bill*, which would have allowed for licensed midwifery in Ontario, Lady Aberdeen—wife of Governor-General John Campbell Hamilton-Gordon—established the Victorian Order of Nurses of Canada. Intended as a charitable nursing organisation, initially Lady Aberdeen wanted to include trained midwives as part of the maternity services offered by the VON, but her plan was quickly abandoned due to opposition from the medical profession.¹ The success of the VON was dependent on the support of physicians—with whom the nurses would work closely—and thus acquiescing to the medical profession was imperative for success. Although licensed midwives were never part of the VON, from the outset, maternity cases represented a substantial portion of the public health nursing performed by VO Nurses. Furthermore, the nurses' ability to act autonomously when providing antenatal and postnatal care—as well as officially assisting physicians in home confinements—means that much of the maternity nursing performed by the VO Nurses was very similar to the work of certified midwives in Britain who were sometimes hired as maternity nurses. Under the rules of the Central Midwives Board (CMB), a maternity nurse was a midwife “who, in any maternity case, is acting under the direct and personal supervision

¹ Suzann Buckley, “Ladies or Midwives? Efforts to Reduce Infant and Maternal Mortality,” in *A Not Unreasonable Claim: Women and Reform in Canada, 1880s–1920s*, ed. Linda Kealey (Toronto: The Women's Educational Press, 1979), 136.

of a registered medical practitioner.”² The Victorian Order of Nurses (VON) was one of several nursing organisations operating in Ontario whose work in many ways mirrored that of British midwives acting as maternity nurses.³ The Victorian Order Nurses were not midwives—and did provide other nursing services—but their emphasis on maternity care makes the VON a viable comparison to British midwifery.⁴

Nurses in Ontario and midwives in Britain asserted their place in the medical profession through their own professional journals. Professional journals such as *Canadian Medical Association Journal (CMAJ)*, *British Medical Journal (BMJ)*, or *The Public Health Journal* were valuable resources for physicians and the model for nursing publications such as *The Canadian Nurse*, *Irish Nursing News*, and *Nursing Notes and Midwives Chronicle*. In Ontario nurses established their professional authority through publication in, and readership of, *The Canadian Nurse*, which was a monthly publication addressing all nursing issues; although there was an emphasis on maternity nursing that reflects the general concerns regarding maternal and infant healthcare. Significantly, *The Canadian Nurse*, which was founded in 1905, predated the *Canadian Medical*

² TNA, Records of the Central Midwives Board, Central Midwives Board: Rules of Conduct, Twentieth Edition (1950), Section E, Part III, 20 “Regulating, Supervising, and Restricting Within Due Limits the Practice of Midwives,” DV 3/8.

³ Other nursing organisations included the Canadian Nurses Association, Saint Elizabeth Visiting Nurses, and the Red Cross. Maternity work by VO Nurses was referred to equally as obstetrical care and maternity care and was not specifically called maternity nursing. Although the VON does not call their work ‘maternity nursing,’ one sees many similarities to the British definition of a maternity nurse. Libraries and Archives Canada (LAC), Victorian Order of Nurses, MG 28 I 171, Vol. 5, Board of Governors. 5th Annual Report, File 37.

⁴ The VON is a national, rather than provincial, organisation and therefore some of their literature and statistics refer to Canada as a whole rather than specifically Ontario. They are the focus of this project, however, because they were the most prominent home nursing organisation in Ontario.

Association Journal, which did not begin publication until 1911. Prior to 1911 Canadian physicians both read and published in medical journals including international journals such as *The Lancet*, and the *British Medical Journal*; regional publications in Canada; and journals with a national scope such as the *Canada Lancet* and the *Canadian Practitioner*. These were not, however, a unified national publication like the *Canadian Medical Association Journal*. Consequently, *The Canadian Nurse* did not predate physicians' active involvement in medical publications, but nurses did have a Canadian journal before a comparable publication existed for Canadian physicians, which indicates nurses' aims to established a unified profession in Canada.

The articles published in *The Canadian Nurse* are indicative of how nurses in Ontario and across Canada sought professional recognition and intellectually stimulating articles. Many articles were published by Canadian nurses, but there were also numerous articles with an international scope as well as articles written by physicians. Unlike *Nursing Notes and Midwives' Chronicle* in Britain or *Irish Nursing News* in Saorstát Éireann, the articles written by physicians were overwhelmingly unique publications for this journal rather than reprints from the *CMAJ*. These unique publications ensured that the physician's viewpoint was being tailored for nurses and did not necessarily offer the same perspective as was presented in the medical journals intended for physicians. In 1930 physician Wesley Bourne published an article "The Administration of Chloroform in Obstetrics by Nurses," which said very little about the actual administration but provided an extensive overview of the physiological effects of chloroform on the major

organs.⁵ This article did not overlap directly with publications in the *CMAJ*, but Bourne also published extensively in the *CMAJ* on the use of anaesthesia in obstetrics.⁶ This overlap means that Canadian nurses were exposed to the professional opinions of physicians across Canada to a greater extent than they may have been without the existence of *The Canadian Nurse*, but not necessarily the same articles and arguments as they would have read in the *CMAJ*.

The articles in *The Canadian Nurse* also expressed the nursing profession's opinion on regulatory practices in Canadian nursing as well as international perspectives.⁷ Authors considered both how regulations influenced nursing practices as well as how international practices and policies might offer educational opportunities for Canadian nursing practice. Nurses recognised that, in spite of midwifery being illegal unless performed by a physician, midwives continued to attend to parturient women and that "50 per cent of all maternity cases in our Dominion are delivered and cared for by midwives."⁸ Rather than dismissing midwives as inconsequential, nurses seemed more willing to acknowledge the persistence of midwives than was the case in the

⁵ Wesley Bourne, "The Administration of Chloroform in Obstetrics by Nurses," *The Canadian Nurse* (November, 1930), 585–587.

⁶ Wesley Bourne, and James W. Duncan, "Nitrous Oxide-Oxygen Analgesia and Anaesthesia in Obstetrics," *Canadian Medical Association Journal* 11, 11 (November, 1921): 818–822; Wesley Bourne, "Anaesthesia in Obstetrics," *Canadian Medical Association Journal* 14, 8 (August, 1924): 702–703; Wesley Bourne, "Vinyl Ether Obstetrical Anæsthesia for General Practice," *Canadian Medical Association Journal* 33, 6 (December, 1935): 629–632

⁷ While I am focusing exclusively on articles related to obstetrical care and maternity practices, it is worth noting that *The Canadian Nurse* had a broad scope of articles and this international and regulatory perspective was present in many of the recurring themes in this journal.

⁸ Johns, "The Practice of Midwifery in Canada," 11.

CMAJ. The official stance of nurses was that pregnancies and births attended by nurses and physicians was the ideal, but also that “we make the fatal mistake of ignoring existing conditions.”⁹ There was also some acknowledgement, including from Charlotte Hanington, Chief Superintendent of the VON from 1917 to 1923, that educating midwives under state control was the only viable option under the circumstances.¹⁰

In spite of the nursing leaders’ personal opinions, the official stance from the Canadian Nurses Association was entirely in keeping with the views expressed by the Canadian Medical Association: “The Canadian Nurses’ Association, which has a membership of 10,000 Registered Nurses in Canada and which is affiliated with the National Council of Women, is opposed to any scheme for the training and licensing of midwives in Canada.”¹¹ During this period, nurses in Ontario were an emerging profession with limited authority. Although their work and contributions to public health nursing helped ensure a level of professional recognition and respect, this professional status was newly-earned. Furthermore, the relationships between nurses and physicians were an essential part of the nurse’s profession and it was in her best interest to maintain a positive relationship. These sorts of dialogues where nurses identify with their patients’ situations while still espousing the need for physician-supervised medical care are indicative of nurses defining their professional autonomy and expressing an opinion on matters considered to be of great national importance.

⁹ Johns, “The Practice of Midwifery in Canada,” 12.

¹⁰ Johns, “The Practice of Midwifery in Canada,” 12.

¹¹ Johns, “The Practice of Midwifery in Canada,” 13.

In addition to the VON's antenatal and obstetrical work, there is evidence suggesting that Canadian nurses from other organisations were interested in the work of certified midwives in England to see how alternatives might improve patient care. Throughout the first half of the twentieth century, the *Canadian Nurse* published many articles addressing licensed, professional, midwifery and maternity care in other countries.¹² Canadian nurses were, like the rest of the medical profession, concerned with improving infant and maternal mortality rates and such articles offered insight into the benefits and drawbacks of other approaches to maternity care. As was the case with comparable articles in the *Canadian Medical Association Journal (CMAJ)*, many of these acknowledged that countries, including the United Kingdom, that relied on trained midwives frequently had better maternal mortality rates than Canada. Unlike articles in the *CMAJ*, however, articles in *The Canadian Nurse* acknowledged the correlation between professional midwifery and improved maternal care—although this should not be misconstrued as meaning that the majority of Canadian nurses supported licensed midwives. Even without endorsing licensing midwifery, the articles identified some of the benefits of midwife assisted care. As Mary Beard, Advisor in Nursing, Rockefeller

¹² In keeping with the concerns about maternal mortality in the 1920s and 1930s, the articles in *Canadian Nurse* that discussed midwifery and the work of midwives were published predominantly during these decades: Mary Beard, "Midwifery in England: Part 1," *Canadian Nurse* (February 1927), 89–94; Mary Beard, "Midwifery in England: Part 2," *Canadian Nurse* (March 1927), 140–144; E. Johns, "The Practice of Midwifery in Canada," *Canadian Nurse* (January 1925) 10–14; Ethel Cryderman, "The Mothercraft Training Society: Highgate, London, England," *Canadian Nurse* (May 1926), 227–239; Anne Slattery, "Midwifery Legislation and Practice in Canada," *Canadian Nurse* (March 1927), 145–146; Mary Chadwick, "Primitive Midwifery," *Canadian Nurse* (January 1928), 3–5; Unknown, "Maternity Service in England," *Canadian Nurse* (May 1935), 209–211.

Foundation, wrote in a 1927 article on midwifery in England, there were benefits to midwifery that included mortality statistics but also broader issues of maternal care:

The technique of the delivery was beautiful, but is not that which is so unforgettable—it is what we must call the psychology of a midwife that made me long to have certified midwives for the mothers of my own country. From the moment of the midwife's arrival in that small attic room a quiet assurance seemed to descend upon the patient and to give her courage, control and endurance such as she had not had before.¹³

The articles acknowledge the many benefits, both medically and for the community, of having trained midwives as the primary medical attendant in normal births. The specifics of midwifery service were debated, but it was understood that even within the contemporary framework “there exist[ed] a definite need for graduate nurses with midwifery training.”¹⁴ Furthermore, it was felt that that the legislation of midwifery was a pertinent matter for nurses as it related to broader aspects of nursing care.¹⁵

As the *Canadian Nurse* was a national publication, nurses in Ontario were exposed to midwifery practices from other parts of the country. Nova Scotia and Québec were the only provinces with legislation permitting the work of midwives, but the opposition to midwifery was stronger—or physicians more successful in achieving their professional aims—in Ontario than in some other provinces.¹⁶ In areas where

¹³ Beard, “Department of Public Health Nursing: Midwifery in England: Part 1,” 89.

¹⁴ Johns, “The Practice of Midwifery in Canada,” 14.

¹⁵ Johns, “The Practice of Midwifery in Canada,” 10; Slattery, “Midwifery Legislation and Practice in Canada,” 146.

¹⁶ In Nova Scotia, the legislation that permitted midwifery was limited and suggests tolerance, rather than support, of midwives. Until 1967, midwives in Halifax—there were only a handful within the city—needed to be qualified and register with the Provincial Medical Board; midwives in the rest of the province were not required to register or show qualifications. *The Medical Act, The Revised Statutes of Nova Scotia*, 1923, 1954, 1967.

physicians expressed less opposition to licensed midwifery there are more cases of nurses openly engaging in midwifery training. In 1945, Mary P. Edwards, a public health nurse from Saskatchewan, published an account of midwifery training she was receiving in New York. This training consisted of a six-month course at the Maternity Centre Association of New York, and provided training in both domiciliary and hospital based births. Edwards' attendance, along with that of another public health nurse from Saskatchewan, was supported by the Department of Public Health in Saskatchewan as part of an experiment to alleviate the dearth of medical care in communities "where no doctor finds it profitable to settle and where it may be too expensive for the Department to put a doctor full-time."¹⁷ Other articles openly acknowledged the situations where nurses acted as independent midwives in areas where doctors were scarce. In one such case, a nurse from Alberta described providing complete maternal care during the delivery—including administering Demerol as an analgesic—assisted only by the patient's husband.¹⁸ These articles, amongst others, openly acknowledged situations where midwifery legislation was less important than providing proper obstetrical care. Reports on the need for nurses with midwifery training were more likely to appear in *The Canadian Nurse* than the *CMAJ*.

Given that the *Canadian Nurse* published two articles by Mary Beard which provided a positive endorsement for using certified midwives as primary birth attendants, it is unfortunate that the follow-up article on midwifery legislation in Canada suggests how an overview of their scarce activity was indeed like "a study of

¹⁷ Mary P. Edwards, "A Course in Midwifery," *Canadian Nurse* (December, 1945), 987.

¹⁸ Beth Laycraft, "Homestead Obstetrics," *Canadian Nurse* (May, 1947), 353–355.

snakes in Iceland.”¹⁹ The article in *The Canadian Nurse* discusses the regulation of midwifery in Nova Scotia and Quebec, and briefly touches on the work of district nurses in Alberta who were British Midwives certified by the Central Midwives Board, but beyond that has little to say on the subject and offers no opinion on whether the dearth of midwives in Canada was detrimental or for the greater good. In contrast, both *Nursing Notes and Midwives’ Chronicle* and *Irish Nursing News* expressed the opinion that trained midwives were an invaluable part of maternity care.²⁰ It appears that nurses in Ontario were willing to take note of the positive aspects of certified midwifery, but were unwilling to threaten their status within the medical community by speaking out against policies set by the provincial and federal health departments.

The emphasis on nurses maintaining positive relationships with physicians to help ensure their professional standing can be seen throughout the period covered by this project. The obstetric work performed by the Victorian Order of Nurses was part of Lady Aberdeen’s original mandate in 1897.²¹ Initial training protocols for the VON included the directive that the nurses must possess “a practical knowledge of midwifery, sufficient to attain a prescribed certificate.”²² In spite of this recognition of the continuing existence of, and need for, midwifery, it was understood that the obstetrical

¹⁹ J. Wilson, “A Postscript to ‘Foreign Midwives and Their Work,’” *Nursing Notes and Midwives Chronicle* (April, 1904), 55.

²⁰ “Modern Midwifery Service,” *Nursing Notes* XL (September 1927), 122; “The Role of the Midwife in the Public Health Scheme,” *Irish Nursing News* (July 1932), 146–151.

²¹ Suzann Buckley, “Ladies or Midwives? Efforts to Reduce Infant and Maternal Mortality.” In Linda Kealey (ed.) *A Not Unreasonable Claim: Women and Reform in Canada, 1880s–1920s* (Toronto: the Women's Educational Press, 1979), 136.

²² LAC, Victorian Order of Nurses, MG 28 I 171, Vol. 5, Lady Aberdeen Correspondence 1897–1936, File 30.

services provided by these nurses should not compete with the obstetrical care offered by medical doctors: “It will probably be desirable that HELPERS should not undertake midwifery cases in towns or villages where there are regular medical men except at their request, as every pain should be taken not to interfere with the legitimate work of the medical men of each neighbourhood.”²³ Again, the acknowledgement of the need is clear, as well as an indirect acknowledgement of the fact many rural and Northern towns had no “regular medical men,” but the fact that the midwife-nurses were simply—and emphatically—classified as helpers indicates the complicated professional politics involved.

These early discussions on midwifery reveal an internal conflict between what services the VON needed to provide and what the gendered and professional hierarchy that defined the relationship of nurses and physicians allowed. The VON could not provide comprehensive midwifery care without being in conflict with physicians. Although evidence shows that VO Nurses did provide obstetrical care to patients, in official policy VO Nurses in Ontario carefully abided by the rulings of the Ontario medical profession. In 1917 a group of Victorian Order nurses gathered in Toronto to protest a report from the honorary secretary of the VON, Dr. Thomas Gibson. Gibson, a Scottish Physician, had come to Canada as the medical Aide-de-camp to the Governor-General Lord Aberdeen.²⁴ Although Dr. Gibson did not challenge the Ontario medical

²³ LAC, MG 28 I 171 Vol. 5, File 30.

²⁴ Dr. Gibson was involved with the VON from its inception and held the post of honorary secretary from 1898 to 1920 and president from 1920 to 1922. G.R. Chevrier, “Obituary: Dr. Thomas Gibson,” *Canadian Medical Association Journal* 45, 2 (August 1941): 192–93.

profession's stance on midwifery, these women, who described themselves as "representing the body of Victorian Order Work in Ontario," were opposed to Dr. Gibson's report, which they read as endorsing midwifery. As they stated in their protest letter "We therefore, in substance, protest against the employment of midwives, V.A.D.'s or any nurse having other than the qualifications required in by-laws above quoted and do hereby express our opinion that the Chief Lady Superintendent should have fully all the above mentioned requirements and be allied with the Graduate Body of Nurses."²⁵ According to one of the letters from Mrs. John Baird Laidlaw, president of the Whitby Branch of the VON, to Dr. Gibson there was "considerable unrest and disappointment among all the Branches," and that many nurses were resigning from the Order due to the report's apparent support for midwives.²⁶ Although there was a shortage of nurses in Ontario in 1917 due to the need for Voluntary Aid Detachment (V.A.D.) nurses in the First World War, the nurses who wrote to Dr. Gibson were emphatically opposed to midwives and also opposed to including V.A.D. nurses in the Victorian order of Nurses.²⁷

In his response to the letters Dr. Gibson stated, "There is absolutely nothing in my report suggesting the acceptance of mid-wives into and V.A.D. nurses into the

²⁵ LAC, Victorian Order of Nurses, MG 28 I 171, Vol. 5, Midwifery, File 31.

²⁶ Mrs. John Baird Laidlaw (née Bertha Fredericka Gunther) was a philanthropist and activist. In spite of her position as president of the Whitby branch there is no indication in any of the correspondence as to whether or not Mrs. Laidlaw was herself a nurse. LAC, Victorian Order of Nurses, MG 28 I 171, Vol. 5, Midwifery, File 31.

²⁷ For the history of Canadian V.A.D. nurses see: Linda J. Quiney, *This small army of women: Canadian volunteer nurses and the First World War* (Vancouver: UBC Press, 2017).

Order.”²⁸ While Dr. Gibson’s report was not intended to endorse midwifery his response to Mrs. Laidlaw and the VO Nurses in Toronto expressed the personal opinion “that unless an adequate supply of trained mid-wives is provided especially for the crowded and foreign elements of our great cities, there will continue to be an enormous amount of illness and loss of life or the development of blindness among the women and children left unattended, or attended by the ignorant and absolutely unsuitable persons.”²⁹ In spite of this belief, however, Dr. Gibson did not feel that midwives should be accepted to the Order and reiterated the view of his colleague and then Superintendent of the Order, Miss MacKenzie, that “it would be at least twenty-five years, perhaps fifty, before any such scheme of an affiliated association for the practice of midwives could be organized in Canada,” although no explanation is provided for this prolonged wait apart from an allusion to “many and serious difficulties that would have to be faced in organizing any such scheme.”³⁰

This exchange emphasises the political tensions surrounding the question of including midwives in the VON. The secretary—a physician—recognised the need for trained midwives, but could not officially endorse it. Furthermore, as the protest shows, VO Nurses were not receptive to the idea of including trained midwives—likely due to the professional competition. The inclusion of trained midwives would have increased nurses’ professional competition and, according to some nurses, could have lowered the status of women. As Mrs. Laidlaw wrote on behalf of VO Nurses: “women who take

²⁸ LAC, Victorian Order of Nurses, MG 28 I 171, Vol. 5, Midwifery, File 31.

²⁹ LAC, Victorian Order of Nurses, MG 28 I 171, Vol. 5, Midwifery, File 31.

³⁰ LAC, Victorian Order of Nurses, MG 28 I 171, Vol. 5, Midwifery, File 31.

midwifery as a separate course and not in connection with any of the training schools of England are of quite a different stamp, unfortunately, have not the social standing that women in the nursing profession deem necessary," Therefore, according to this interpretation of midwifery training, the inclusion of midwifery in the Order would challenge their professional status, and associated social status, which they felt was superior to that of certified midwives.³¹

The obstetrical services offered by the VON were in keeping with the medical profession's mandate and the obstetrical work by VO Nurses focused on assisting the attending physician.³² Nurses did, however, step in to do the job in the many instances where there was no attending physician.³³ Nor were these cases, where nurses acted as midwives without physician supervision, inconsequential. By 1925, at Red Cross Outposts in Northern Ontario, Alberta, Saskatchewan, and Manitoba where there were few physicians to attend births, 1,609 babies had been delivered.³⁴ Thus nurses, especially in isolated parts of Ontario, provided medical care to pregnant and parturient women that was very similar to the work performed by midwives in England. As the medical profession was aware of the autonomous work of nurses in childbirth, the

³¹ LAC, Victorian Order of Nurses, MG 28 I 171, Vol. 5, Midwifery, File 31.

³² LAC, Victorian Order of Nurses, MG 28 I 171, Vol. 6, Histories of Victorian Order of Nurses For Canada 1897–1967, File 1.

³³ In 1943 the VON of Canada attended 6,946 home confinements. Officially their role at confinements was to assist the attending physician, but records from individual branches indicate that the physician did not always arrive; either because there was not enough time for the physician to reach the expectant mother or because the physician was never called. LAC, Victorian Order of Nurses, MG 28 I 171 Vol. 6, House of Commons Special Committee on Social Security, File 6.

³⁴ E. Johns, "The Practice of Midwifery in Canada," *Canadian Nurse* (January, 1925), 14.

difference between some Ontario nurses and British professional midwives and maternity nurses is a matter of regulation rather than practice.

While Red Cross nurses were the main nurses in Outpost communities, in urban and rural areas the majority of nursing care was offered by Victorian Order Nurses. VO Nurses were valued healthcare providers in Ontario and across Canada and assisted many mothers during their pregnancy and early weeks of the child's life. As noted, obstetrical care was a prominent component of the Order's work from the outset. An analysis of VON obstetrical care in 1902 showed that "The Nurses are now doing so much obstetrical work, and doing it with such success, that we must consider the Order a great life-saving organization."³⁵ The prominence of obstetrical work increased rapidly in the early decades of the twentieth century. By 1929, the VON had a staff of 303 nurses working at 74 centres across the country.³⁶ In this same year, Victorian Order Nurses provided care for 64,356 patients. Of this number, 14,218, or over twenty per cent were obstetrical cases. More significant than those numbers, however, is the fact that in 1929 the VON provided care for approximately 6 per cent of all births occurring in Canada.³⁷ As obstetrical cases were a significant component of the VO Nurse's work, much of their employment mirrored that of a British maternity nurse. These figures

³⁵ LAC, Victorian Order of Nurses, MG 28 I 171, Vol. 5, Board of Governors. 5th Annual Report, File 37.

³⁶ The reports do not indicate how many of these nurses worked in Ontario, but of the 82 centres operating in 1930, 41 were located in Ontario. Local associations served 1,389,000 individuals in Ontario, or roughly 43% of the population. LAC, Victorian Order of Nurses, MG 28 I 171, Vol. 6, Report of a Survey made of the Activities of the Order in 1930, File 4.

³⁷ LAC, Victorian Order of Nurses, MG 28 I 171 Vol. 6, Report of a Survey Made of the Activities of the Order in 1930 by Grant Fleming, File 4.

show the influence that the VON, a single organisation, had over birthing practices in Canada. Although these rates were notably lower than the percentages of mothers cared for by midwives in the British Isles, the VON was the most influential organisation in Ontario during this period. The value of their work, however, also served to highlight the need for more trained nurses to assist pregnant women and new mothers. In Ontario in 1922, 5,751 mothers were cared for by VO Nurses. While their services were to be lauded given the proven benefits of supervised pregnancies, these statistics also meant that 55,418 mothers were “looked after by the private duty nurses, other organizations, and the inevitable ‘handy-woman’—who certainly appears to do the major part of the obstetrical nursing in the province.”³⁸ The successes of the VON highlighted the need for improved maternal care in Ontario and the need to ensure all expectant and new mothers had access to trained nurses.

In spite of the professional stance on childbirth held by Ontario nurses—and in spite of the nurses’ belief that British midwifery training was inferior to their training—there remain many similarities between the daily practice of the VO Nurse and the British maternity nurse. For all intents and purposes, despite the prevailing view that medicalization should be led by physicians and subsequent limitations on training and practice, VO Nurses were the closest parallel to British midwives. Furthermore, maternity work became a more substantial portion of the VO Nurse’s caseload even though the number of hospital births in Ontario increased dramatically between 1930 and 1950. During this period the rate of hospital-based births in Canada increased from

³⁸ Margaret Duffield, Reg. N, “Department of Public Health: Maternal Care in Ontario,” *Canadian Nurse* (July 1925), 360.

26.8% in 1931 to 86.5% in 1955; during this same period hospital-based births in Ontario increased from 38.2% to 96.7%.³⁹ Meanwhile, between the late 1920s and the early 1940s obstetric cases attended by the VON increased from 22% of all cases to 51% of all cases.⁴⁰ The rapid increase in maternity care had almost stabilised by the 1940s; however, it did increase slightly by the mid-1950s, at which point 54% of VON patients were admitted for maternity care.⁴¹ Reports from individual branches within Ontario indicate an emphasis on obstetrical and antenatal care that was in keeping with these national statistics.⁴² Such a correlation likely indicates a rise in professional attendance during pregnancy and birth: while more women were having physician-attended hospital-based births there was also an increase in pre and postnatal care provided by nurses and VON attendance at home confinements.

The increase in VON maternity cases during this period was integral to an active national campaign by Canadian health care workers to increase antenatal care as a means of reducing maternal and infant mortality rates.⁴³ The model of medicalization

³⁹ “Percentages of Live Births Hospitalized, by Province, 1931–61,” *Canada Year Book, 1963–64* (Ottawa: Roger Duhamel, Queen’s Printer, 1964), 229.

⁴⁰ LAC, Victorian Order of Nurses, MG 28 I 171, Vol. 6, Report of a Survey Made of the Activities of the Order in 1930 by Grant Fleming 1930, File 4; LAC, Victorian Order of Nurses, MG 28 I 171, Vol. 6, House of Commons Special Committee on Social Security, 1943, File 6.

⁴¹ LAC, Victorian Order of Nurses, MG 28 I 171, Vol. 6, Histories of Victorian Order of Nurses For Canada 1897–1967, File 1.

⁴² LAC, Victorian Order of Nurses, MG 28 I 171, Vol. 5, Histories of Victorian Order of Nurses For Canada Branches, File 45.

⁴³ The connection between the antenatal care and the campaign to reduce maternal mortality rates has been addressed in several Canadian studies; Comacchio, *Nations are Built of Babies*, 92–115; Heather MacDougall, *Activists and Advocates, Toronto’s Health Department, 1883–1983* (Toronto: Dundurn Press, 1990), 176–180; Mitchinson, *Giving*

promoted in Ontario argued for the primacy of the physician in healthcare services; however, physicians in Ontario and Canada, the Canadian federal government, and national organisations such as the Canadian Welfare Council (CWC) supported antenatal care, such as that offered by the VON, as a means of reducing infant and maternal mortality. In the mid-1920s the Department of Health, Division of Child Welfare, produced a study, the Report of the Mortality Enquiry, on the leading causes of maternal mortality in Canada.⁴⁴ The assessment of the 1925 maternal death rate showed there was a strong correlation with a lack of antenatal care and a high maternal death rate as “only 190 of the 1,532 dead Mothers had Pre-Natal Care.”⁴⁵ These studies, unlike those prepared by British counterparts such as the NBTF, argued for supervised pregnancy without advocating the use of obstetrical technology such as gas-air apparatuses. Safety, rather than medicalized childbirth practices or maternal comfort, was the goal. Improving this death rate was considered imperative as a means of supporting Canada as a nation.

Physicians showed an unwillingness to consider training nurses and midwives as primary medical providers during childbirth, but did highlight the medical and national importance of ensuring expectant mothers received care from professional nurses. As Grant Fleming, physician and public health activist, expressed in a 1930 survey: “The Victorian Order of Nurses has a moral obligation to bring its maternity service within

Birth in Canada, 119–158; Oppenheimer, “Childbirth in Ontario: The Transition from Home to Hospital in the Early Twentieth Century,” 36–60.

⁴⁴ Helen MacMurchy, *Maternal Mortality in Canada* (Ottawa: F.A. Acland Printer to the King’s Most Excellent Printer, 1928).

⁴⁵ Helen MacMurchy, *Mother: The Little Blue Books, National Series No. 3* (Ottawa: F.A. Acland Printer to the King’s Most Excellent Printer, 1928), 18.

reach of every Canadian mother.”⁴⁶ In 1936, the support for antenatal care, and Dr. Fleming’s stance on the obligation of the VON, were echoed in the *Times* statement of the mother’s centrality in Canadian national development.⁴⁷ As the *Times* was quoted in the preface to Dr. Helen MacMurchy’s *Canadian Mother’s Book*: “No national Service is greater or better than the work of the Mother in her own home. The Mother is ‘The First Servant of the State.’”⁴⁸ The mother’s national importance was such that she was supposed to be supported, not only by her family and community but by the entire nation: “Your husband and family and all Canadians realize that the Canadian Mother has too many labours and burdens, and we all went to help you. Tell us how. Do no very hard work, and if possible, do not work outside your own home for the last two or three months before the baby comes.”⁴⁹ Antenatal care, therefore, not only helped to reduce maternal mortality rates it supported Canada’s greatest national service.

As later chapters will show, this emphasis on nationalism was nowhere near as apparent in Britain and this ideological difference is part of why Ontario and Britain chose different models of medicalization. Nevertheless, the regulations of the CMB similarly viewed antenatal care as integral to a midwife’s services. The rules of conduct instructed that “the midwife must interview her patient at the earliest opportunity” and

⁴⁶ LAC, Victorian Order of Nurses, MG 28 I 171, Vol. 6, Report of a Survey Made of the Activities of the Order in 1930 by Grant Fleming, File 4.

⁴⁷ The foreword to the 1936 edition of *The Canadian Mother’s Book* does not specify whether it was written by the *Times* of London or the *New York Times*, but the lack of specification indicates that it was most likely the *Times* of London.

⁴⁸ Helen MacMurchy, *The Canadian Mother’s Book* (Ottawa: Department of National Health, Canada, 1936), preface by the *Times*.

⁴⁹ MacMurchy, *The Canadian Mother’s Book* (1936), 33.

keep notes of their antenatal visits.⁵⁰ The emphasis on nationalism was not the only distinction between Ontario and Britain. While both countries emphasised the importance of antenatal care as a means of reducing maternal mortality rates, the relevant discourses demonstrate markedly different opinions of the risks associated with pregnancy and motherhood. These differences are worth exploring as they help explain the divergent approaches to licensed medical professionals and the chosen models for medicalized pregnancy and childbirth.

Evidence suggests that the efforts of VO Nurses greatly improved conditions for Canadian mothers and contributed to reducing mortality rates, as the maternal death rate of VON cases was roughly half of the official national rate.⁵¹ By the late 1930s the effectiveness of VON obstetrical care was apparent:⁵²

Table 1: Victorian Order of Nurses, Maternal Death Rates

Maternal Death Rate			Neonatal Death Rate			VON Obstetric Cases	
Year	Dominion	Victorian Order	Year	Dominion	Victorian Order	Year	# of cases
1938	4.2	1.5	1938	32	19.45	1938	11,256
1939	4.2	2.0	1939	31	13.80	1939	17,308
1940	3.5	1.7	1940	30	13.90	1940	18,349
1941	3.5	1.3	1941	31	14.00	1941	19,281
1942	3.0	1.2	1942	28	11.00	1942	20,141

⁵⁰ TNA, Records of the Central Midwives Board, Central Midwives Board: Rules of Conduct, Eighth Edition (1926), Section E "Regulating, Supervising, and Restricting Within Due Limits the Practice of Midwives," DV 3/8.

⁵¹ LAC, Victorian Order of Nurses, MG 28 I 171, Vol. 6, House of Commons Special Committee on Social Security, 1943, File 6.

⁵² All figures for 1942 are tentative: LAC, Victorian Order of Nurses, MG 28 I 171, Vol. 6, House of Commons Special Committee on Social Security, File 6.

These statistics from the VON show the effectiveness of their maternal care in reducing the number of maternal and neonatal deaths. While campaigns to prevent maternal mortality peaked in the 1920s and early 1930s these figures from the late 1930s and early 1940s show that there was both a sustained benefit from VON care as well as an increase in mothers availing themselves of the VON's services.

In Ontario, the benefits of obstetrical care from Victorian Order Nurses were particularly striking due to the number of mothers they assisted. The benefits of antenatal care were not, however, limited to visiting nurses. Statistics from Toronto General Hospital show that the maternal mortality rate for mothers without antenatal care could be nearly nine times that of mothers with supervised pregnancies. In public wards where the women had no antenatal care, the maternal mortality rate was 35 per 1,000 births. In contrast, women on public wards who had supervised pregnancy and antenatal care only had a maternal mortality rate of 4 per 1,000 births.⁵³ Such statistics meant that women on public wards who had supervised pregnancies had half the maternal mortality rate of mothers in semi-private wards, which suggests that antenatal care had a greater effect on maternal mortality than did socioeconomic conditions.⁵⁴

Nursing manuals from the Victorian Order Nurses reflect this emphasis on the importance of maternal care throughout pregnancy, birth, and the beginning of the child's life. Nurses were told that "in no type of home visiting is the approach of the nurse to her patient of more important" than in antenatal visits and that "each case will

⁵³ LAC, Victorian Order of Nurses, MG 28 I 171, Vol. 6, Articles On and By the Victorian Order of Nurses For Canada, File 8.

⁵⁴ LAC, Victorian Order of Nurses, MG 28 I 171, Vol. 6, Articles On and By the Victorian Order of Nurses For Canada, File 8.

need individual consideration, and teaching must be practical and of such a nature as can be applied to the particular situation.”⁵⁵ Nurses in Ontario were also provided with detailed instructions on how to care for the expectant mother—and later the newborn—and guidelines for both home and hospital confinements. In these manuals many of the similarities between the Victorian Order of Nurses and British Certified Midwives become apparent. Although their position of authority in the prevailing models of medically supervised pregnancy and birth was strikingly different, the prescribed antenatal care was similar. Certified Midwives were instructed to conduct antenatal and postnatal visits in addition to caring for women during their confinement. During the postnatal visits the midwife was responsible for supervising the health of the mother and baby. As the 1928 edition of the *CMB Rules of Conduct* indicated,

The midwife shall personally supervise and be responsible for the cleanliness, comfort and proper dieting of the mother and child during the lying-in period, which shall be held, for the purpose of these regulations, and in a normal case, to mean the time occupied by labour and a period of ten days thereafter.⁵⁶

Victorian Order Nurses were prescribed similar protocols of care for mother and infant. Nurses were to bathe the baby and mother, ensure that proper infant feeding—preferably breastfeeding—was occurring, and generally supervise the wellbeing of both mother and child. On the eighth day of postnatal visits the nurse was to weigh the baby, and child welfare visits began when the child was twelve days old.⁵⁷

⁵⁵ LAC, Victorian Order of Nurses, MG 28 I 171, Vol. 6, Victorian Order of Nurses for Canada Nursing Manual First Edition (1925), File 21.

⁵⁶ The National Archives United Kingdom (TNA), Records of the Central Midwives Board, Central Midwives Board: Rules of Conduct, Tenth Edition (1928), Section E 12, DV 3/10.

⁵⁷ LAC, Victorian Order of Nurses, MG 28 I 171, Vol. 6, Victorian Order of Nurses for Canada Nursing Manual First Edition (1925), File 21.

The home visits from Victorian Order Nurses also helped to enforce the principles of scientific motherhood and, officially, the nurse was supposed to ensure that a physician was the supervising medical practitioner. The VON home visits also provided an opportunity to instil middle-class values of hygiene in mothers of a lower economic status. These values were reinforced with practical advice: mothers were offered advice on how to sterilize equipment and how to make hygienic pads for use as part of a home delivery.⁵⁸ In mothercraft classes offered by the VON, personal hygiene and home sanitation were considered two of the most important topics for nurses to cover during the lessons.⁵⁹ In keeping with public health objectives that emphasized the benefits of breastfeeding, mothers were expected to breastfeed their newborn. This emphasis on both sanitation and breastfeeding were medically important irrespective of the scientific motherhood movement, as one of the leading causes of infant mortality was gastrointestinal illness caused by contaminated infant formula and breastfeeding was encouraged on both sides of the Atlantic. The nursing manual for the VON also made breastfeeding part of the new mother's routine, and one to be supervised by the visiting nurse.⁶⁰ Thus the home nursing visits provided by the VON reinforced prevailing ideas about the need for medical supervision during pregnancy, childbirth, and

⁵⁸ LAC, Victorian Order of Nurses, MG 28 I 171, Vol. 6, Victorian Order of Nurses for Canada Nursing Manual First Edition (1925), File 21.

⁵⁹ LAC, Victorian Order of Nurses, MG 28 I 171, Vol. 6, Victorian Order of Nurses for Canada Nursing Manual First Edition (1925), File 21.

⁶⁰ While the benefits of breastfeeding were medically sound, the policies surrounding infant feeding were not always straightforward. The issue of promoted breastfeeding has been thoroughly addressed in Nathoo and Ostry's book: Tasnim Nathoo and Aleck Ostry, *The One Best Way? Breastfeeding History, Politics, and Policy in Canada* (Waterloo: Wilfrid Laurier University Press, 2009).

motherhood. The structure of the visits placed the physician in authority above the nurse, while also emphasising the mother's need for advice from healthcare professionals.

A key question of this study is 'what role did professionalization play in women's access to obstetrical care?' The establishment of certified midwifery in Britain and the redefinition of the midwife as a licensed medical professional makes it possible to argue for the midwives' valuable role in the medicalization of childbirth, and for their active participation in the medical profession. The twentieth-century midwife in Britain was a different professional than the nineteenth-century Nightingale nurse. In Ontario this question of the professional status of nurses is less contested. Professional nursing organizations such as the Victorian Order Nurses did not represent a stark break from the status of late nineteenth century nurses. Prior to the Nightingale reforms to nursing in the mid-nineteenth century, the status of nurses was not much greater than that of uncertified midwives, but by the early twentieth century these reforms were so firmly entrenched in Great Britain and North America that there was little question about the quality of care offered by nursing.⁶¹ Nevertheless nurses in Ontario were limited in their professional responsibilities and were not allowed to be fully autonomous in their work. They were also mostly excluded from the medical advancements available to midwives in Britain. In Ontario it is possible to see many cases where nurses *did* work

⁶¹ In the mid-nineteenth-century Nightingale reformed nursing by emphasising the importance of training and education. The Nightingale School of Nursing was opened in London 1860. See also: Stuart Wildman and Alistair Hewison, "Rediscovering a history of nursing management: From Nightingale to the modern matron," *International Journal of Nursing Studies* 46 (2009): 1650–1661.

autonomously due to the unavailability of, or lack of access to, a physician, but officially they were restricted in this capacity. While midwives occupied a different position in the medical profession, limitations on their practice make the transatlantic comparison of nurses and midwives viable. In Britain, midwives were officially permitted to work autonomously but were required to defer to physician in any case where there was an “abnormality or complication” with the pregnancy, labour and delivery, or baby.⁶² Understanding the freedoms awarded by and limitations of professionalization, which was in place in both models of medicalization, reveals nuances about the gendered aspects of professional hierarchies, and how both nurses and midwives pushed the limits of their autonomy in order to best assist their patients.

By the middle of the twentieth century, the Victorian Order of Nurses had asserted their professional status and established a clearly defined role in the Canadian medical profession. Home births had drastically declined by the late 1940s and early 1950s but, as I have argued, the decline in home births changed the nature of VON obstetrical care while also increasing the number of maternity cases supervised by VON Nurses. Their participation in antenatal and postnatal care for Canadian mothers was an integral part of the nurses’ work. In addition to home visits the VON established antenatal classes that included instruction on the stages of pregnancy, what to expect during delivery, and exercises and lifestyle choices to aid the pregnancy. These classes

⁶² TNA, Records of the Central Midwives Board, Central Midwives Board: Rules of Conduct, First Edition (1907), Section E “Regulating, Supervising, and Restricting Within Due Limits the Practice of Midwives,” DV 3/1.

attained a notable status for helping expectant mothers. As one Canadian mother recalled her experience of giving birth in the mid-twentieth century:

I truly feel sorry for the millions of mothers who have babies without knowing all the “whys” of the different stages of labor. I remember saying, “Is this transition?”, surprised it was so soon, pleased that I knew what it was. Had I not been told about it I would have been frightened by the sudden violence as the body begins to take over the person. “You’ve been to the V.O.N. classes, haven’t you?” the nurse asked. “We can always tell.”⁶³

This recollection of the antenatal classes provided by the VON also describes a camaraderie between expectant mothers and implies that the Nurses were helping to build community ties in addition to providing invaluable obstetrical guidance. As a 1946 report from the Brantford Branch of the VON indicates, “In the year 1915 the annual report records 216 confinements attended, in 1935 there were 151, and in 1946 only 33 were attended. Pre-natal and post-natal visits have greatly increased as had medical and surgical nursing, and health instruction visits.”⁶⁴ The increased rates of antenatal care throughout the first half of the twentieth century show that VON maternity care evolved to fit the needs of the community. Physician led medicalization in Ontario meant that, by the middle of the twentieth century, the nature of the nurse’s work had changed. Nurses, however, remained important as maternity nurses and complemented the physician dominated model of medicalization.

While this chapter has focused primarily on the similarities between nurses in Ontario and British midwives there is one distinction that had a significant influence on

⁶³ “Mine Was a V.O.N. Baby,” *V.O.N Quarterly*. Victorian Order of Nurses for Canada. Volume 8, No. 3, September, 1955.

⁶⁴ LAC, Victorian Order of Nurses, MG 28 I 171, Vol. 5, Historical Sketch 1907–1945, VON Brantford Branch, September 13th 1946, File 45.

the nature of their work: the relative populations and geographic areas of Ontario and Britain meant that Ontario nurses worked under vastly different conditions than was the case for British midwives. In 1911 the population of Ontario was 2,523,208 in contrast with the 36.1 million people who lived in England and Wales.⁶⁵ In comparing their largest cities, the population for all districts of Toronto in 1911 was 327,753, whereas the population of Inner London was 4,522,000; its population density was nearly twice that of Toronto. Furthermore, only Toronto, Ottawa, London, Hamilton, Kingston, and York South had higher population densities than the density of the entire countries of England and Wales—which indicates that even in urban areas the districts covered by midwives were physically larger in Ontario, and more sparsely settled, than in Britain.⁶⁶ Research on the history of medicine in Ontario has discussed the limited availability of physicians in sparsely populated, often remote, areas. As this project highlights, such variations in the population and population density of Ontario and England and Wales also had a notable influence on nursing and midwifery practices. Authorities in England and Wales acknowledged and attempted to address the difficulty maintaining the staffing of certified midwives in rural communities, as the sparse population meant that

⁶⁵ “Area and population of Canada by provinces and districts,” *The Canada Year Book, 1911* (Ottawa: C.H. Parmelee, Printer to the King’s Most Excellent Majesty, 1912), 4.

⁶⁶ In 1911 the population density of England and Wales was 618.49/mi². Toronto, Ottawa, London, Hamilton and Kingston all had vastly higher population densities than England and Wales, while York South had a slightly higher density at 624.13/mi². The average population density for York Centre, York North, and York South was only 251.41. “Area and population of Canada by provinces and districts,” *Canada Year Book, 4*.

it was difficult for midwives to earn a living wage.⁶⁷ The difficulties of providing medical care to rural and small communities in Ontario were exponentially worse. Regarding the broader question of the appropriate model for medically managed birth, these population statistics help to illustrate why unlicensed midwives continued to work in Ontario for much of the first half of the twentieth century—a significant number of women had no other option for obstetrical care. The number of cases available in areas of low population density also reveals some of the difficulties of visiting nurses, including those working in the relatively populated areas of Southwestern Ontario.

It was not possible for the structure of nursing care to be the same on either side of the Atlantic. In England and Wales the bicycle was the midwife's primary mode of transportation. Even in rural areas it was considered important that the midwife live close enough to her patients that she be able to attend confinements by bicycle, with a distance of no more than three miles being considered an acceptable commute for the midwife.⁶⁸ Such ambitions were simply impossible to realize in Ontario. Even in towns, the landscape of Ontario meant that visiting nurses often had to travel distances greater than three miles, which makes it unsurprising that bicycles were never discussed as an option for these nurses. In Britain, bicycles were an affordable mode of transportation available to midwives and visiting nurses, but visiting nurses in Ontario did not have access to such easy transportation. The distances faced by nurses such as those in the

⁶⁷ The National Archives (TNA), Ministry of Health, Grants for the training of Midwives, Health Visitors and Nurses – transfer of Administration from Board of Education, MH 55/235.

⁶⁸ Alice Reid, "Birth Attendants and Midwifery Practice in Early Twentieth-Century Derbyshire," *Social History of Medicine* Vol. 25, No. 2, (2012): 385.

VON meant that vehicular transport became a common consideration for visiting nurses. As early as 1910 records of Victorian Order Nurses branches discussed their use of automobiles or of using funds to purchase a new car.⁶⁹ In the 1930s, branches across Canada produced a series of cartoons depicting the life of a Victorian Order Nurse. All cartoons included a drawing of a car in a minimum of one frame.⁷⁰

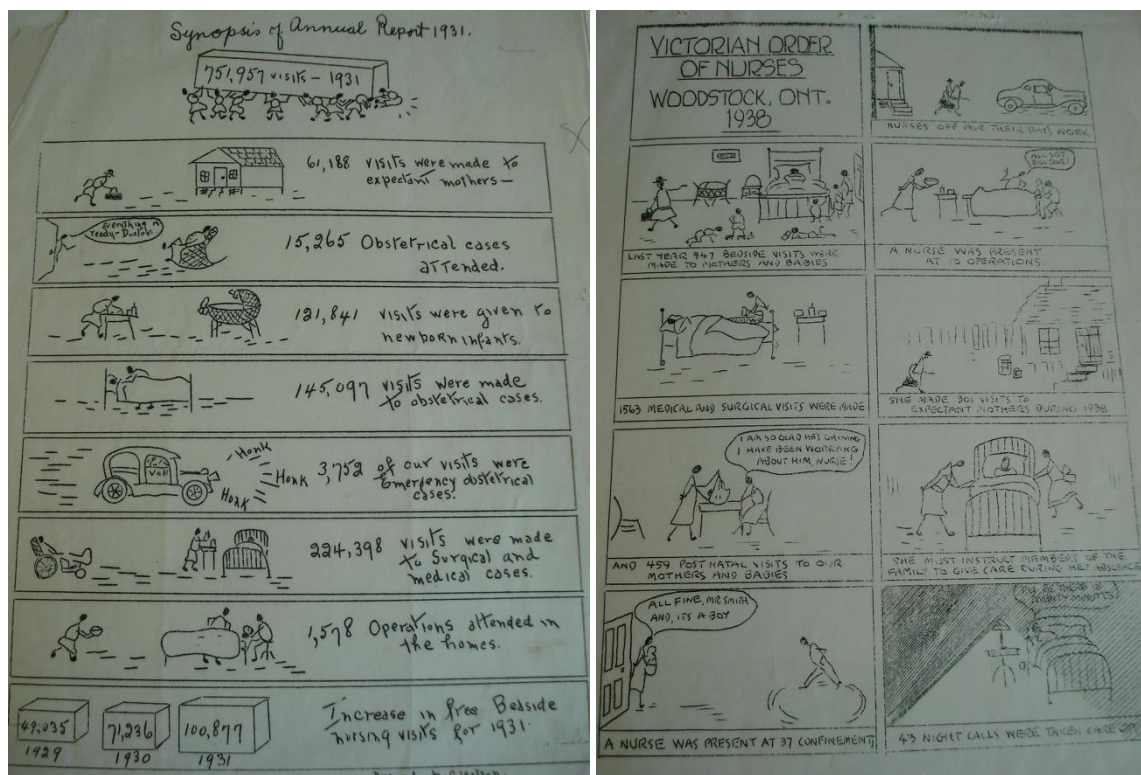


Figure 1: Victorian Order of Nurses, “Hour by Hour” (1931, 1938)

In 1938, Woodstock, Ontario, which had a population of 11,395 at the time of the 1931 census, the VON report used a car in the frame with the caption “nurses off to their day’s work,” suggesting that vehicles were a regular part of providing nursing

⁶⁹ LAC, Victorian Order of Nurses, MG 28 I 171, Vol. 6, Histories of the Victorian Order of Nurses For Canada 1897–1967, File 1.

⁷⁰ LAC, Victorian Order of Nurses, MG 28 I 171, Vol. 6, Articles On and By the Victorian Order of Nurses For Canada, File 8.

services.⁷¹ Similarly, a cartoon providing a synopsis for Victorian Order work across Canada in 1931 used an illustration of a car to accompany the statistic that 3,752 of their 751,957 visits for that year were for emergency obstetrical cases.⁷² Obstetrical care provided by Victorian Order Nurses in Ontario was very similar to that provided by trained midwives in Britain, but, as these figures show, there were significant variations based as much, if not more so, on physical geography as on professional differences. The expense of operating a vehicle and distance travelled to visit patients influenced the daily structure of nursing practice. As well as dictating aspects of nursing practice, the limitations of distance and population are indicative of the hurdles that many women in Ontario faced when trying to access medical assistance of any kind.

Recognising the commonalities and differences in the work of trained midwives in the British Isles and visiting nurses in Ontario highlights some of the factors that influenced the medical care available to parturient women on either side of the Atlantic. In both cases it was medically trained women, rather than physicians, that provided most of the antenatal and postnatal care to expectant mothers. While the status and expected role of the physician depended on the predominant model of medical care, in both systems women were the primary contact for expectant and new mothers. Nurses and midwives provided medical care in the home, and expressed their professional status in numerous ways including the publication of journals such as *The Canadian Nurse*, *Nursing Notes and Midwives' Chronicle*, and *Irish Nursing News*. The striking

⁷¹ "Live Births in Cities and Towns of 10,000 Population or Over, 1933–37," *The Canada Year Book 1939* (Ottawa: J.O. Patenaude, I.S.O. King's Printer, 1939), 119; LAC, Victorian Order of Nurses, MG 28 I 171, Vol. 6, Hour By Hour, File 10.

⁷² LAC, Victorian Order of Nurses, MG 28 I 171, Vol. 6, Hour By Hour, File 10.

difference, however, was that visiting nurses in Ontario received instruction in obstetrical nursing only as part of a general nursing education—perinatal care was central to their daily practice, but not an area in which they had specialised training. Midwives in the British Isles, on the other hand, often had general nursing certificates, but were not permitted to act as midwives or maternity nurses unless they had completed a certificate in midwifery training, which focused on the science and practice of obstetrics. The implications of these distinctions will become apparent in subsequent chapters on the regulation of midwifery and on the period’s advancements in obstetrical medicine and technology.

3 FROM “SAIREY GAMP” TO STATE CERTIFIED MIDWIFE: THE PROFESSIONALIZATION OF MIDWIFERY IN THE BRITISH ISLES

The professional organisation of nurses in Ontario reveals many facets of the gendered professional hierarchies in the medical field. In the previous chapter it was shown that visiting nurses in Ontario operated as the closest parallel to professional midwives in the British Isles. Although these nurses were not officially allowed to attend confinements without the supervision of a medical doctor, records show that they frequently attended women during childbirth without a supervising physician. The antenatal care offered by visiting nurses also closely paralleled the work done by licensed midwives and maternity nurses in Britain. This chapter focuses on the professionalization of midwifery and explores how professional hierarchies influenced midwives' practice.

In the British Isles, this legislative process occurred initially in England and Wales and later in Scotland, Ireland, and in corners of the Empire far from Great Britain. I endeavour to demonstrate how certified midwives in Great Britain and Ireland operated with relative autonomy despite the established professional limits. Although midwifery legislation in the United Kingdom and Ireland ensured that midwives were valued professionals and birth was not monopolised by physicians, this legislation did not exclude midwives from strict regulations imposed by physicians. In addition to training requirements and medical regulations, certified midwives were subjected to many of the same—and at times stricter—standards based on perceptions of appropriate behaviour for women. Midwives were professionals, but legislation governing their

practice and conduct show that the midwife was judged in relation to gender roles as well as on her professional competency.

The standards of conduct expected from midwives in the twentieth century demonstrate a marked break from the stereotypical nurse or midwife of the Victorian years. In 1843–1844 Charles Dickens published *Martin Chuzzlewit*, in which he introduced the character Sairey Gamp, a self-proclaimed midwife and monthly nurse—a nurse who attended parturient women and provided assistance for the first month following the birth. Mrs. Gamp came to represent nurses of this period:

She was a fat old woman, this Mrs. Gamp, with a husky voice and a moist eye, which she had a remarkable power of turning up, and only showing the white of it. Having very little neck, it cost her some trouble to look over herself, if one may say so, at those to whom she talked. She wore a very rusty black gown, rather the worse for snuff, and a shawl and bonnet to correspond...The face of Mrs. Gamp—the nose in particular—was somewhat red and swollen, and it was difficult to enjoy her society without becoming conscious of a smell of spirits. Like most persons who have attained to great eminence in their profession, she took to hers very kindly; insomuch that, setting aside her natural predilections as a woman, she went to a lying-in or a laying-out with equal zest and relish.¹

Sairey Gamp is emblematic of nineteenth-century concerns about midwives and nurses.² Prior to the substantive changes to nursing brought about by ‘modern’ nurses such as Florence Nightingale, the prevailing belief was that nurses and midwives were unclean, incompetent, and likely inebriate. Such views persisted until formal nursing

¹ Charles Dickens, *Martin Chuzzlewit* (Ware, Hertfordshire: Wordsworth Editions, 1997, Kobo Edition), chapter XIX.

² The parallels between Sairey Gamp and physicians’ views of nurses and midwives has been addressed in other works on the history of midwifery: Lucinda McRay Beier, *For Their Own Good: The Transformation of Working-Class Health Culture, 1880–1970* (Columbus: The Ohio State University Press, 2008); Heather Stanley, “Sairey Gamps, Feminine Nurses and Greedy Monopolists: Discourses of Gender and Professional Identity in the *Lancet* and the *British Medical Journal*,” *Canadian Bulletin of Medical History* 29, 1 (2012): 49–68.

training and the establishment of the Nightingale School of Nursing, founded 1860, ensured that nurses had a professional status warranted by their education and training.³ As Nightingale herself surmised, “midwives are so ignorant that it is almost a term of contempt.”⁴

Mid-nineteenth-century Canadian medical views presented the “meddlesome” midwife as posing a danger to the expectant mother and child due to her medical incompetence, very much in keeping with the Dickensian caricature.⁵ In Britain, the regulation of midwifery in the twentieth century was intended to ensure that midwives provided proper medical care from trained professionals and eliminate any associations with the fictional Sairey Gamp. Their conduct was expected to be markedly different from that of the slovenly Sairey Gamp: cleanliness, competence, and temperance were the three most cited concerns at the Central Midwives’ Board’s disciplinary hearings.

In Britain, three organisations were actively involved in the training, certification, and supervision of midwives: the Midwives’ Institute, the Central Midwives’ Board, and the Local Supervising Authority. Of these three, the Central Midwives’ Board (CMB) was

³ The significance of ‘Nightingale’ reforms is applicable in both Ontario and Britain. Nursing organisations such as the Victorian Order of Nurses were lauded for their use of trained nurses who displayed competence and embodied modern ideas of hygiene. Kathryn McPherson, *Bedside Matters: The Transformation of Canadian Nursing, 1900–1990* (Toronto: Oxford University Press, 1996); Christina Bates, Dianne Dodd, and Nicole Rousseau, eds., *On All Frontiers: Four Centuries of Canadian Nursing* (Ottawa: University of Ottawa Press, 2005); Stuart Wildman and Alistair Hewison, “Rediscovering a history of nursing management: From Nightingale to the modern matron,” *International Journal of Nursing Studies* 46 (2009): 1650–1661.

⁴ Florence Nightingale, “Appendix: Midwifery as a Career for Educated Women,” in *Nightingale on Women, Medicine, Midwifery and Prostitution*, ed. Lynn McDonald (Waterloo: Wilfrid Laurier University Press, 2005), 325.

⁵ Wendy Mitchinson, *The Nature of Their Bodies: Women and Their Doctors in Victorian Canada* (Toronto: University of Toronto Press, 1991), 164–65, 208.

by far the most active and influential. The CMB governed most aspects of trained midwifery and was responsible for the *Rules of Conduct*, for policies relating to the training of midwives, and for disciplinary hearings. Their work, however, was made possible by the efforts of the Midwives' Institute and Local Supervising Authorities (LSA). The Midwives' Institute was established in 1881, and incorporated in 1889, by writer Miss Louisa Maria Hubbard and midwife and nurse Mrs. Henry Smith (née Zepherina Veitch). Smith, a highly skilled nurse, was concerned about the lack of maternity care available to poor women; they could not afford the doctor's fee and the local midwives could not be relied on to provide adequate care. Smith approached Hubbard after reading her articles on "Nursing as a Profession for Educated Women."⁶ Hubbard's interest in the Midwives Institute, initially called the Matrons' Aid, or Trained Midwives Registration Society, stemmed from work as an advocate for women's education and employment. As the editor of the *Englishwoman's Year-Book*, the *Women's Gazette*, and *Work and Leisure*, Hubbard examined midwifery practices and professional status and was dismayed with her discovery:

She found that the majority of women calling themselves midwives then actually at work in Great Britain were not only untrained and inexperienced, but ignorant, superstitious, and often of very low character...This state of things seemed to her the more remarkable because she found that on the Continent [Europe] the calling of midwife was followed by trained and educated women whose title, being protected by Government, was looked upon as a feminine dignity, and commanded the highest sympathy and respect.⁷

⁶ Betty Cowell and David Wainwright, *Behind the Blue Door: The History of the Royal College of Midwives, 1881–1981* (London: Ballière Tindall, 1981), 12.

⁷ Edwin A. Pratt, *A Woman's Work for Women: Being the Aims, Efforts, and Aspirations of "L.M.H." (Miss Louisa M. Hubbard)* (London: George Newnes Limited, 1898), 82.

In light of these concerns, Hubbard began advocating for trained midwifery and the Committee of the Society for Promoting the Employment of Women supported the “movement for raising the efficiency and improving the status, social and moral, of midwives.”⁸ The Committee also provided the first temporary address for the Matrons’ Aid Society.

Although the institute originally consisted of only ten members, they launched an active campaign to establish compulsory registration of midwives. The Institute was instrumental in establishing legislation for regulated midwifery in England and Wales. Organisations for the advancement of women were influential in Britain, and the Midwives’ Institute’s efforts in the late nineteenth century were notable. Such important professional publications as the *British Medical Journal* frequently referred to the proposed Midwives’ Bill as “the Bill of the Midwives’ Institute.”⁹ The institute remained relevant following the passing of the 1902 *Midwives Act* and was actively involved in the training and examination regulations for midwives. Most notably, the Midwives’ Institute set the written examination for pupil midwives.¹⁰ In 1947, over sixty years after it was first established, the Matrons’ Aid, or Trained Midwives Registration Society/the Midwives’ Institute changed names again and became the Royal College of Midwives—which remains an important supervising authority for midwives in the twenty-first century.

⁸ Louisa Maria Hubbard, *Work and Leisure: The Englishwoman’s Advertiser, Reporter, and Gazette* (London: Strangeways and Sons, 1882), 14.

⁹ Cowell and Wainwright, *Behind the Blue Door*, 31.

¹⁰ “Midwives Institute and Trained Nurses’ Club,” *Nursing Notes* XIV (September 1901): 124.

In the early decades of the twentieth century, the other regulatory branch that was crucial in monitoring trained midwives in Britain was that of the Local Supervising Authorities (LSA). The LSA worked in counties across England and Wales and Scotland—an equivalent LSA operated in Saorstát Éireann following independence in 1922. Under Section 10 of the 1902 Act, midwives were not permitted to practice unless they had first notified the LSA that they were a certified midwife who intended to work in that district. Midwives were also required to give the LSA notice at the beginning of every year that they intended to practice:

Every woman certified under this Act shall, before holding herself out as a practising midwife or commencing to practise as a midwife in any area, give notice in writing of her intention so to do to the local supervising authority, or to the body to whom for the time being the powers and duties of the local supervising authority shall have been delegated under this Act, and shall give a like notice in the month of January every year thereafter during which she continues to practise in such area.

Such notice shall be given to the local supervising authority of the area within which such woman usually resides or carries on her practice, and the like notice shall be given to every other local supervising authority or delegated body within whose area such woman at any time practises or acts as a midwife, within forty-eight hours at the latest after she commences so to practise or act.¹¹

In England and Wales, the *Midwives Act* dictated that “every council of a county or county borough...shall, on the commencement of this Act, be the local supervising authority over midwives within the area of said county or county borough.”¹² While worded slightly differently, the *Midwives (Scotland) Act* similarly declared “the local

¹¹ The National Archives United Kingdom (TNA), Records of the Central Midwives Board, Central Midwives Board: Rules of Conduct, First Edition (1907), *Midwives Act* (1902), Section 10, DV 3/1.

¹² TNA, Records of the Central Midwives Board, Central Midwives Board: Rules of Conduct, Fourth Edition (1916), *Midwives Act* (1902), Section 8, DV 3/1.

authority of every district, in which this Act is operative, shall be the local supervising authority over midwives within such district.”¹³

In cases where midwives were charged with failing to adhere to the rules of the CMB, including Section 10 of the 1902 Act, it was the Local Supervising Authority’s responsibility to notify the Board of the midwife’s transgression. Similarly, in Saorstát Éireann, the Act dictated that “A local supervising authority shall investigate every charge of disobeying the rules of the Board or of other misconduct reported to them against a midwife practising in their district and if, consequent upon such investigation, they consider that there is a *prima facie* case against the midwife, they shall report to the Board accordingly.”¹⁴ In many cases the transgression included failure to provide the LSA with the correct forms and official notification in cases of births that fell outside the defined parameters of ‘normal birth.’ While the LSA was, for the most part, an aspect of the county council and had little authority in the discipline of midwives, they were responsible for the regular supervision of practice and also for communications with the CMB. The LSA was therefore instrumental in working with the Central Midwives’ Boards in the regulation of midwifery.

While the LSA was the midwife’s primary point of contact, the CMB was the national organisation responsible for the regulation of midwives. Established in 1903 to administer the 1902 *Midwives Act* for England and Wales, the powers of the Board did not extend to either Scotland or Ireland although comparable Boards were established

¹³ TNA, Records of the Central Midwives Board, Central Midwives Board: Rules of Conduct, Fourth Edition (1916), *Midwives Scotland Act* (1915), Section 16, DV 3/1.

¹⁴ Irish Statute Book, *Midwives Act* (1944), Section 33, <http://www.irishstatutebook.ie/1944/en/act/pub/0010/print.html>

under the *Midwives (Scotland) Act*, *Midwives (Ireland) Act*, and later the CMB Saorstát Éireann. Under Section 3 of the 1902 Act, the Board was to consist of nine appointed members: four registered medical practitioners, one each to be appointed by the Royal College of Physicians of London, the Royal College of Surgeons of England, the Society of Apothecaries, and the Incorporated Midwives' Institute. Five individuals, appointed for three year terms, did not have to be medical practitioners: two of these, one of whom was required to be a woman, were appointed by the Lord President of the Council, with the remaining three appointed one each by the Association of County Councils, the Queen Victoria's Jubilee Institute for Nurses, and the Royal British Nurses Association.¹⁵ Of these positions the appointment by the Incorporated Midwives' Institute is noteworthy. During the establishment of the Central Midwives' Board, the Midwives' Institute lobbied for representation on the Board:

The Midwives Bill affects three classes: the Public; Medical Men; and Midwives. The first, and by far the most important section, the public, have three representatives on the Central Board [Clause 4 (2)], medical men have three representatives [Clause 4 (1)]. As the Bill stands, Midwives have only one representative, who must be *a registered medical practitioner*, and the Midwives' Institute maintains that no legislation can be just that does not provide representation for a class whose interests will be specifically affected by the Act.¹⁶

The Institute's concerns about being represented on the Board indicate the gendered and professional hierarchies that affected the regulation of midwifery in England in spite of the strides achieved by its on-going professionalization.

¹⁵ TNA, Records of the Central Midwives Board, Central Midwives Board: Rules of Conduct, First Edition (1907), *Midwives Act* (1902), Section 3, DV 3/1.

¹⁶ "Reasons why the Midwives' Institute should be represented on the Central Board," *Nursing Notes* XV (April, 1902): 50.

As the governing body, the Central Midwives' Board defined the professional autonomy of midwives while closely regulating their training and practice. It supervised training institutions and the examination process by approving accreditation of training schools and setting the final exams for student midwives. The Board also established the rules governing midwifery practice, including the rules regarding their own proceedings and regulatory powers.¹⁷ All of these regulations regarding the training and practice of midwives, as well as the structure and authority of the Board, were established in the published *Rules of Conduct*. Local Supervising Authorities were required to notify the Board of any midwife who committed any "felony, misdemeanour, offence, act of disobedience of the rules and regulations, or other misconduct."¹⁸ Midwives charged with such offences were brought before the Central Midwives' Board's "Penal Cases Committee," which held special meetings to address penal cases against midwives.¹⁹ Under the rules of the Board, regular meetings were to be held on the last Thursday in each month, but "the Chairman may at any time convene a meeting of the Board."²⁰ Penal cases against midwives were always discussed at these additional "Special Board Meetings." Officially other business could also be discussed at a Special Board Meeting, but very few such meetings addressed any issues apart from penal cases against practicing midwives. The Special Board Meetings were attended by most, but not

¹⁷ TNA, Records of the Central Midwives Board, Central Midwives Board: Rules of Conduct, First Edition (1907), *Midwives Act* (1902), Section 3 I, DV 3/1.

¹⁸ TNA, Records of the Central Midwives Board, Central Midwives Board: Rules of Conduct, First Edition (1907), Section D.1 "Removal of a name from the roll," DV 3/1.

¹⁹ Records of the Central Midwives Board, Central Midwives Board: Rules of Conduct, First Edition (1907), Section D.1 "Removal of a name from the roll," DV 3/1.

²⁰ TNA, Records of the Central Midwives Board, Central Midwives Board: Rules of Conduct, First Edition (1907), Section A.4 "Meetings," DV 3/1.

necessarily all, Board members. The regulatory powers of the Board were also such that from the 1930s onwards the Board was responsible for overseeing legislation regarding a midwife's right to carry drugs, as well as the regulation of analgesics and analgesic technologies. Cumulatively, the regulatory powers of the Central Midwives' Board meant that both medical practice and the conduct of midwives were thoroughly controlled.

One of the principal roles of the Central Midwives' Board was in the accreditation and supervision of instructors and training institutions. In the training and certification of midwives some significant regional variations in Britain become apparent. In Britain, unlike Canada where health care is under provincial jurisdiction, the unitary system allowed for considerable influence by the CMB over all of England and Wales, and the CMB established by the *Midwives (Scotland) Act* and *Midwives (Ireland) Act* were similarly unitary and virtually identical to the CMB for England and Wales. The different legislative systems make it practical to compare that influence to medical authority in Ontario. In spite of the national health care system, the regional variations between England and Wales, Ireland, and Scotland, as well as regional variations within England and Wales, are worth addressing in terms of their effects for the training and regulation of midwifery.

The first *Midwives Act* (1902) was applicable in England and Wales and specifically stated "This Act shall not extend to Scotland or Ireland."²¹ Midwives were able to receive training at the Rotunda Hospital in Dublin, but in the Act's early years the

²¹ TNA, Records of the Central Midwives Board, Central Midwives Board: Rules of Conduct, First Edition (1907), *Midwives Act* (1902), Section 17, DV 3/1.

CMB's regulations imposed notable restrictions on the approved training institutions; the Nursing Certificate of the Irish Chartered Maternity Hospitals was not considered acceptable by the Central Midwives' Board in spite of the request from the President and the General Secretary of the Royal Academy of Medicine in Ireland. Although the President and General Secretary felt the training offered by the Chartered Maternity Hospitals was more than adequate, the Board's objection was that the Chartered Maternity Hospitals could not ensure that their pupil-midwives would attend enough patients "to comply with the Rules of the Board as to personal delivery of twenty cases and a ten days' puerperium."²² Furthermore, the recognition of the Rotunda hospital as a training institution for midwives was only granted after a statement from the Rotunda Hospital that the Rotunda was a leading school for the teaching of midwives in the United Kingdom, that the teaching at the Rotunda was at least as good as at any other lying-in hospital, that its training was longer than that provided by training hospitals in London, and that if, as proposed, the Bill applied only to England and Wales it would disqualify all Irish midwives from practising in those parts unless they passed an examination under the Central Midwives' Board on which it was not proposed to have an Irish representative.²³

Although the initial *Midwives Act* did not apply outside of England and Wales, in 1915 the *Midwives (Scotland) Act* was introduced, followed by the *Midwives (Ireland)*

²² TNA, Records of the Central Midwives Board, Central Midwives Board: Minutes, Board Minutes, February 25, 1904, DV 1/1.

²³ Mary A. Kelly, "The Development of Midwifery at the Rotunda: Part II: Lady Superintendents and Matrons of the Rotunda, 1891–1995," in *Masters, Midwives and Ladies-in-Waiting: The Rotunda Hospital 1745–1995* edited by Alan Browne (Dublin: A&A Farmar, 1995), 89.

Act in 1918.²⁴ These Acts were not fundamentally different from the *Midwives Act* governing England and Wales, yet they were the subject of extensive debates, especially in Scotland, as not all individuals were happy with the Bill's phrasing.²⁵ The requirements for certification and conduct of midwives were virtually identical, but there were some distinctions in the establishment of regulatory boards and accompanying regulations that were not connected to the midwives' practice. In Ireland, for example, the Act provided free emergency medical aid to mothers who otherwise did not qualify for free medical care.²⁶ In both Scotland and Ireland, the selection of members of the Central Midwives' Board differed from the CMB for England and Wales, and there were distinctions in their regulatory powers in spite of the similarities of the three Acts.²⁷

Following the establishment of the Irish Free State / Saorstát Éireann in 1922, the Central Midwives Board of Ireland became the Central Midwives Board for the Irish Free State. Midwifery in Northern Ireland, meanwhile, was regulated under the Joint Nursing and Midwives Board of Northern Ireland. This political separation gave the Irish Free State / Saorstát Éireann indisputable autonomy in their own jurisdictions, although,

²⁴ TNA, Records of the Central Midwives Board, Central Midwives Board: Rules of Conduct, Fourth Edition (1916), *Midwives (Scotland) Act* (1915), DV 3/4; TNA, Records of the Central Midwives Board, Central Midwives Board: Rules of Conduct, Sixth Edition (1921), *Midwives (Ireland) Act* (1918), DV 3/6.

²⁵ "Midwife Notes: Midwives (Scotland) Bill," *Nursing Notes* (September, 1914), 258.

²⁶ Lindsey Earner-Byrne, *Mother and child: Maternity and child welfare in Dublin, 1922–60* (Manchester: University of Manchester Press, 2007), 11.

²⁷ TNA, Records of the Central Midwives Board, Central Midwives Board: Rules of Conduct, First Edition (1907), *Midwives Act* (1902), DV 3/1; Rules of Conduct, Fourth Edition (1916), *Midwives (Scotland) Act* (1915), DV 3/4; Rules of Conduct, Sixth Edition (1921), *Midwives (Ireland) Act* (1918), DV 3/6.

as was the case in Canada, until the Statute of Westminster in 1931 established sovereignty for Britain's commonwealth members, the British government continued to significantly influence the governance of Saorstát Éireann. In spite of the initial separation in 1922 and a further legislative split in 1931, there remained a great deal of interaction between the CMB for England and Wales and the CMB Saorstát Éireann. The two countries maintained more reciprocity agreements than was the case with other commonwealth countries; unsurprisingly, given the original connections, concerns about midwifery in Saorstát Éireann were more often in the records of the CMB for England and Wales than was the case for other commonwealth countries.²⁸ Most correspondence the Board received surrounding reciprocity or reduced training were usually sent by individual midwives, but the CMB Saorstát Éireann corresponded with the CMB for England and Wales regarding any proposed changes to their rules that may "prevent reciprocity between England and the Irish Free State."²⁹ The formation of separate midwives' boards was practical, as it meant authorities in each country could have a voice on the Board in spite of location. The separate Boards also allowed closer

²⁸ Most Board meetings included a list of midwives who were added to the Roll for England and Wales after providing proof that they held "a certificate of having passed the Examination of the Central Midwives' Board for Scotland or the Central Midwives Board for Ireland." TNA, Records of the Central Midwives Board, Central Midwives Board: Minutes (1922–1949), DV 1/10–DV 1/17.

²⁹ In the five years following the establishment of the Irish Free State, the CMB for England and Wales discussed reciprocity and training of Irish midwives on several occasions. In contrast the only discussions about midwifery in commonwealth countries were a few issues regarding CMB training in India and one request from New Zealand from a midwife looking to sit the CMB exam without additional training. TNA, Records of the Central Midwives Board, Central Midwives Board: Minutes (1922–1927), June 26, 1924; May 7, 1925; September 25, 1925; December 2, 1926, DV 1/10–DV 1/12.

interaction with the Local Supervising Authorities, which acknowledged regional differences in a midwife's practice—even while under the same regulatory framework.

Arguably similar distinctions existed within Ontario as the province included, amongst other communities, urban centres in South-Western Ontario; Mennonite communities, particularly in Waterloo Region; Aboriginal settlements in Northern Ontario; and Franco-Ontarians, especially around Sault Ste. Marie and the eastern part of the province.³⁰ The Central Midwives Board differed from the Ontario health care authorities in the response to such diversity. Whereas Ontario medical laws outlawed midwifery everywhere in the province regardless of regional variations, British laws and midwifery regulations in Ireland reflected regional needs. To this end, the Board established regulations allowing the practice of midwifery throughout the empire.

The imperial influence was such that, during the period considered here, the Central Midwives Board was responsible for monitoring the training and registration of

³⁰ Several Canadian authors have discussed the connections between region and maternity care in Ontario in the twentieth century: Marlene Epp, "Midwife-Healers in Canadian Mennonite Immigrant Communities: Women who 'made things right,'" *Histoire Sociale/Social History* 40 (November 2007): 323–344; Marlene Epp, "Catching Babies and Delivering the Dead: Midwives and Undertakers in Mennonite Settlement Communities," in Myra Rutherdale (ed.) *Caregiving on the Periphery: Historical Perspectives on Nursing and Midwifery in Canada* (Montreal & Kingston: McGill-Queen's University Press, 2010), 61–83; Georgina Feldberg, "On the Cutting Edge: Science and Obstetrical Practice in a Women's Hospital, 1945–1960," in Georgina Feldberg, Molly-Ladd-Taylor, Alison Li, and Kathryn McPherson (eds), *Women, Health, and Nation* (Montreal & Kingston: McGill-Queen's University Press, 2003), 123–143; Sheryl Nestel, "The Boundaries of Professional Belonging: How Race has Shaped the Re-emergence of Midwifery in Ontario," in Ivy Lynn Bourgeault, Cecilia Benoit, and Robbie Davis-Floyd, *Reconceiving Midwifery* (Montreal & Kingston: McGill-Queen's University Press, 2004), 287–305; Judith Bender Zelmanovits, "'Midwife Preferred': Maternity Care in Outpost Nursing Stations in Northern Canada, 1945–1988," in *Women, Health, and Nation*, 161–188.

midwives in such distant locations as India and Hong Kong. Records of training institutions from this time show that pupil midwives in these areas were completing training and sitting the CMB examinations, and indeed there were several approved training locations within India.³¹ Even within England and Wales the Board acknowledged regional diversity as a number of Welsh midwives did not speak enough English to complete the examination in English—training was offered in Welsh in some institutions in Wales as many individuals in Wales spoke Welsh as their first or only language.³² To accommodate the language barrier, in 1906 the Board began providing interpreters for midwives wishing to complete the examination in Welsh.³³ Similar accommodations were not made for Irish Gaelic speakers for two key reasons. Most importantly, at the turn of the century, only 14 per cent of the population spoke Irish and less than 1 per cent of the population were monolingual Irish-speakers.³⁴ Linguistic accommodations were simply unnecessary. Furthermore, although the Gaelic Revival was strong at this time, the Gaelic League was closely tied to Irish Nationalism and not supported by England. Through the establishment of separate national Boards within

³¹ The first training institution in India was the Government Maternity Hospital in Madras in 1907. Over the decades the Board approved several other institutions in India as well as a couple in Hong Kong. TNA, Records of the Central Midwives Board, Central Midwives Board, Minutes, October 4, 1906, DV 1/2.

³² At the turn of the century the “Welsh speaking core,” areas of Wales where over 88 per cent of the population spoke Welsh, was dominant. W.T.R. Pryce, “Language Zones, Demographic Changes, and the Welsh Culture Area 1800–1911,” in *The Welsh Language and its Social Domains, 1801–1911*, ed. Geraint H. Jenkins (Cardiff: University of Wales, 2000), 69.

³³ TNA, Records of the Central Midwives Board, Central Midwives Board, Minutes, July 26, 1906, DV 1/2.

³⁴ Timothy G. McMahon, *Grand Opportunity: The Gaelic Revival and Irish Society, 1893–1910* (New York: Syracuse University Press, 2000), 14.

the United Kingdom, the accommodations for monolingual Welsh midwives, and the establishment of training institutions in Hong Kong and India, the CMB established a unified system of professional midwifery in spite of substantial regional variations. The recognition of widespread regional variation also highlights the regulatory powers of the Board; by 1920 the Board was responsible for 45,000 midwives and three *Midwives Acts*, spanning six countries across four continents.³⁵

As well as this international presence under its own authority, the Central Midwives Board engaged in reciprocal agreements with midwifery and nursing associations in some commonwealth countries. As early as 1911 the Board received communication from the Deputy Registrar of Nurses and Midwives, New Zealand, asking the Board “to admit to the Roll women holding the State Midwifery Certificate of New Zealand, or alternately to recognise training schools in the Dominion,” as well as similar communication from “Sister Henrietta of St Michael’s Home,” in Kimberly, Cape Colony, South Africa.³⁶ At that time the Board replied that it had “no power to grant reciprocal terms of treatment to women holding midwifery certificates in other parts of His Majesty’s dominions,” but also expressed a willingness to reconsider the issue if a law was passed that would allow the Board to grant reciprocal terms.³⁷ In 1922 the question of reciprocal agreements with New Zealand arose again. At that time the Registrar of

³⁵ TNA, Records of the Central Midwives Board, Central Midwives Board: Midwives Roll, Central Midwives Board: The Midwives Roll. Aaron to Zwilling (1920), DV 7/18.

³⁶ TNA, Records of the Central Midwives Board, Central Midwives Board: Minutes, Board Minutes, March 23, 1911, DV 1/4.

³⁷ TNA, Records of the Central Midwives Board, Central Midwives Board: Minutes, Board Minutes, March 23, 1911, DV 1/4.

Midwives, New Zealand, wrote to the Board offering that, on the condition of a reciprocal agreement, he was willing to concede:

The midwives trained outside institutions and registered on that training by the Board, might, on production of proof of after residency and work in an approved maternity training school for the term needed as equivalent to that required under the New Zealand Act, be accepted for registration, and that, failing such additional experience, they might make up the time in the Dominion and sit for the State Examination.³⁸

Section 10 of the 1918 *Midwives Act* for England and Wales prevented the Central Midwives' Board from entering any such reciprocal agreement, but the Board did state that it was "quite willing to recognise the training undergone by midwives registered in New Zealand, and will not require any such midwives as may wish to sit for the Board's Examination to undergo further training."³⁹

While this was not the reciprocal agreement sought by health authorities in New Zealand, it did show the Board's willingness to recognise the training of midwives offered in some commonwealth countries. Finally, in 1933, a reciprocal agreement was arranged between the two countries so that British certified midwives could sit the Board examination in New Zealand, and vice versa, without undergoing further training.⁴⁰ Only a small percentage of midwives achieved certification following training in another country, but these numbers were not insignificant. By the end of the Second World War, 3,880 out of 71,857 certified midwives had been awarded certification

³⁸ TNA, Records of the Central Midwives Board, Central Midwives Board: Minutes, Board Minutes, October 12, 1922, DV 1/10.

³⁹ TNA, Records of the Central Midwives Board, Central Midwives Board: Minutes, Board Minutes, October 12, 1922, DV 1/10.

⁴⁰ TNA, Records of the Central Midwives Board, Central Midwives Board: Minutes, Board Minutes, March 2, 1933, DV 1/13.

following training in a colonial institution or “by Reason of the Possession of the Certificate of the Central Midwives Board for Scotland, or the Joint Nursing and Midwives Council for Northern Ireland, the Central Midwives Board, Eire, or one of the Australian or New Zealand Nurses’ Boards, Gained After Examination by one of those Bodies.”⁴¹

As these discussions of reciprocal training agreements suggest, the training of midwives was a key part of the CMB’s function. Midwives had training options that included institutions and private instruction. The length of the training programme, requirements for qualification, and examinations were, however, all monitored by the Board. The CMB was similarly responsible for granting individuals and institutions the right to provide training for pupil midwives so that they could sit the Board examinations. Initially very few institutions achieved such accreditation. The 1902 *Midwives Act* for England and Wales only recognised four official training institutions “the Royal College of Physicians of Ireland, or from the Obstetrical Society of London, or the Coombe Lying-in Hospital and Guinness’s Dispensary, or the Rotunda Hospital for the Relief of the Poor Lying-in Women of Dublin,” with the caveat allowing for other certificates approved by the Board.⁴² Throughout the early decades of the twentieth century, the number of approved training institutions increased rapidly. By the time the third *Midwives Act* was passed in 1936, there were 176 approved institutions and instructors across England and Wales, as well as further institutions in Scotland and

⁴¹ TNA, Records of the Central Midwives Board, Central Midwives Board: Midwives Roll. Central Midwives Board: The Midwives Roll, Aanesen to Zipfel (1946), DV 7/47.

⁴² TNA, Records of the Central Midwives Board, Central Midwives Board: Rules of Conduct, First Edition (1907), *Midwives Act* (1902), Section 2, DV 3/1.

Ireland governed by their respective Boards. Perhaps unsurprisingly, there was a congregation of centres in urban areas. Of these 176 institutions, 40 were in London, 132 were in England excluding London, and 4 were in Wales. Even in Wales institutions were predominantly in urban centres and 3 of 4 training institutions were located in Cardiff—the largest city in Wales.⁴³

In addition to their responsibilities in the regulation of institutions and instructors, the Central Midwives Board paid close attention to pupil midwives sitting examinations and tracked the number of midwives sitting exams at different centres as well as the failure rate of examinations. As there were many training centres and a high frequency of exams the number of pupils from each training school was often very low with only one or two pupils sitting the examination. Cumulatively, however, several thousand pupils attempted the examination each year. A breakdown of examination results from 1924–25 illustrates the distribution of examination results:⁴⁴

⁴³ “List of Institutions, Homes and Midwives at Which, and Under Whom, Pupil Midwives May be Trained Under the Rules of the Central Midwives Board,” TNA, Ministry of Health: Health Divisions: Public Health Services, Examination of reports: consideration of grants for training of midwives, MH 55/670.

⁴⁴ The training of midwives in Poor Law Institutions was permitted for the training of their own officers but did not have a notable impact on the supply of midwives in ordinary practice. “Training of Midwives, Mr. George Newman,” TNA, Ministry of Health: Health Divisions: Public Health Services, Grants for the training of midwives, health visitors and nurses: transfer of Administration from board of education, MH 55/236.

Table 2: Central Midwives' Board Examinations

Exam Date	Training School	Total	Passed	Failed	% of Failures
February 2nd, 1925	Non-Poor Law	480	383	97	20.2
	Poor Law	118	91	27	22.9
	Grand Total	598	474	124	20.7
April 1st, 1925	Non-Poor Law	477	367	110	23
	Poor Law	128	89	39	30.5
	Grand Total	605	456	149	24.6
June 3rd, 1925	Non-Poor Law	539	433	106	19.7
	Poor Law	158	123	35	22.2
	Grand Total	697	556	141	20.2
August 4th, 1925	Non-Poor Law	442	331	111	25.1
	Poor Law	122	101	21	17.2
	Grand Total	564	432	132	23.4
October 1st, 1925	Non-Poor Law	512	398	114	22.3
	Poor Law	96	81	15	15.6
	Grand Total	608	479	129	21.2
December 1st 1925	Non-Poor Law	486	397	89	18.3
	Poor Law	142	114	28	19.7
	Grand Total	628	511	117	18.6
Total 1925	Non-Poor Law	2936	2309	627	21.4
	Poor Law	764	599	165	21.6
	Grand Total	3700	2908	792	21.4

These figures do include training institutions in Ireland, India, and places with agreements such as Melbourne, but do not account for the many instructors or institutions that were accredited but did not have enough pupils to be represented at every examination.

The training and examination of midwives was established as part of the 1902 *Midwives Act*. Under the initial regulations there were no entrance examinations for

women seeking admittance to a training programme, but it was felt that “steps should be taken to secure that the students admitted are likely, from their character and previous education, to profit by the training and instruction given.”⁴⁵ Any woman wishing to practice midwifery also needed to provide a certificate of birth or baptism showing that she was “not under twenty-one years of age, and, where the candidate has been married, the certificate of marriage also.”⁴⁶ In this respect, the requirements for trained midwives mirrored those of bonâ fide midwives: untrained midwives were permitted to practice as certified midwives if they “had been for at least one year in bonâ fide practice as a midwife,” as character was assessed as a prerequisite to formal training.⁴⁷ Changes to training regulations throughout the first half of the twentieth century indicate the inclusion of midwives in medicalized birth. As birthing practices evolved to include more medical science and technology, and an associated professional status, midwives were required to complete additional training. Initially midwives underwent three months of training before they were permitted to sit the Board examinations, but by July 1916 the requirements increased to a minimum of six months

⁴⁵ “Board of Education: Draft Regulations for the Training of Midwives,” TNA, Ministry of Health: Health Divisions: Public Health Services, Grants for the training of midwives, health visitors and nurses: transfer of Administration from board of education, MH 55/236.

⁴⁶ The Rules of Conduct did not stipulate a maximum age for midwives, and midwives would continue to practice until they applied to have their name removed from the Roll on the grounds specified as old age. TNA, Records of the Central Midwives Board, Central Midwives Board: Rules of Conduct, First Edition (1907), Section B, 1 (a), DV 3/1; TNA, Records of the Central Midwives Board, Central Midwives Board: Minutes, DV 1..

⁴⁷ TNA, Records of the Central Midwives Board, Central Midwives Board: Rules of Conduct, First Edition (1907), *Midwives Act* (1902), Section 2, DV 3/1.

of training.⁴⁸ As midwives gained more medical autonomy, the Board eventually decided to increase the mandatory training period to twelve months in order to provide education in subject areas such as ante- and postnatal care and the management of ophthalmia neonatorum, which is conjunctivitis caused by passage through the vagina of a mother who has chlamydia or gonorrhoea.⁴⁹

Although mandatory training did increase to 12 months, there was a period when training institutions offered the option of either a 6 or 12-month course. By the mid-1930s most pupils were opting for the 12-month course, but this was by no means universal. While training was increasing to promote the midwife's inclusion in medically managed birth, the nature of the profession was such that not all student midwives elected to complete optional training. A list of voluntary institutions approved by the Ministry of Health shows that, from 1935 to 1936, 324 pupils were in a 12-month training programme while 258 were in a 6-month programme.⁵⁰ The distribution of 6 and 12-month programmes was not, however, equal and the ratio of pupils enrolled in 6 or 12-month programmes varied greatly from institution to institution. There is not an apparent regional explanation for the variation, and it is likely that individual institutions influenced enrolment patterns. For example, at the Gloucester District Nursing Society there was only 1 pupil in a 12-month course whereas there were 14 in a 6-month

⁴⁸ "Training of Midwives, Mr. George Newman," TNA, Ministry of Health: Health Divisions: Public Health Services, Grants for the training of midwives, health visitors and nurses: transfer of Administration from board of education, MH 55/236.

⁴⁹ Janet Campbell, *The Training of Midwives* (Ministry of Health, London, Published by His Majesty's Stationery Office, 1923), 2, 15.

⁵⁰ "List of Institutions in England for the Training of Midwives recognized by the Ministry of Health," TNA, Ministry of Health: Health Divisions: Public Health Services, Examination of reports: consideration of grants for training of midwives, MH 55/670.

course. Conversely, at Plaistow Maternity Hospital in East London there were 94 pupils enrolled in a 12-month programme while only 1 pupil was in the 6-month course.⁵¹ Such figures help to highlight the variations in midwifery training during the early years of the Act.

During the first two decades of the twentieth century, education fees also influenced access to training programmes. In these initial years of the Act, pupil midwives were required to pay for their own training as well as board and lodgings during the training.⁵² Changes to the training requirements, the implementation of the 1918 *Midwives Act* for England and Wales, and the transfer of medical education from the Board of Education to the Ministry of Health, however, prompted discussions on training grants for midwives that were similar to the funding for probationer nurses.⁵³ Initial training grants—which were first awarded in 1919—were provided to institutions for midwives at a rate of £20 per student per 4, 6, or 12 month course, which was expected to provide for their maintenance as well as tuition.⁵⁴ It was also possible for midwives to apply for a grant to assist in the associated costs of training and beginning their practice “the items which may be included in this part of the application are the

⁵¹ “List of Institutions in England for the Training of Midwives recognized by the Ministry of Health,” TNA, Ministry of Health: Health Divisions: Public Health Services, Examination of reports: consideration of grants for training of midwives, MH 55/670.

⁵² Campbell, *The Training of Midwives*, 16.

⁵³ Such training grants were not unusual in countries that supported trained midwives. As the Canadian study from the mid-1930s shows, the Netherlands also subsidised the salaries of midwives in rural areas as staffing rural areas with limited patients was a problem in most countries. *Need our mothers die?: a study made by a special committee of the division on maternal and child hygiene* (Council House, Ottawa: Canadian Welfare Council, December 1935), 75.

⁵⁴ TNA, Ministry of Health, Grants for the training of Midwives, Health Visitors and Nurses – transfer of Administration from Board of Education, MH 55/235.

expenses of starting the new Association and of obtaining and equipping the midwife—including for the present cost of training, where a trained midwife cannot be obtained without paying the expenditure on training—bicycle, maternity bag, uniform, etc.”⁵⁵

In the early 1920s grants for the training of midwives ran to the figure of about £10,000–£13,000 per year. For the 1920–21 fiscal year the expenditure for training grants was £10,004 and 7,064 names were added to the Midwives Roll.⁵⁶ These figures suggest that, of the 7,064 newly registered midwives, only 500 could have received training grants. The deficit in grants was particularly apparent in rural areas, where there was a shortage of midwives, a problem exacerbated by the fact that “no [rural] midwife can make a living on this work only” and limited access to training or start-up grants did little to increase the number of licensed midwives in rural areas.⁵⁷

Consequently many communities had a serious shortage of trained midwives. In 1923, out of 11,814 parishes across England, 4,367 had no trained midwives and 3,560 were

⁵⁵ “Grant in aid of Midwifery,” TNA, Ministry of Health: Health Divisions: Public Health Services, Grants for the training of midwives, health visitors and nurses: transfer of Administration from board of education, MH 55/236.

⁵⁶ TNA, Ministry of Health, Grants for the training of Midwives, Health Visitors and Nurses – transfer of Administration from Board of Education, MH 55/235; TNA, Records of the Central Midwives Board, The Midwives Roll, Aanensen to Zwilling (1922), DV 7/20.

⁵⁷ The question of salaries for midwives in rural areas was a common concern in many countries establishing state supervised midwifery and income subsidies were a common topic of conversation. In the Netherlands, midwives in rural districts were sometimes paid “a public subsidy to bring her income from private cases up to a minimum fixed by the State.” *Need our mothers die?: a study made by a special committee of the division on maternal and child hygiene* (Council House, Ottawa: Canadian Welfare Council, December 1935), 75; TNA, Ministry of Health, Grants for the training of Midwives, Health Visitors and Nurses – transfer of Administration from Board of Education, MH 55/235.

“entirely unprovided.”⁵⁸ This shortage of midwives was unevenly distributed amongst the counties. Hertfordshire had 130 parishes and all of them had trained midwives. Yorkshire, East Riding, on the other hand, had 324 parishes, 312 of which had no trained midwives and 179 of which were “entirely unprovided.”⁵⁹ Many communities in Northern England faced similar shortages.

The need for licensed midwives in remote areas suggests the benefits of including midwives in medicalized birth. Areas that were “entirely unprovided” also had less access to the newest medical training and technology, and along with a dearth of midwives, Yorkshire had the highest rates of maternal mortality in England in the mid 1920s.⁶⁰ High maternal mortality rates prevailed in many communities in Northern England, where the midwife shortage was acute. There was a known connection between trained midwives and improved maternal health. Health officials concerned with staffing communities with trained midwives also noted the need to ensure that all communities had access to trained midwives. The rural areas where midwives were unlikely to earn a living wage without assistance were “very often exactly those in which their presence is most necessary from the poverty, and (in some cases) the sparseness of the population.”⁶¹ Grants for midwives were therefore essential to achieving improvements in maternal and infant safety.

⁵⁸ Campbell, *The Training of Midwives*, 42–43.

⁵⁹ Campbell, *The Training of Midwives*, 43.

⁶⁰ Janet Campbell, *Maternal Mortality* (Ministry of Health, London: Published by His Majesty’s Stationery Office, 1924), 14.

⁶¹ TNA, Records of the Central Midwives Board, minutes, Board Minutes, March 19, 1908, DV 1/3.

While there was a recognised need for training grants, these grants were often insufficient: there were not enough grants available and the sum offered was inadequate. As noted, the funding for grants meant that only a very small percentage of pupils could receive assistance. At the same time, the funding of training grants was but part of the annual expenditures in the training and supervision of midwifery. In addition to the costs of a midwife's training and accommodation during the 6 or 12-month programme, the Board was responsible for examiners' fees for the bi-monthly examinations. The physicians who graded the examinations received an examiner's fee of approximately £9–£16; in 1920, the Board's annual expense for examiners' fees amounted to £3,330.⁶² Given the extensive costs of training and certification, training grants were a financial concern in spite of their clear need in the interests of improved midwifery care in many communities.

One of the Board's significant challenges in the implementation of training grants was the fact that not all midwives who received them would take up midwifery practice. In the early 1930s an analysis of training grants showed that "the proportion of certified midwives stated to be in practice is 25%, while of the total number who pass the examination in each year the proportion subsidised by us on the footing that they intend to practice is also approximately 25%."⁶³ While these figures suggested that the Ministry was not funding more pupils than would practice, there was no guarantee that midwives who received the grants would register as practising midwives. The Ministry of

⁶² TNA, Records of the Central Midwives Board, Central Midwives Board: Minutes, Board Minutes (1920–1922), DV 1/9.

⁶³ TNA, Ministry of Health: Health Divisions: Public Health Services, Examination of reports: consideration of grants for training of midwives, MH 55/670.

Health therefore felt it was necessary to change the rulings so that pupil midwives would make a firmer commitment to future midwifery practice. This commitment was also intended to ensure that grants serviced rural areas: the Ministry aimed to “cut out the person who does not seriously intend to practise and who probably drifts to the urban areas or to nursing appointments.”⁶⁴

Following the completion of an approved training course, midwives had to pass an examination which was overseen by the Central Midwives’ Board. The written examination was set by the Midwives’ Institute for the CMB and the CMB administered the examination and tested pupil midwives on their understanding of pregnancy and how to deal with potential complications during labour and delivery. For the examination pupil midwives were required to answer six questions covering pregnancy, delivery, and potential complications, and each examination was three hours long.⁶⁵ The language used in the examination is indicative of the medical knowledge expected from the midwife: her place in medicalization was such that she was supposed to understand medical treatment during pregnancy and birth. Sample examinations from the first decade of professional midwifery included questions such as:

- How can you tell that a baby is premature?
- What special treatment is necessary for a baby born six weeks before full time?
- If you have to attend to a woman in her confinement who during a former lying-in became insane, but has since recovered, to what points would you pay special attention in advising her?

⁶⁴ TNA, Ministry of Health: Health Divisions: Public Health Services, Examination of reports: consideration of grants for training of midwives, MH 55/670.

⁶⁵ RCOG, Records of the Royal College of Midwives, Examination papers of the CMB, RCM/E4/1/2.

- What is the usual cause of Ophthalmia Neonatorum? What would you do to prevent it?
- What is meant by the terms—(a) presentation of the cord, (b) prolapse of the cord? What are the dangers of each? And how would you treat them till the doctor arrives?⁶⁶

Following the establishment of the Irish Midwives' Board, examinations set by the CMB Saorstat Eireann were in the same format, with similar questions.⁶⁷

Once midwives had completed the training and examination requirements set by the Central Midwives' Board, they were required to register with the CMB, notify their Local Supervising Authority (LSA) of their intent to practice, and adhere to the *Rules of Conduct*. Throughout the first half of the twentieth century, the *Rules of Conduct* for midwives were published every few years and provided a comprehensive overview of both the rules for daily practice, and also the requirements for registration, intent to practice, and forms notifying the Local Supervising Authority.⁶⁸ Early editions of rules "Regulating, Supervising, and Restricting Within Due Limits the Practice of Midwives," provided minimal regulations in comparison to later editions and also addressed a different type of midwife than was prevalent by the mid-twentieth-century. The first edition, published in 1907, contained only twenty-six rules regulating and supervising

⁶⁶ Royal College of Obstetricians and Gynaecologists (RCOG), Records of the Royal College of Midwives, Examination papers for pupil midwives, RCM/E4/1/1; Examination papers of the CMB, RCM/E4/1/2.

⁶⁷ Catholic Nursing Guild, "Central Midwives Board for Ireland: Examination Paper," *Irish Nursing News*, January 1928, 41.

⁶⁸ The first edition of the *Rules of Conduct* was not published until 1907. The rules contained within the first edition, however, were made available to midwives when the Act came into place on April 1st 1903. As well as informal publications midwives could find both the regulations and extensive explanation of the rule in monthly articles in *Nursing Notes*. *Nursing Notes* XVIII (1905).

the midwifery practices.⁶⁹ These regulations were largely restricted to issues of disinfection and the correct procedure for patient contact. In addition to outlining practices for disinfection, there was more emphasis on appropriate attire for a midwife: “She must wear a dress of washable material, and over it a clean apron,” than on proper procedure during childbirth.⁷⁰ Early twentieth-century certified midwives were expected to be clean birthing assistants versed in modern hygiene, and also to defer to medical authority for all cases outside of the narrowly defined realm of normal birth. These standards fit both the prevailing birthing practices and training available for midwives in the early years of the twentieth century.

The early editions of the Rules of Conduct indicate both the level of training a midwife received and the general requirements for a woman intending to practice midwifery in England or Wales. The first *Midwives Act* presented two avenues for women who wished to obtain the status of “certified midwife” so as to practice midwifery “habitually and for gain.” As mentioned in the discussion on training courses, women could be certified if they held a certificate from the Obstetrical Society of London, the Royal College of Physicians of Ireland, Coombe Lying-in hospital, the Rotunda Hospital, or any certificate in midwifery approved by the Central Midwives Board.⁷¹ Such training was not, however, required under the first (1902) or second (1918) *Midwives Act* for England and Wales. It was also possible to obtain the status of

⁶⁹ TNA, Records of the Central Midwives Board, Central Midwives Board: Rules of Conduct, First Edition (1907), Section E, DV 3/1.

⁷⁰ TNA, Records of the Central Midwives Board, Central Midwives Board: Rules of Conduct, First Edition (1907), Section E, DV 3/1.

⁷¹ TNA, Records of the Central Midwives Board, Central Midwives Board: Rules of Conduct, First Edition (1907), *Midwives Act* (1902), Section 2, DV 3/1.

certified midwife if a woman were to produce “evidence, satisfactory to the Board, that at the passing of this Act she had been for at least one year in bonâ fide practice as a midwife, and that she bears a good character.”⁷² This character had to be proven with a Certificate of Moral Character, which “had to be signed by a Justice of the Peace, a minister of religion or a registered medical practitioner” and “it was hoped that this was some guarantee.” Later penal cases show that the certificate was not a sure-fire guarantee of good character.⁷³

Records of the Central Midwives’ Board frequently refer to cases where a practising, untrained, midwife had written to the Board seeking certification. While the contents of most of these letters are unknown, surviving excerpts suggest that the Board was satisfied if there was evidence of the midwife’s competency. In 1904, a Mrs. R. Haytree was certified following a letter to the Board indicating that “she had not undertaken cases without doctors, but had been advised by a medical man that she need not be afraid to do so, and added that she herself did not feel in any way afraid of so acting.”⁷⁴ Mrs. Haytree was but one of many women who contacted the Board in the first decade of professionalization seeking certification without official training. At the time their presented credentials were approved, but later penal cases show authorities passing negative judgement on those who were not part of the trained medicalized profession.

⁷² TNA, Records of the Central Midwives Board, Central Midwives Board: Rules of Conduct, First Edition (1907), *Midwives Act* (1902), Section 2, DV 3/1.

⁷³ “Certificate of Moral Character,” *Nursing Notes* XXII (March, 1909), 49.

⁷⁴ TNA, Records of the Central Midwives Board, Central Midwives Board: Minutes, Board Minutes, March 24, 1904, DV 1/1.

These records also show that, in the early years of certification, many midwives were certified as bonâ fide midwives rather than trained midwives. In 1907, there were 24,338 midwives registered on the Midwives Roll. Of these approximately 90 per cent were bonâ fide midwives and only 2,406, or roughly ten per cent, were listed “in virtue of having passed the Examination of the Central Midwives Board.”⁷⁵ By the passing of the 1918 *Midwives Act* the percentage of trained midwives had increased fivefold, but untrained midwives still accounted for forty-five per cent of the 43,886 certified midwives.⁷⁶ It is also worth noting that the persistence of untrained midwives was not merely a carryover from the high percentage of untrained midwives in early years of the Act. Not only did bonâ fide midwives account for nearly half of all registered midwives in 1918, of the 11,449 midwives who notified the Board of their intent to practice in 1917, 6,896 had completed training programs and 5,553 were bonâ fide midwives who intended to practice.⁷⁷ It is important to note that the distribution of trained and untrained midwives was unequal across the country, and, once again, Northern communities were less likely to be served by trained midwives. In Derbyshire, statistics from 1909–1913 show a sharp incline in the percentage of all births attended by trained midwives, 9.7 per cent to 23.5 per cent, but during the same period the percentage of all births attended by untrained midwives also increased minutely from 47.9 per cent to

⁷⁵ TNA, Records of the Central Midwives Board, Central Midwives Board: Midwives Roll. Central Midwives Board: The Midwives Roll, Aaron to Zwirn (1907), DV 7/5.

⁷⁶ TNA, Central Midwives Board: Midwives Roll. Central Midwives Board: The Midwives Roll, Aaron to Zwilling (1918), DV 7/16.

⁷⁷ TNA, Central Midwives Board: Midwives Roll. Central Midwives Board: The Midwives Roll, Aaron to Zwilling (1918), DV 7/16.

51.4 per cent.⁷⁸ In 1923, 94 of Derbyshire's 276 civil parishes were without trained midwives, and 79 were entirely unprovided for.⁷⁹ Similar patterns can be seen across the Northern communities. Studies have found that, in 1920, 80 per cent of births nationwide were attended by trained midwives, but in the Northern towns of Lancaster and Preston, less than half of all births were so attended—Lancaster 46 per cent, Preston 47 per cent.⁸⁰ At the end of the second decade of the twentieth century, nearly half of all practising midwives in the United Kingdom were still untrained or *bonâ fide* midwives, but in some communities the rates were much higher. Such statistics are important because they illustrate that the inclusion of midwives in medicalized childbirth was an active decision and not an automatic response to legislation.

Professionalization of midwifery did not immediately equate to formally trained midwives. *Bonâ fide* midwives were untrained even though they were deemed competent and qualified. In addition to trained midwives and *bonâ fide* midwives, unqualified, working-class midwives, commonly known as “handywomen” worked in many areas for much of the first half of the twentieth century.⁸¹ While *bonâ fide* midwives were regulated even though they were untrained, handywomen were both untrained and unregulated. Officially the regulations of the CMB dictated that handywomen were only permitted to attend parturient women under the supervision of

⁷⁸ Loudon, *Death in Childbirth*, 209.

⁷⁹ Campbell, *The Training of Midwives*, 42–43.

⁸⁰ Beier, *For Their Own Good*, 279.

⁸¹ The term “handywoman” appeared often in journal articles about the practice of untrained midwives and physicians who assisted these women. “Uncertified Practice,” *Nursing Notes XXV* (May 1912): 130.

a medical doctor, but in many such cases handywomen were the primary attendant.⁸²

As Campbell noted in her 1923 publication, the British medical profession recognized that the co-operation between physicians and handywomen was a problem:

It is unfortunately true that certain medical practitioners are willing to work with handy-women as midwifery assistants. The patient engages a doctor and a handy-woman and in some cases the doctor agrees to accept a low fee, it being well understood that he will not be called on to deliver the patient except in case of emergency.⁸³

The actions of such physicians were seen as lowering the standard of medical care offered to expectant mothers. Even while the *Midwives Act* permitted handywomen, the co-operation between handywomen and physicians was generally disapproved of by trained midwives and the medical profession. The General Medical Council (GMC) held disciplinary hearings, much like the CMB's Penal Sessions, to discuss the actions of physicians who were accused of "covering" uncertified midwives by enabling them to practice as if they were certified.⁸⁴ The ways physicians benefited from this arrangement—albeit unethically—was different from the grudging tolerance that Ontario physicians had for nurses or untrained women practicing midwifery.

In light of these concerns about uncertified midwives, the 1936 *Midwives Act* removed provisions that granted handywomen any right to work as midwives. This change to the Act was intended to enhance maternal and infant welfare, but the ruling had negative repercussions in some working-class communities. During the early decades of the century, rural and working-class communities were often served by bonâ

⁸² Alice Reid, "Birth Attendants and Midwifery Practice in Early Twentieth-Century Derbyshire," *Social History of Medicine* Vol. 25, No. 2 (2012): 381.

⁸³ Campbell, *The Training of Midwives*, 34.

⁸⁴ "Covering Uncertified Practice," *Nursing Notes* XXIX (July, 1916), 156.

fide midwives rather than trained midwives. The number of bonâ fide midwives, however, decreased as women retired or ceased practicing, and in many rural communities there was difficulty replacing them with trained midwives.⁸⁵ This problem was exacerbated by the significant decrease in untrained midwives: by 1935, untrained midwives represented only 537 of the 15,442 midwives who notified the Board of their intent to practice.⁸⁶ The efforts to medicalize childbirth through the inclusion of trained midwives were assisted by the reduction in untrained midwives and the high percentage of trained practising midwives indicates expanding professionalization—a change that is also reflected in the rules of the Board.⁸⁷

There were, however, also repercussions to this shift. As British physician and senior medical officer to the Ministry of Health Dame Janet Campbell addressed the issue in a 1923 report on the training of midwives:

The gradual elimination of the less competent midwife and, as one hopes, of the handy woman, might leave many poor women who are unable to pay reasonable fees entirely unprovided for. A considerable increase might then be necessary in

⁸⁵ “Maternal Mortality in Connection With Child-Bearing,” *Nursing Notes* XXIX (January 1916), 9.

⁸⁶ TNA, Central Midwives Board: Midwives Roll. Central Midwives Board: The Midwives Roll, Aanensen to Zoutendyk (1935), DV 7/35.

⁸⁷ Only a small percentage of women on the Midwives’ Board notified the Board of their intent to practice in any given year. There were 43,886 names on the Midwives Roll for 1918, but only about one quarter of these women, 11,449, notified the Board of their intent to practice. During the first half of the twentieth century the number of registered midwives increased far more rapidly than the number of practising midwives. In 1935 there were 64,280 names on the Roll, but only 16,648 intended to practice. By 1946 the gap had grown wider still and only 16,680 out of 71,857 certified midwives notified the Board of their intent to practice. The majority of the remaining names were nurses who wished to have certification in midwifery but did not intend to practice midwifery as her primary profession. TNA, Central Midwives Board: Midwives Roll. Central Midwives Board: The Midwives Roll, (1918) DV 7/16; (1935) DV 7/35; (1946) DV 7/47.

the partially or wholly subsidised midwifery service in the urban and rural districts in order that adequate attendance could be obtained at low fees by those in need of it.⁸⁸

While the changes to the 1936 Act were intended for maternal safety, they had only a limited effect in most areas, while also posing some problems. In working-class communities, handywomen were often preferred by mothers due to their familiarity and affordability: until the 1930s, they were often deliberately chosen over physicians or trained midwives.⁸⁹ In such communities, both the promotion of trained midwives by the Medical Officers of Health (MOsH) and the continued personal preference for *bonâ fide* midwives and handywomen reveal the socioeconomic outcomes of professionalization. The MOsH wished to remove the ‘old-fashioned’ midwife who was popular in working-class communities and replace her with a younger, trained, midwife—regardless of the valued community connections with the ‘old-fashioned’ midwife.⁹⁰ This conflict between community desires in working-class areas and official attempts to change childbirth practices influenced the early regulation of midwifery.⁹¹

⁸⁸ Campbell, *The Training of Midwives*, 18.

⁸⁹ Lycinda McCray Beier, “Expertise and Control: Childbearing in Three Twentieth-Century Working-Class Lancashire Communities,” *Bulletin of the History of Medicine* 78 2 (Summer 2004): 400.

⁹⁰ Lucinda McCray Beier, *For Their Own Good: The Transformation of English Working-class Health Culture, 1880–1970* (Columbus: Ohio State University Press, 2008), 86.

⁹¹ This desire to replace ‘old-fashioned’ midwives with younger women trained to follow and promote the health department’s objectives was not unique to Britain. Fraser’s study of African American midwifery in Virginia highlights the movement to replace midwives who had “old beliefs and practices” with younger women who were considered more intelligent. Gertrude Jacinta Fraser, *African American Midwifery in the South: Dialogues of Birth, Race, and Memory* (Cambridge, Massachusetts: Harvard University Press, 1998), 108.

The inclusion of untrained handywomen in the early decades of the Act suggests both acknowledgement of the experience midwives gained without formal training and a perception that the midwife should not work autonomously. Midwives were required to notify the family to call a physician in any scenario other than a “normal” childbirth. Thus midwives were only permitted to work autonomously in cases of uncomplicated birth. In the early years of professional midwifery, this definition of uncomplicated childbirth was very narrow, obliging midwives to notify physicians in many instances.⁹² By the mid-1930s there were many changes to the section of the rules regarding “Sending For Medical Aid.” There were more listed reasons for a midwife to contact a physician than in the first edition of the rules, but these reasons also reflected new definitions of uncomplicated birth and new understanding of a midwife’s medical competence. The 1907 *Rules of Conduct* required a midwife to send for medical assistance in cases such as excessive sickness during pregnancy, a purulent discharge during labour, excessive bleeding during labour, or abdominal swelling and tenderness during the lying-in period.⁹³ Many of these reasons were still cited in the 1935 edition of the *Rules of Conduct*, but new editions also included more specific medical concerns such as albumin in the urine, reflecting advances in obstetrics and medical testing during

⁹² Under the first edition of the *Rules of Conduct* a midwife was required to send for medical help “in all cases of abortion, of illness of the patient or child, or of any abnormality occurring during pregnancy, labour, or lying-in, a midwife must explain that the case is one in which the attendance of a registered medical practitioner is required, and must hand to the husband or the nearest relative or friend present the form of sending for medical help.” TNA, Records of the Central Midwives Board, Central Midwives Board: Rules of Conduct, First Edition (1907), Section E 18, DV 3/1.

⁹³ TNA, Records of the Central Midwives Board, Central Midwives Board: Rules of Conduct, First Edition (1907), Section E 19, DV 3/1.

these years.⁹⁴ Likewise, midwives were expected to pay closer attention to detail when identifying patient problems. For example, in 1907 midwives observing a patient during the lying-in period were expected to call a physician if there was a rise of temperature above 100.4°F for more than twenty-four hours.⁹⁵ By the 1930s they were expected to observe this rise in temperature, but also call a physician if there was “a rise of temperature above 99.4°F on three successive days.”⁹⁶ The changes to regulations reflected the fact that midwives were being allowed greater access to medication, and had more medical training than earlier professional midwives. Consequently, while they were still required to notify a physician in many cases, the definition of what treatment was within a midwife’s province had expanded to allow them, overall, greater autonomy as medical professionals.

Changes to the rules “Regulating, Supervising, and Restricting Within Due Limits the Practice of Midwives” reflect the increasingly medicalized and autonomous midwifery practice. These changes consisted predominantly of an increase in regulations that reflect overarching ideas of medicalization and the professionalization of medicine. As the establishment of regulations was overseen by the medical practitioners on the Central Midwives’ Board, these changes were approved by medical professionals. While all of the original stipulations regarding cleanliness and patient contact remained, many of these were rewritten in greater detail. There were also new rules reflecting the

⁹⁴ TNA, Records of the Central Midwives Board, Central Midwives Board: Rules of Conduct, Twelfth edition (1935), Section E 12, DV 3/12.

⁹⁵ TNA, Records of the Central Midwives Board, Central Midwives Board: Rules of Conduct, First Edition (1907), Section E 19, DV 3/1.

⁹⁶ TNA, Records of the Central Midwives Board, Central Midwives Board: Rules of Conduct, Twelfth edition (1935), Section E 12, DV 3/12.

expanding medical training of pupil midwives. In 1950, two years after the introduction of the *National Health Services Act*, the seventh edition of the *Rules of Conduct* was published. The culmination of changes throughout the first half of the twentieth century was such that, by the seventh edition, midwifery practice had expanded but was also increasingly defined, to the point that there were now 61 rules in place for practising midwives—a noticeable increase from the original 26.

More than just the sheer number of rules, the newer regulations were written to clearly define the midwife as a qualified member of the medical profession, professionally distinct from the hygienic birthing assistant of the early years of professionalization. The most notable change was the definition of duties and associated title. Early editions simply addressed “the practice of midwifery.” By the late 1940s, the regulations were subdivided into five categories addressing four distinct employment positions. These new regulations were applicable to all midwives. There were also rules for midwives working in domiciliary practice, with separate regulations for midwives practising as such and midwives acting as maternity nurses.⁹⁷ Midwives acting as such in institutions had separate rules depending on whether they were practising in an institution with a resident medical officer, and with fifteen maternity

⁹⁷ The rules of the CMB defined a maternity nurse as a midwife who “in any maternity case, is acting under the direct and personal supervision of a registered medical practitioner,” when the medical practitioner was engaged to deliver the patient and was responsible for the case throughout the entire lying-in period. TNA, Records of the Central Midwives Board, Central Midwives Board: Rules of Conduct, Twentieth Edition (1950), Section E, Part III, 20 “Regulating, Supervising, and Restricting Within Due Limits the Practice of Midwives,” DV 3/20.

beds or more.⁹⁸ Finally, there were also specific regulations for “Midwives acting as maternity nurses in an institution (including a nursing home) which does not fulfil the requirements of Part IV of Section E” regarding maternity beds and the resident medical officer.⁹⁹ Many of the rules overlapped categories. Regardless whether the midwife was working as such or as a maternity nurse, or whether she was working in an institution or in domiciliary practice, the rules of conduct were concerned with many of the same basic aspects of midwifery practice: registration of cases and preservation of records; treatment outside a midwife’s scope of practice; situations where a midwife was permitted to lay out a dead body; communication with medical practitioners; and general regulations about disinfection and the practicalities of midwifery.¹⁰⁰

These regulations for midwives were the basis of penal cases against midwives.

Beginning in 1907—the same year as the first edition of *Rules of Conduct* was published—the CMB’s Penal Cases Committee regularly held “Special Board Meetings”

⁹⁸ TNA, Records of the Central Midwives Board, Central Midwives Board: Rules of Conduct, Twentieth Edition (1950), Section E, Parts IV and V, “Regulating, Supervising, and Restricting Within Due Limits the Practice of Midwives,” DV 3/20.

⁹⁹ TNA, Records of the Central Midwives Board, Central Midwives Board: Rules of Conduct, Twentieth Edition (1950), Section E, Part VI, “Regulating, Supervising, and Restricting Within Due Limits the Practice of Midwives,” DV 3/20.

¹⁰⁰ Under the rules of the CMB midwives were only permitted to lay out the body if she had been in attendance and if she had been present in the capacity of midwife, maternity nurse, or nurse. Historically unregistered midwives were sometimes called upon to lay out the dead body of community members, and not only patients, a practice that was common amongst unregistered midwives in both Canada and Britain. TNA, Records of the Central Midwives Board, Central Midwives Board: Rules of Conduct, Twentieth Edition (1950), Section E, “Regulating, Supervising, and Restricting Within Due Limits the Practice of Midwives,” DV 3/20; Marlene Epp, “Catching Babies and Delivering the Dead: Midwives and Undertakers in Mennonite Settlement Communities,” in *Caregiving on the Periphery: Historical Perspectives on Nursing and Midwifery in Canada*, edited by Myra Rutherford (Montreal & Kingston: McGill-Queen’s University Press, 2010), 61–83.

to address charges against midwives.¹⁰¹ Local Supervising Authorities were responsible for notifying the Board of any alleged misdemeanours by midwives in their district. Throughout the 1910s and 1920s these meetings were generally held a minimum of once a month, but by the 1930s the frequency of meetings had dropped drastically. At the Special Board Meetings the midwife's transgressions were outlined to the Board members, who then deliberated and determined an appropriate resolution; in all but a few cases the midwife was either cautioned, censured, severely censured, or had her name struck from the Roll and her certificate cancelled. The midwife was permitted to be in attendance and/or to have a representative on her behalf, but in the vast majority of cases neither the midwife nor a representative were present.¹⁰² There is some evidence that a midwife could receive a lesser penalty if she and her representative attended the hearing, but this was far from guaranteed and many women attended hearings only to have their names removed from the Midwives Roll and their certificates cancelled.

Throughout the 1910s and 1920s over one hundred cases were brought before the Board each year. While some midwives only faced a single charge, most faced a

¹⁰¹ TNA, Records of the Central Midwives Board, Central Midwives Board: Minutes, Board Minutes (1905–1907), (1907–1909), DV 1/2–DV 1/3.

¹⁰² In most cases, especially if the charges were proved, the midwife was required to pay her own travel expenses if she appeared before the Board; however, the 1918 Act allowed that "The Central Midwives' Board may, if they think fit, pay all or any part of the expenses incurred by any midwife who may be required to appear before them in her own defence." TNA, Records of the Central Midwives Board, Central Midwives Board: Rules of Conduct, Sixth Edition (1921), Midwives Act (1918), Section 7(1), DV 3/6.

hearing for either multiple offences or multiple violations of the same rule.¹⁰³ Many of these cases were for offences relating to midwifery practice: failure to call a physician; failure to adhere to regulations regarding cleanliness and disinfection; failure to keep a proper case book; failure to understand the use of a clinical thermometer and/or failure to take the patient's temperature, and other similar transgressions. While not a part of medical malpractice, specifically during childbirth, midwives who provided women with drugs to procure abortions were similarly charged.¹⁰⁴

In addition to these cases, however, women were brought before the Board for charges that were not as immediately connected to medical competence. Midwives who displayed drunkenness, either while on duty or in their everyday lives, were also liable to be charged. Women who were found guilty of non-medical criminal offences also faced subsequent hearings with the CMB. Of the criminal offences committed by midwives, larceny and theft were by far the most common. Most charges related to minor theft, such as can be seen in the 1925 case involving Alice Maud Turner of London. Turner had been sentenced to three months' imprisonment for "stealing 1 fur, 1 box of chocolates, 4 tablets of soap and other articles, value together £1 16s. 5½d.,

¹⁰³ The minutes from the Special Board Meetings unfortunately do not include any record of the midwife's defence or revealing details. Some of these details are likely available in the CMB's Penal Board Case files, but the files are closed for 75 years and I was unable to access them during my research.

¹⁰⁴ There were twenty-five instances of women facing charges for providing drugs to procure an abortion throughout this period. Assisting a mother with an abortion was one of the offences that, when proven, resulted in the midwife losing her status as a state certified midwife. TNA, Records of the Central Midwives Board, Central Midwives Board: Minutes, Board Minutes 1905–1951, DV 1/2–DV 1/17.

the property of Bon Marché Limited.”¹⁰⁵ But the Board also convened to discuss cases of women who had been charged with prostitution or running a brothel, and even such violent crimes as manslaughter and murder.¹⁰⁶ While the CMB minutes do not reveal many details, they do offer a glimpse at the offence and sentencing for such crimes. One Martha Waldron of Liverpool had her certificate cancelled by the CMB after being imprisoned for six months for “keeping a bawdy house”; unfortunately there is no further description of the charges.¹⁰⁷ In some cases the name of the victim was provided, such as the 1918 charges against Florence Annie Parkes of Exeter who was convicted at the Assizes “for the manslaughter of Alfred Leonard Lee and sentenced to six months imprisonment.”¹⁰⁸ Unless special circumstances could be proven, in every case involving a criminal charge the Board voted to remove the midwife’s name from the roll and cancel her certificate.

The one criminal offence more closely related to midwifery, while not a particularly common charge, involved midwives brought before the Board for assisting a woman in the procurement of an abortion—usually by providing abortifacient drugs.

¹⁰⁵ TNA, Records of the Central Midwives Board, Central Midwives Board: Minutes, Board Minutes February 5, 1925, DV 1/11.

¹⁰⁶ During the first half of the twentieth century eighty-two women were brought before the board for criminal charges unrelated to midwifery, medical care, or childcare: 61 had been charged with larceny, theft, fraud, or embezzlement; 3 faced manslaughter charges; 5 were charged for offences relating to prostitution; 4 had been arrested for assault (including one case where the midwife assaulted a police constable); and 9 had committed public misdemeanours such as indecent exposure, libel, or drink driving. TNA, Records of the Central Midwives Board, Central Midwives Board: Minutes, Board Minutes 1905–1951, DV 1/2–DV 1/17.

¹⁰⁷ TNA, Records of the Central Midwives Board, Central Midwives Board: Minutes, Board Minutes May 4, 1939, DV 1/15.

¹⁰⁸ TNA, Records of the Central Midwives Board, Central Midwives Board: Minutes, Board Minutes March 20, 1918, DV 1/8.

The rules of the Central Midwives Board firmly stated that midwives were forbidden from helping to procure an abortion under the umbrella legislation that dictated that midwives who committed any felony would have their name removed from the Midwives Roll and their certificate cancelled.¹⁰⁹ What makes the issue in Britain complex is that the very existence of the Central Midwives Board and the Local Supervising Authority meant that midwives who were acting as abortionists were usually discovered and brought before the Board. As such, while circumstantial evidence suggested that self-proclaimed midwives in Ontario also worked as abortionists, in Britain, their licensing and continued supervision allow for statistical evidence.¹¹⁰ Midwives did provide women with assistance in procuring an abortion, but the small number of cases brought before the Central Midwives' Board suggest that either this was not a common occurrence or the midwives who assisted with abortions escaped detection. In the fifty-year period examined here, only twenty-nine cases related to induced abortions were brought before the Board.¹¹¹ Given the thousands of practising midwives in England and Wales, the number of midwives accused of abortion is very low. Even allowing for the possibility that many cases of abortion went unreported, these statistics show that the Board dealt with many more cases relating to the morality and behaviour of midwives than it did abortion cases.

¹⁰⁹ TNA, Records of the Central Midwives Board, Central Midwives Board: Rules of Conduct, First Edition (1907), Section D "Rules of Procedure on the Removal of a Name From The Roll, and on the Restoration to The Roll of a Name Removed," DV 3/1.

¹¹⁰ Angus McLaren and Arlene Tigar McLaren, *The Bedroom and the State: The Changing Practices and Politics of Contraception and Abortion in Canada, 1880–1980* (Toronto: McClelland and Stewart, 1986).

¹¹¹ TNA, Records of the Central Midwives Board, Central Midwives Board: Minutes, Board Minutes (1902–1951), DV 1/1–DV 1/17.

There were also charges that were entirely unrelated to a woman's ability to act as a competent assistant in childbirth. During the first half of the twentieth century, twenty-one women were brought before the Board after being accused of giving birth to an "illegitimate"¹¹² child, and a further twenty-one women were accused of moral misconduct in the form of adultery or cohabiting with a man who was not her husband.¹¹³ These figures mean that nearly twice as many women were accused of immorality than were accused of helping to procure an abortion. Of these forty-two cases of moral misconduct, only eight did not result in the midwife having her name removed from the roll and certificate cancelled. Of the eight midwives not removed from the roll, the charges were not proved in two cases, unspecified special circumstances were allowed for in two cases, dismissed in one as there was no live birth, and postponed for reassessment in two cases.¹¹⁴ In 1936 Mabel Clark—who was in attendance at the hearing and accompanied by a Barrister-at-law—was found guilty of committing adultery with two men, but no further action was taken in the case. Of all 42 cases related to extra marital affairs hers was the only one where the case was

¹¹² Until the *Legitimacy Act, 1926*, any child born to unmarried parents could not be receive "legitimation." The 1926 Act allowed for circumstances under which a child could receive "legitimation" if the parents subsequently married, but there were numerous situations that could prevent a child from receiving "legitimation." The Central Midwives Board thus had legislative support for its response to midwives who were guilty of "moral misconduct."

¹¹³ TNA, Records of the Central Midwives Board, Central Midwives Board: Minutes, Board Minutes 1905–1951, DV 1/2–DV 1/17.

¹¹⁴ TNA, Records of the Central Midwives Board, Central Midwives Board: Minutes, Board Minutes, February 17, 1921, June 22, 1921, DV 1/9; February 21, 1924, DV 1/10; March 31, 1926, DV 1/11; June 7, 1928, January 3, 1929, DV 1/12; March 7, 1935, DV 1/14.

dismissed without special circumstances.¹¹⁵ The cases related to illegitimate children and extramarital affairs regularly referred to the midwife's "immorality" as well as misconduct. One woman, charged with helping to procure an abortion and also with running a brothel, faced a specific misconduct charge for allegedly providing the board a false certificate of moral character.¹¹⁶ This assessment of the midwife's moral conduct was permissible due to the ruling in the *Midwives Act* that a bonâ fide midwife acting as a certified midwife had to bear good character.¹¹⁷

The belief that a midwife had to "bear a good character" was intended to protect expectant mothers as well as acting as a credential for bonâ fide midwives. The medical community believed that a midwife of poor moral character would pose a risk to expectant mothers. Following a High Court ruling in 1915, which reversed the CMB's decision to remove a midwife's name from the roll, an editorial in *The Lancet* commented that "It is difficult to imagine any person whose opportunity for mischief would be greater if she herself were to be of loose morals and at the same time endowed with the training and skill which the Midwives' Act, 1902, was passed to promote."¹¹⁸ Rather than equating this judgement of moral character with a gendered concern of the capabilities of women, it was—at least in theory—intended as symbolic of the professional status of midwives. The belief was that professional midwives were

¹¹⁵ TNA, Records of the Central Midwives Board, Central Midwives Board: Minutes, Board Minutes, February 6, 1936, DV 1/14.

¹¹⁶ TNA, Records of the Central Midwives Board, Central Midwives Board: Minutes, Board Minutes, March 23, 1909, DV 1/4.

¹¹⁷ TNA, Records of the Central Midwives Board, Central Midwives Board: Rules of Conduct, First Edition (1907), *Midwives Act* (1902), Section 2, DV 3/1.

¹¹⁸ "Editorial Notices," *The Lancet* 185, 4791 (June 26, 1915): 1381.

“members of a specially protected body,” and that they should be worthy of the “exclusive rights” awarded by this status.¹¹⁹

There are many cases that highlight how the rulings of the Central Midwives’ Board judged midwives on their perceived professional conduct in ways unrelated to their medical competence. Some of these charges, as the criminal cases indicate, uncovered obvious reasons for censure, or even dismissal, of the midwife in question. Other cases, however, are more directly related to the midwife’s character. For example, in 1927 Agnes Elizabeth Mary Donlay of London was brought before the Board on a charge of misconduct that was explicitly related to her moral conduct:

That on diverse dates since February 1925 you were guilty of immorality with the husband of one of your maternity patients namely one F.J.F. Hoyne by reason whereof his wife—Lilian Dora Hoyne, of Sinclair Road, London, obtained a decree nisi which was subsequently on August 17, 1927, made absolute in the Probate, Divorce and Admiralty Division of His Majesty’s High Court of Justice.¹²⁰

Agnes Donlay was not in attendance, nor was any representative present on her behalf. The Matron of Parkside Maternity Hospital and Matron of Westminster Hospital, London, however, were both in attendance and gave evidence supporting the charge. The result was that Agnes Elizabeth Mary Donlay had her name removed from the Roll of Midwives and her Certificate was cancelled. In most cases, including cases involving serious medical malpractice, the resolution ended with the removal from the roll and cancelling of the certificate with no additional action indicated. In Donlay’s case, the Board further resolved “That Agnes Elizabeth Mary Donlay be prohibited from attending

¹¹⁹ “Maternity and Child Welfare.” *Nursing Notes and Midwives Chronicle* XXVIII (August, 1915): 193.

¹²⁰ TNA, Records of the Central Midwives Board, Central Midwives Board: Minutes, Board Minutes, October 6, 1927, DV 1/12.

women in childbirth in any other capacity.”¹²¹ Further details of this case are not available and the minutes do not state why the CMB felt that this additional resolution was necessary, but the case reveals the Board’s authority. Midwives were professionals, but also expected to operate within contemporary gender roles.

The true extent of the Board’s emphasis on moral conduct becomes apparent when examining the charges against midwives in relation to the possession and administration of drugs. Of the forty-two midwives brought before the Board on charges related to her moral conduct, thirty-four were fired. In contrast, of the twenty women brought before the Board on drug infractions (excluding charges related to abortion or alcohol), only seven had their name struck from the Board and their certificate cancelled.¹²² Many of the cases that resulted in the midwife being censured or cautioned involved instances where the midwife provided treatment outside her province. Several cases involved midwives who administered medications during childbirth, such as pituitrin outside of an emergency, which were safe and appropriate for the situation, but for which the midwife had not received training or authorisation.¹²³ In such cases the censure sometimes included the requirement that the midwife receive further training on the possession and administration of drugs regulated by the *Dangerous Drugs Act*.

¹²¹ TNA, Records of the Central Midwives Board, Central Midwives Board: Minutes, Board Minutes, October 6, 1927, DV 1/12.

¹²² TNA, Records of the Central Midwives Board, Central Midwives Board: Minutes, Board Minutes 1905–1951, DV 1/2–DV 1/17.

¹²³ TNA, Records of the Central Midwives Board, Central Midwives Board: Minutes, Board Minutes, January 19, 1917; July 26, 1917; February 20, 1918; February 4, 1937; November 3, 1938; June 1, 1939; October 7, 1943; November 28, 1944; March 3, 1949; December 7, 1950, DV 1/7–1/17.

For these professional misdemeanours, understandably, the midwife was not prohibited from working. In other cases, however, it is surprising that the midwife did not lose her position given the Boards' stance on moral misconduct. Two midwives found guilty of possession of dangerous drugs, and fined accordingly, had their cases adjourned to allow for treatment and an assessment of "mental health and habits and conduct."¹²⁴ Another midwife pled guilty in the Petty Sessional Division of stealing drugs—including morphine and cocaine—and administering them to herself. She was fined £12 and bound to reside at Carlton Hayes for treatment for twelve months, yet when her case was brought before the CMB it was decided "That no action be taken on the case."¹²⁵ The discrepancies between the cases involving moral misconduct and drug infractions shows the Board's emphasis on professional hierarchies and the caveat that a midwife must "bear a good character."

The penal cases against midwives demonstrate the gendered and professional hierarchies that characterized early twentieth century medical practice and how some of these interpretations changed as childbirth practices began involving increasing levels of medical supervision and intervention. Midwifery was deemed to be of a lower professional ranking than the work performed by physicians and surgeons. In spite of this hierarchy, however, physicians from the County Councils Association expressed the opinion that midwives were superior to physicians in cases of normal childbirth and that "that many medical practitioners now obtain so little practice in this work that they

¹²⁴ TNA, Records of the Central Midwives Board, Central Midwives Board: Minutes, Board Minutes, January 24, 1924, DV 1/10; July 5, 1934, DV 1/14.

¹²⁵ TNA, Records of the Central Midwives Board, Central Midwives Board: Minutes, Board Minutes, January 9, 1947, DV 1/17.

cannot be regarded as having sufficient obstetric skill to advise a midwife.”¹²⁶ In teaching institutions, pupil midwives were given priority over medical students when attending births; the pupil midwife was required to assist at the birth and the medical student was relegated to observation if there were not enough deliveries for the pupil midwife and medical student to attend separate cases:

In certain medical schools outside London it is not uncommon to find a student and a pupil midwife going together to a case which may thus "count" for both. The obvious disadvantage of this is that the pupil midwife *must* herself deliver if she is to count the case, whereas the student need not, and, consequently, the student too frequently watches the midwife deliver and takes no active part himself.¹²⁷

While this arrangement was clearly detrimental to medical students, it also shows the professional support of midwifery and the emphasis on developing the obstetrical skills of midwives. Nevertheless, in spite of the benefits of their training, professional hierarchies were enforced by the requirement that a midwife contact a medical doctor in any case where parturient care fell outside the definition of normal or uncomplicated childbirth.¹²⁸ Throughout the 1910s and 1920s the majority of cases brought to Special

¹²⁶ TNA, Ministry of Health, Maternal mortality report: observations and recommendations regarding doctors to be called in by midwives Circular 1705, MH 55/682.

¹²⁷ Janet Campbell, *Notes on the Arrangements for Teaching Obstetrics and Gynaecology in the Medical Schools* (Ministry of Health, London, Published by his Majesty's stationery office, 1923), 45.

¹²⁸ Specific instances for calling a medical practitioner were outlined in early editions of the *Rules of Conduct*, and addressed earlier in this chapter, but the basic premise of cases requiring medical attendance is outlined in the 1950 *Rules of Conduct*: “A practising midwife must call in a registered medical practitioner in all cases of illness of the patient or child or in the case of any abnormality becoming apparent in the patient or child during pregnancy, labour or the lying-in period, or in the event of the resumption of her attendance within 28 days after the end of the labour,” TNA, Records of the Central Midwives Board, Central Midwives Board: Rules of Conduct, Twentieth

Board Meetings of the CMB were for cases where the midwife failed to notify the patient that the situation was such that a medical practitioner should be called as the midwife only had limited autonomy.¹²⁹ These penal cases clearly highlight the gendered and professional constraints on midwifery, and midwives who failed to recognise their professional limitations were censured by the Board.

These professional limitations, while an important aspect of a midwife's practice, were not fixed, and evolved as medical practice and midwifery training advanced. Regulations in the *Rules of Conduct* and penal cases against midwives both indicate the changes to the definition of "normal birth" in relation to a midwife's scope of practice. As I highlighted earlier in the chapter, early versions of midwifery regulations provided a very narrow definition of normal birth and there were many scenarios in which a midwife was required to contact a medical practitioner for supervision and a transfer of patient care. Such regulations were indicative of the limited medical care midwives were permitted to deliver in the course of normal practice—exceptions to the rules were made for certain emergency situations. Throughout the 1930s and 1940s, however, the midwife's scope of practice was redefined along with the requirements for contacting a medical practitioner. As birthing practices became more medicalized, so too did the

Edition (1950), Section E, Part II, 12 "Regulating, Supervising, and Restricting Within Due Limits the Practice of Midwives," DV 3/20.

¹²⁹ In 1916 seventy-five midwives were brought before Central Midwives Board on penal charges. In the same year there were 129 charges for breaking rules E 20–21, "Conditions in Which Medical Help Must Be Sent For." This ratio of cases and charges is representative of penal cases in the 1910s and 1920s. TNA, Records of the Central Midwives Board, Central Midwives Board: Rules of Conduct, Fourth edition (1920) Section E 20–21, "Regulating, Supervising, and Restricting Within Due Limits the Practice of Midwives," DV 3/4; TNA, Records of the Central Midwives Board, Central Midwives Board: Minutes, Board Minutes (1914–1916), (1916–1917), DV 1/6, DV 1/7.

midwife's role. Midwives were still required to send for a medical practitioner, and inform the family of this need, but the midwife was allowed to engage in more complex medical practice and was not required to obtain a physician's assistance in as many scenarios as was the case in the early decades of the twentieth century.

This change in the definition of normal birth and shift in the professional status of midwifery are reflected in both the regulations of the CMB and the subsequent penal cases against midwives. In the early 1930s the number of penal cases dealt with by the CMB dropped from close to 100 cases per year to approximately twenty cases per year.¹³⁰ In addition to the decrease in the number of cases, and the frequency of the Special Board Meetings, the nature of charges against midwives changed drastically in the 1930s. Beginning in the 1930s more of the penal cases related to specific instances of medical malpractice or misconduct rather than a midwife's moral conduct. While some of the changes suggest that the Local Supervising Authorities were assuming more responsibility in the regulation of midwifery, other changes are indicative of evolving medical practices. Offences such as failure to keep a proper case register or failure to notify the patient of the need to contact a medical practitioner remained common charges, but the penal cases also indicated more specific concerns relating to medical practice. Such changes reflect the fact that birth was becoming increasingly medicalized—and British midwives were key players in this process of medicalization. The changes to penal cases reflect the training and expectations of midwives. By the mid-twentieth century, the professionalization and medicalization of British midwives

¹³⁰ TNA, Records of the Central Midwives Board, Central Midwives Board: Minutes, Board Minutes 1905–1951, DV 1/2–DV 1/17.

was such that they bore no resemblance to the Sairey Gamp caricature of the Victorian era, and little resemblance to the Nightingale nurses. This is evident in the midwife's expanding autonomy and access to medical treatments, and also apparent in how the midwife was allowed to present herself to the public. Physicians regularly used initials following their names to denote their professional status, indicating that they were a qualified medical doctor, as well as their specialties and collegial affiliations.¹³¹ In the early years of midwifery licensing, midwives were not allowed to use this format. The Rules of the Central Midwives Board stipulated that "The proper designation of a certified midwife is 'Certified Midwife,' thus *e.g.* Mary Smith, Certified Midwife. No abbreviation in the form of initial letters is permitted, nor any other description of the qualification."¹³² The rationale behind this ruling is not explained in the Board's records, but it is probable that the midwife was not allowed to use abbreviations for clarity of identification, and due to the professional associations implied by abbreviations.

Midwives who violated this rule, either by using the abbreviation SCM or an unapproved title such as 'Trained Midwife' and 'Certified by examination,' were brought before the Central Midwives Board and censured for their actions. Usually a couple of midwives faced this charge each year, which, while not a lot, is about the same number as midwives who were charged for performing abortions.¹³³ In 1934, however, two years before the third *Midwives Act* removed provisions for anyone other than a trained

¹³¹ Examples of such notations include: J.W. Ballantyne, MD, FRCPE (Medical Doctor, Fellow of the Royal College of Physicians Edinburgh).

¹³² TNA, Records of the Central Midwives Board, Central Midwives Board: Rules of Conduct, First Edition (1907), Section E Number 26, DV 3/1.

¹³³ TNA, Records of the Central Midwives Board, Central Midwives Board: Minutes, Board Minutes (1902–1934), DV 1/1–DV 1/13.

and certified midwife to practice, the Board changed its ruling on the title for midwives. The Board still preferred the full title “State Certified Midwife,” but also allowed that “A State Certified Midwife, may, if she so desires, use the initial letters ‘S.C.M.’ in place of the above description, but the use of any other initial letters indicating a midwifery qualification is not permitted.”¹³⁴ While a small change to the regulations, this ruling suggests the recognition that certified midwives now received from the medical community and the general public.

The increased professional recognition of certified midwifery is apparent in numerous changes during the first half of the twentieth century. Along with changes to the rules for midwives, I have outlined changes to the regulation of midwives through penal cases brought before the Central Midwives Board. In the first three decades of the twentieth century midwives were frequently brought before the Board on charges stating they had violated rules of the CMB. While many of these cases were for issues relating to medical competence and correct procedure in the practice of midwifery, many cases also focused on the most basic principles of professional midwifery—cleanliness, disinfection, and when to call a medical practitioner. Midwives were also charged on issues relating to their personal conduct and character as the midwife was expected to “bear a good character.” In the late 1920s however, there were notable changes to these penal cases; the number of cases each year dropped dramatically and midwives were more likely to be charged for issues directly relating to their ability to practice medicine. This transition also reflects the increasingly medicalized aspects of

¹³⁴ TNA, Records of the Central Midwives Board, Central Midwives Board: Rules of Conduct, Eleventh Edition (1934), Section E Number 32, DV 3/11.

midwifery as the definition of normal birth expanded and midwives were granted access to certain drugs and analgesics.

4 **“A GREAT HELP TO ALL MOTHERS”: BRITISH MIDWIVES AND ANALGESICS 1930–1950**

In the preceding chapter I addressed the regulation of midwifery in Great Britain and highlighted the changes to the rules and requirements governing midwives through the first half of the twentieth century. That professional midwifery in the British Isles became increasingly regulated was, somewhat ironically, reflective of the increased professional status and autonomy of midwives. The changes to the *Rules of Conduct* and penal cases in the late 1920s and early 1930s also indicate how professional midwives in Britain were expected to attain higher levels of medical knowledge. As obstetrical procedure and technology advanced, the midwife was part of this advancement rather than excluded from it. The midwife’s involvement in the medicalization of birth is especially notable in contrast to the practice of midwifery—by physicians, nurses, and untrained midwives—in Ontario. Healthcare providers in Ontario argued for physician-attended birth on the basis that birth supervised by a trained medical professional was the safest option for both mothers and babies; the related belief was that medicalized birth was attainable only through physician dominance. Arguments in favour of legalized midwifery were countered by the Canadian Medical Association and provincial health officials who were unanimous in their opinion that only physicians should practice midwifery. Even nurses in Ontario were secondary in the medicalization of childbirth—key agents and professionally trained, but only as assistants to physicians. This chapter challenges the Ontario physicians’ contemporary argument that medicalized birth was

synonymous with physician-attended birth by showing the involvement of British midwives in the process. It also highlights how midwives increased their professional autonomy through access to drugs and medical technology, and how such autonomy was expressed through participation in international organisations such as the International Confederation of Midwives (ICM).

The development of obstetrical analgesic technologies in the 1930s and 1940s demonstrates the midwife's centrality to the medicalization of childbirth in the British Isles. Rather than being excluded from attempts to ensure that parturient women were attended by trained professionals with access to medical intervention, the midwives' specific needs were considered and there were apparatuses designed specifically for their use. The use of analgesics, anaesthetics, and some drugs by British midwives highlights the fact that the medicalization of childbirth was not dependent on physician dominance or hospital based births. In the early 1930s there were 52,120 registered midwives—46,955 of whom completed training and the CMB examination—but only 14,908 registered midwives, 14,187 trained and 721 untrained, notified the Board of their intent to practise in 1931.¹ These 14,908 practising midwives were responsible for attending the majority of births.² Rather than viewing the prevalence of midwife assisted births as a professional threat, as was the case in Ontario, British physicians recognised the professional benefits of midwife assisted births and felt their inclusion would lessen the physician's need to attend lengthy births for low pay. Consequently,

¹ TNA, Records of the Central Midwives Board, Central Midwives Board: Midwives Roll, Central Midwives Board: The Midwives Roll, Aanensen to Jones Vol I., 1933, DV 7/32.

² TNA, Ministry of Health, Training of Midwives, Board of Education Regulations. Conditions of Grant, 1919–1930, MH 55/236.

the medical profession believed that training midwives in obstetrical analgesics and anaesthesia lessened the burden on medical doctors:

...if at least 90 per cent of the 600,000 of the mothers delivered in this country every year were to have the pains of labour abolished, the analgesic must be in the hands of midwives. Even if a doctor was engaged he could not spend 10 to 12 hours on each case. Doctors attended less than half the confinements in the country, midwives conducting most of the cases alone, and during most of the labour period the midwife had nothing to do. The method of using chloroform could soon be taught, and in intelligent hands there was no danger.³

This belief in the ability of midwives to safely administer analgesics and anaesthetics resulted in the development of apparatuses deemed safe for a midwife to use and tailored to suit their specific needs.

This chapter traces developments in obstetrical anaesthesia and analgesia and discusses the discovery and design of anaesthetics and analgesics, the regulation of midwives' use of these and other drugs, the distribution of analgesic devices, mothers' responses to the new medication, and the overarching impact these developments had on the medicalization and professionalization of midwifery and childbirth. The most significant advancement to obstetrics in the first half of the twentieth century came in the form of analgesia and anaesthesia for use during labour and delivery. Scottish obstetrician Sir James Young Simpson first discovered the anaesthetic properties of chloroform in the mid-nineteenth century, and soon after experimented with obstetrical

³ "Modern Methods of Alleviating Pain in Childbirth." Discussion at the Section of Obstetrics and Gynaecology of the Royal Society of Medicine on June 17th, 1932. Reprinted from *The Lancet*, June 25, 1932, p. 1361. Reports and articles on use of chloroform capsules. National Birthday Trust Fund. Wellcome Library. SA/NBT/H.1/5.

uses for chloroform.⁴ Safer than ether, which was known to cause lung irritation and often caused fatal overdoses as it was easy to administer too much of the drug, chloroform was a highly effective anaesthetic that remained in use through the early twentieth century. In spite of its relative safety, however, chloroform could also be risky. These dangers were first identified in the mid-nineteenth century by Professor C.C. Hüter at the University of Marburg, and the foremost risk was the transfer of anaesthetic gases across the placenta to the foetus.⁵ Initially only physicians were permitted to administer chloroform, but as midwifery practice evolved to include more medical training, regulations changed to allow midwives limited access to chloroform.

Initial reports on the use of analgesics and anaesthetics by midwives focused on the administration of chloroform capsules. Chloroform capsules were designed to administer a carefully measured dose to reduce the chance of overdose, but despite the early emphasis on the administration of chloroform by midwives, the risks associated with chloroform meant that any studies attempting to discern a suitable method of chloroform administration were short lived. Medical professionals and scientists sought to develop a reliable analgesic that was safe for parturient women and easy to deliver. The development of nitrous oxide inhalers as a gas-air analgesic was consequently a notable advancement: their relative safety made them ideal for use by midwives.

⁴ The introduction of chloroform as an obstetrical anaesthetic has been well documented by Donald Caton and Jacqueline Wolf in their respective monographs on responses to pain during childbirth: Donald Caton, *What a Blessing She Had Chloroform: The Medical and Social Response to the Pain of Childbirth from 1800 to the Present* (New Haven: Yale University Press, 1999); Jacqueline Wolf, *Deliver Me From Pain: Anaesthesia and Birth in America* (Baltimore: Johns Hopkins University Press, 2009).

⁵ Caton, *What a Blessing She Had Chloroform*, 77.

Examining the design of gas-air inhalers and their specific connections with midwifery practices reveals the midwife's centrality in the medicalization of childbirth in Britain. Once again, their integral role in this process differs greatly from that of registered nurses in Ontario, the only legal childbirth attendants besides physicians in the province. Rather than educating nurses on the proper usage of chloroform, nitrous oxide, scopolamine, morphine, and other drugs, the medical profession generally contended that "it is not in the province of the nurse to familiarize herself too much with the meticulous details that go along with the use of these substances."⁶ As well as the strictly delineated professional hierarchy in Ontario, such statements reflect the gendered hierarchy in the medical profession at a time when the majority of doctors were male. Physicians felt that nurses were incapable or unsuited for the "meticulous details" required in the administration of anaesthesia. None of the articles in the *Canadian Medical Association Journal (CMAJ)* on chloroform, nitrous-oxide, and Trilene during the interwar years discuss the possible role of registered nurses in their administration during labour and parturition.⁷ Furthermore, some of these articles

⁶ Wesley Bourne, MD, "The Administration of Chloroform in Obstetrics by Nurses," *Canadian Nurse* (November, 1930), 587.

⁷ Gordon G. Copeland, "Nitrous Oxide-Oxygen Analgesia and Anæsthesia in Obstetrics," *Canadian Medical Association Journal* 7, 5 (May 1917): 405–411; "Nitrous Oxide-Oxygen Analgesia in Obstetrics," *Canadian Medical Association Journal* 7, 5 (May, 1917): 446–447; Wesley Bourne, and James W. Duncan, "Nitrous Oxide-Oxygen Analgesia and Anaesthesia in Obstetrics," *Canadian Medical Association Journal* 11, 11 (November, 1921): 818–822; Wesley Bourne, "Anaesthesia in Obstetrics," *Canadian Medical Association Journal* 14, 8 (August, 1924): 702–703; A.D.B. "Anaesthesia During Childbirth" *Canadian Medical Association Journal* 23, 4 (October, 1930): 564–565; Leighton C. Conn and John Ross Vant, "The Relief of Pain During Labour," *Canadian Medical Association Journal* 33, 5 (November, 1935): 484–489; Wesley Bourne, "Vinyl

emphasised the need to keep chloroform solely in the hands of physicians. As a 1925 “Obstetrical Retrospect” explicitly argued, chloroform would be the means to ensure total physician monopoly of childbirth:

The midwife...who up to a short time ago enjoyed the confidence of the public has now been almost entirely eliminated except among the ignorant or the foreign population. But once these benighted foreigners get a whiff of chloroform, the midwife will have to yield and our monopoly will be even still further tightened.⁸

Although most articles in the *CMAJ* are not as extreme, and many looked to applications in Britain where the use of obstetrical analgesics was more established, only two acknowledged the use of such medications by certified midwives in Britain.⁹ Canadian nurses were permitted to participate in the on-going development of medicalized childbirth, but only as assistants to physicians. British midwives were included in this modernizing process on the premise that they could help improve the health and welfare of pregnant women and their infants and that they were capable of participating in technological advancements. In Britain, child and maternal welfare were the ultimate motivation; in Ontario (and most of Canada), physician dominance marginalized all other participants.

As noted, both British and Canadian health authorities, in and outside of government, were extremely concerned by maternal and infant mortality rates in the

Ether Obstetrical Anæsthesia for General Practice,” *Canadian Medical Association Journal* 33, 6 (December, 1935): 629–632.

⁸ O. Bjornson, “An Obstetrical Retrospect,” *Canadian Medical Association Journal* 15, 12 (December, 1925): 1236–37.

⁹ Dame A. Louise McIlroy, “Analgesia and Anaesthesia in Childbirth,” *Canadian Medical Association Journal* 24, 1 (January, 1931): 21–27; Alan B. Noble and Sheila H. Cattanach, “Obstetrical Analgesia With Trilene,” *Canadian Medical Association Journal* 62, 4 (April, 1950): 327–330.

early twentieth century. Both countries launched campaigns to reduce these rates. In both, as well, charitable organisations played a central role in shaping and delivering government policy and programs designed to benefit maternal and infant health. While the Victorian Order of Nurses (VON) and the Red Cross Society were two of the key organisations in Canada, their closest counterpart in England was the National Birthday Trust Fund (NBTF). Established in 1928, the NBTF was a philanthropic organisation originally focused on reducing maternal mortality in working-class communities.¹⁰ In the 1930s, the Trust's mandate expanded to make obstetrical analgesics available to "all mothers and not merely to the rich, who could afford to pay."¹¹ The socioeconomic components of infant and maternal health were central to the NBTF's work. In Canada, the VON was founded by Lady Aberdeen, wife of then Governor General John Campbell Hamilton-Gordon, and in England the NBTF was led by prominent women in British society such as Lady Rhys Williams and Countess Baldwin (wife of Prime Minister Stanley Baldwin).

Their charitable work reflected a genuine concern for working-class families and the rural poor, yet their views were also at times patronizing. The Trust claimed to want equal services for all women and children, regardless of class and social status, but its wealthy patrons clearly had no idea how the lower classes lived. The Birthday Trust initially endeavoured to collect a shilling from each individual, which was a prohibitively

¹⁰ For a detailed history of the NBTF see Susan Williams, *Women & Children in the Twentieth Century, A History of the National Birthday Trust Fund, 1928–93* (Thrupp, Gloucestershire: Sutton Publishing Limited, 1997).

¹¹ Wellcome Library, National Birthday Trust Fund, Queen's Institute of District Nursing Survey of the use of Gas and Air Analgesia in Rural Areas, SA/NBT/H.2/2.

high cost—“more than a fifth of the weekly income, net of housing costs, of many British people.”¹² Yet, if the Trust was emblematic of the very socioeconomic discrepancies it sought to remedy, it was nevertheless crucial to both the advancement of obstetrical analgesics in Britain and midwives’ involvement in their administration. The NBTF’s funding for, and promotion of, obstetrical analgesics and technology separate their actions from otherwise comparable moral reform movements in Ontario.

The Birthday Trust was vital to a campaign lobbying the government to allow midwives to administer such analgesics as chloroform capsules and gas-air inhalers.¹³ It also worked closely with the Central Midwives Board to produce analgesic apparatuses, often paid for by the Birthday Trust, that were suitable for the specific requirements of midwives. This inclusion of midwives in the medicalization of childbirth helped ensure the achievement of the Birthday Trust’s social aims. At a practical level, the NBTF advanced the use of obstetrical analgesics by donating hundreds of gas-air machines and chloroform and Trilene inhalers to hospitals and midwives across the United Kingdom. Furthermore, the Trust conducted surveys on the efficacy of these analgesics and anaesthetics administered by midwives to aid in their design and use.¹⁴ Their efforts to promote the midwives’ use of analgesics also prompted a study by the Royal College

¹² Williams, *Women & Childbirth in the Twentieth Century*, 39

¹³ Caton, *What a Blessing She Had Chloroform*, 164.

¹⁴ The NBTF surveyed thousands of mothers who received analgesics during hospital-based births. They provided statistical information about the mother: name and age; number of previous confinements; premedication; stage in labour; frequency and duration of analgesics during labour and delivery; the midwife’s overall assessment of the labour; and the condition of the newborn. These surveys also questioned the mother on her perception of the efficacy of the analgesic and asked for her specific remarks on the experience. Wellcome Library, National Birthday Trust Fund, Analgesia Investigations, SA/NBT/H.2/4.1–4.3.

of Obstetricians and Gynaecologists that shows physicians willingness to include midwives in this obstetrical advancement.¹⁵ This 1936 report, "Investigation into the use of Analgesics suitable for administration by midwives," endeavoured to ascertain if there was a form of analgesia "that could be used with safety and success by a midwife in the absence of a medical practitioner."¹⁶ Almost immediately following the report's publication, the Central Midwives Board became actively involved in establishing regulations and training protocols for midwives intending to administer analgesia and anaesthesia, ensuring legislation kept pace with medical advancement. The Board felt that it was essential that "Rules be drafted in accordance with the recommendations of the Committee."¹⁷ By October 1936, the Board had established rules "to permit midwives, in certain cases, to administer gas and air [nitrous oxide and oxygen] by Minnitt's or similar apparatus for the purpose of producing analgesia during labour," provided that the midwife had received special instruction in the essentials of obstetrical analgesia.¹⁸

Throughout the 1930s and 1940s, the primary anaesthetic/analgesic apparatuses used by midwives were nitrous oxide and oxygen inhalers, often called gas-air inhalers. There were initial discussions and trials to make chloroform available to midwives that predated the availability of nitrous oxide or Trilene inhalers. The early emphasis on

¹⁵ Wellcome Library, National Birthday Trust Fund, Queen's Institute of District Nursing Survey of the use of gas and air analgesia in rural area, SA/NBT/H.2/2.

¹⁶ "Investigation into the use of Analgesics suitable for administration by midwives," (London: Royal College of Obstetricians and Gynaecologists, 1936), 4.

¹⁷ TNA, Records of the Central Midwives Board, Central Midwives Board: Minutes (May 7, 1936), DV 1/14.

¹⁸ TNA, Records of the Central Midwives Board, Central Midwives Board: Minutes (October 1, 1936), DV 1/14.

chloroform is explained by the fact that chloroform was a recognised obstetrical anaesthetic since the mid-nineteenth centuries; thus, early discussions among both midwifery organisations and physicians about allowing midwives to administer analgesics were in reference to chloroform. As early as 1932, the CMB board discussed the rules regarding the chloroform administration by midwives.¹⁹ In spite of the aforementioned report from the Royal Society of Medicine, “Modern Methods of Alleviating Pain in Childbirth,” which stated the benefits of training midwives in the administration of chloroform, as well as persuasive letters from the National Birthday Trust Fund to the CMB, the Board was not initially convinced of the benefits of allowing unsupervised midwives to administer chloroform—or indeed any analgesic. Board members contended that, unless the midwife was “under the direction and personal supervision of a duly qualified medical practitioner,” as analgesics were outside her province.²⁰ The Board’s shift in attitude can be explained, at least in part, due to the adjustments to midwifery training that expanded her scope of practice.

There is little evidence of midwives administering chloroform without following proper protocol. During the first half of the twentieth century, only twenty women were brought before the Board on charges related to the possession and administration of drugs—excluding charges related to alcohol or medication to procure an abortion. These infractions included offences such as theft of drugs, administering medication contrary to a physician’s orders, or administering drugs outside of the midwife’s

¹⁹ TNA, Records of the Central Midwives Board, Central Midwives Board: Minutes, Board Minutes (June 8, 1932; May 4, 1933), DV 1/13.

²⁰ TNA, Records of the Central Midwives Board, Central Midwives Board: Minutes, Board Minutes (October 4, 1934), DV 1/14.

province. Of these twenty cases, only one midwife was brought before the Board on charges directly related to the use of chloroform. In 1937, Clodagh Gould, a midwife from Somerset, was charged on the premise that she administered chloroform capsules, failed to record the use of chloroform, and did not provide “the name and dose of the drug and the time and cause of its administration or application,” as required by the CMB’s Rules E 11 and 34.²¹ The penalty for the administration of chloroform was not as severe as it was for many other charges. The comparative leniency is not explained, but may be because the charge was a legislative violation rather than a legal violation—such as providing abortifacients. In this case the midwife in question did not immediately have her certificate cancelled.²² Minutes from the Board meeting state that Gould had written a letter to the Board “setting forth her defence to the charges,” and was in attendance at the Special Board Meeting and “gave evidence on her own behalf and subsequently addressed the Board.” But the minutes do not record the content of the letter or the evidence she provided in person.²³ The sentence was postponed, and the case was reviewed at 3, 6, 9, and 12 months. The initial sentence stated that if Gould was found to have displayed “proper conduct” during that time, her certificate would not be cancelled. Special Board Meetings on June 3, October 7, and November 4 all acknowledged receipt of an interim report from the Local Supervisory Authority, but

²¹ TNA, Records of the Central Midwives Board, Central Midwives Board: Minutes, Board Minutes (February 4, 1937), DV 1/14.

²² The detailed records of the prosecution of midwives by the Central Midwives Board are closed for 75 years. Regrettably the files I was interested in, including Clodagh Gould’s, were closed at the time of my research trip and so I do not have access to further information.

²³ TNA, Records of the Central Midwives Board, Central Midwives Board: Minutes, Board Minutes (February 4, 1937), DV 1/14.

provide no detail about the content of these reports. On March 3, 1938, the Board received the final report from the LSA and decreed, “That no further action be taken with regard to Clodagh Gould, No. 92909.”²⁴

The Board’s leniency in the case of Clodagh Gould perhaps foreshadows the acceptance of regulated analgesics just two years later. Their concerns regarding the administration of chloroform by midwives reflected the inherent risks of chloroform more so than an attempt to restrict midwives’ access to advancements in obstetrics. These concerns about safety are apparent in all discussions in the 1930s about the administration of chloroform. As it was imperative that chloroform be given only in meticulously measured doses—the drug is very poisonous and accidental overdose is easy—chloroform was administered via capsule and inhalation mask. Each glass chloroform capsules contained a single measured dose initially intended for use by physicians, and midwife administration only under physician supervision. Furthermore, in spite of concerns about the specific safety of chloroform, the principal figures in the regulation of midwifery—including physicians and members of the Midwives’ Institute—considered it “incumbent on the medical profession to work out some means of giving analgesia that can be used by the midwife and will suffice to ease the final pangs of childbirth without interfering with normal parturition and without risk to mother and foetus, and therefore welcomes a full trial of the capsules.”²⁵

²⁴ TNA, Records of the Central Midwives Board, Central Midwives Board: Minutes, Board Minutes (March 3, 1938), DV 1/15.

²⁵ “Early Impressions of Chloroform Capsules,” *Nursing Notes* Vol. XLVI, (November 1933), 36.

The dangers of chloroform meant that it had limited use by midwives, but, as per the requests of physicians who believed their own practice would benefit from allowing midwives to administer anaesthetics and analgesics, studies were conducted and chloroform was made available to some midwives. The National Birthday Trust Fund led surveys on the efficacy and safety of chloroform as administered by midwives and manufactured and distributed chloroform capsules specifically for use by midwives.



Figure 2: National Birthday Trust Fund Chloroform Capsules (circa 1930s)

The chloroform marketed by the Birthday Trust came in boxes of one dozen glass capsules, each wrapped in cotton batting.²⁷ Each capsule contained 20 minims of

²⁶ Wellcome Library. Box containing chloroform capsules. CMAC SA/NBTF/HI/7.

chloroform, which, when used with a mask, provided approximately ten minutes of sedation, although midwives' comments on patient reports frequently indicate that the capsules were administered 5–7 minutes apart. Most women received 2–5 chloroform capsules during labour, but some refused a second capsule and a few others received as many as ten or eleven capsules.²⁸

Specific statistics from Queen Mary's Maternity Home, Hampstead, showed that many mothers surveyed found the chloroform capsules to be beneficial:

in 84 per cent of cases there was no apparent effect on the uterine contractions, whereas only 16 per cent showed a decrease. In 95 per cent of cases there was apparent lessening of pain felt, while 5 per cent showed no difference. Voluntary effort was apparently unaffected in 60 per cent and diminished in 37 per cent while in 3 per cent of cases there was a definite increase.²⁹

Such benefits were observed by midwives and physicians as well as expressed by patients. Nevertheless, while the capsules were a relatively safe means of administering chloroform to patients, the chloroform itself still posed risks and was not the ideal obstetrical analgesia. Although the Royal Society's 1932 discussion on "Modern Methods of Alleviating Pain in Childbirth" referenced chloroform as an analgesic that could be safely applied by midwives, and although the NBTf helped to make chloroform accessible to women and midwives, the problems associated with the drug made gas-air

²⁷ Boxes of intact chloroform capsules can be found in the records of the National Birthday Trust Fund. Wellcome Library, National Birthday Trust Fund, Sample Box of Capsules, SA/NBT/H.1/7.

²⁸ In the early 1930s the Birthday Trust assessed the use of chloroform capsules in approximately 2,000 cases across the country where midwives, in both hospital and domiciliary practice, administered chloroform capsules to parturient women. Wellcome Library, National Birthday Trust Fund, Completed report forms on effectiveness of capsules, August 1932–January 1935, SA/NBT/H.1/6.

²⁹ Arthur Rees, "Report on the use of chloroform capsules during labour," *Nursing Notes* Vol. XLVI (September 1933), 133.

inhalers the primary focus during the 1930s.³⁰ Gas-air inhalers used by British midwives in the 1930s and 1940s were designed to deliver a combination of oxygen and either nitrous-oxide or Trilene (trichloroethylene). The design and manufacturing of these machines were supported by physicians, the Central Midwives' Board, and the NBT as appropriate obstetrical analgesics for application by midwives. In fact, such apparatuses were designed to meet the specific needs of midwives. Physicians' models were significantly larger and intended primarily for use in hospitals. The smaller models were meant to be used by midwives and were consequently built to fit on the back of a bicycle, the midwife's primary mode of transportation.³¹ In designing obstetrical analgesics for midwife administration, it was understood, for this reason, that "portability is of the utmost importance."³² The concern about transporting these machines on bicycles was due to the understanding that obstetrical analgesia would not reach enough patients unless it could be readily administered by domiciliary midwives in both rural and urban settings.

Proponents of obstetrical analgesics developed technological advancements that increased the medical care available to parturient women without attempting to alter underlying childbirth practices. Initial regulations required that, as well as the trained

³⁰ In the early 1930s the National Birthday Trust Fund developed chloroform capsules for use by midwives, but their use was discontinued after 1936: Williams, *Women & Childbirth in the Twentieth Century*, 130–131.

³¹ The design that allowed the gas-air machine to be neatly strapped to a rear carrier on a bicycle was used as a marketing point for the Queen Charlotte's Gas Air Analgesia Apparatus in the late 1930s: Wellcome Library, National Birthday Trust Fund, Correspondence re distribution of machines, "Queen Charlotte's Gas Air Analgesia Apparatus: Recognised by the Central Midwives Board," SA/NBT/H.3/2/3

³² TNA, Records of the Central Midwives Board, Analgesic apparatus manufacturers: British Oxygen Company, DV 11/5.

midwife, “one other person, being a state certified midwife, or a state registered nurse, or a senior medical student or a pupil midwife, is present at the time of administration in addition to the midwife in charge of the case.”³³ Such legislation was clearly intended for maternal safety, but in practicality it also meant that analgesics were seldom available in rural areas due to insufficient numbers of local attendants. The response to these limitations was to advocate for changes that would be possible within the existing system, without increasing maternal and infant risks. Efforts by both the National Birthday Trust Fund and the National Federation of Women’s Institutes helped to bring about changes to this legislation to increase the availability of obstetrical analgesics. While they saw the benefit of having two trained attendants at the birth if analgesics were administered, these groups contended that the second attendant could have only a Home Nursing Certificate or be a retired certified midwife.³⁴ This modified requirement suggests the centrality of efforts to make analgesics available to all parturient women, regardless of socio-economic status and geography.³⁵

Ultimately, it was agreed that, to make obstetrical analgesics available to all women, the apparatuses for delivering the nitrous oxide-oxygen mixture had to be suitable for administration by midwives. The CMB was intimately involved in the design and manufacturing of this equipment and developments were designed to fit the

³³ TNA, Records of the Central Midwives Board, Central Midwives Board: Minutes (October 1, 1936), DV 1/14.

³⁴ TNA, Records of the Central Midwives’ Board, Analgesic apparatus: correspondence with National Federation of Women’s Institutes, on use in rural areas, DV 11/4.

³⁵ Lycinda McCray Beier, “Expertise and Control: Childbearing in Three Twentieth-Century Working-Class Lancashire Communities,” *Bulletin of the History of Medicine* 78 2 (Summer 2004), 405.

midwife's specific needs. Midwives who were trained in the use of gas-air analgesia were only permitted to use designs authorised by the Central Midwives Board.³⁶ Such authorisation was neither a token gesture nor indicative of endorsements of specific companies. Correspondence between the Central Midwives Board and manufacturers such as the British Oxygen Company, the Dental Manufacturing Company, the medical and surgical equipment manufacturers H.G. Carsberg and Son, and Medical Pneumatics LTD all demonstrate the Board's involvement in the design of this equipment with the end goal of creating equipment for use by midwives.³⁷ While some of the Board's concerns reflected the specific needs of midwives, many of these related to the amount of authority that midwives could have in deciding to use the machines. Although early prototypes for midwife-appropriate gas-air inhalers were developed and produced in the 1930s, the larger debates surrounding what was appropriate for their administration persisted well into the 1950s. This regulatory aspect of gas-air apparatus usage reflects both the CMB's belief that midwife autonomy should be limited, and the belief that midwives were an integral part of maternity services. Once again the conflicting

³⁶ Under the rules of the Central Midwives Board the administration of gas-air analgesia was considered within her province provided she "either before or after enrolment, received at an institution approved by the Board for the purpose, special instruction in the essentials of obstetric analgesia and has satisfied the institution that she is thoroughly proficient in the use of the apparatus." TNA, Records of the Central Midwives' Board, Analgesic apparatus training: London County Council, DV 11/10.

³⁷ TNA, Records of the Central Midwives Board, Analgesic apparatus: Chassar-Moir attachment, DV 11/2; Analgesic apparatus manufacturers: British Oxygen Company, DV 11/5; Analgesic apparatus manufacturers: Dental Manufacturing Company, DV 11/6; Analgesics Manufacturers: HG Carsberg & Son, DV 11/7; Analgesics Manufacturers: Medical Pneumatics LTD, DV 11/8; Analgesia Policy File, DV 11/221.

expectations of the midwife are evident even as her place in medicalized birth was ensured and enhanced by these developments.

Central to the CMB's regulation of the design of analgesic apparatuses was the view that gas-air machines needed to be simple enough for safe use by all midwives, regardless of experience, a belief that, although paternalistic, also granted midwives some medical autonomy. Throughout the 1930s and 1940s, and even well into the 1950s, the Central Midwives' Board and physicians in the United Kingdom expressed variants of the opinion that "no method of giving relief from pain in maternity can ever be of general use unless it can be entrusted to midwives."³⁸ Such an opinion shows the dichotomy that was prevalent in legislation and practice surrounding obstetrical analgesics. There was respect for the professional capabilities of midwives, but it was actualized in designing gas-air machines for midwives that allowed them very little control over the device; while midwives could choose when to administer the analgesic, the dosage was fixed and could not be adjusted by the midwife. Physician's models did not have the same limitations and physicians were able to adjust the ratio of oxygen to nitrous oxide. Physician's models could also be fitted with the Chassar Moir attachment a device that allowed several breaths of pure nitrous oxide to be delivered in advance of the mixture of nitrous oxide and oxygen.³⁹ The attachment was a 2.5 litre reservoir bag that allowed for several breaths of pure nitrous oxide at the beginning of a contraction

³⁸ TNA, Records of the Central Midwives Board, Analgesic apparatus: Chassar-Moir attachment, DV 11/2.

³⁹ The Chassar Moir was designed by obstetrician/gynaecologist J Chassar Moir who worked at Queen's University in Kingston Ontario during the early 1950s, TNA, Records of the Central Midwives Board, Analgesic apparatus: Chassar-Moir attachment, DV 11/2.

rather than the usual mixture of oxygen and nitrous oxide—an attachment that was not approved for use by midwives as it was perceived as requiring more training and greater medical knowledge.



Figure 3: The Minnitt Gas Air Apparatus (circa 1930s)

Professional hierarchies were enforced even as midwives became key agents in medicalization by the imposition of certain conditions on their use of medical technologies. Gas-air machines used by midwives were to be “so arranged that the

⁴⁰ The model on the left shows the Minnitt’s Gas Air Apparatus approved for use by midwives, while the model on the right shows the same apparatus with the Chassar Moir attachment available to physicians. TNA, Records of the Central Midwives’ Board, Analgesic apparatus manufacturers: British Oxygen Company, DV 11/5.

proportion of nitrous oxide and air cannot be altered by the midwife using it in the authorised manner.”⁴¹ If the ratio of nitrous oxide to oxygen was increased, there was a risk that the high dose of gas would act as an anaesthetic rather than an analgesic. The Board recognised that restricting the flow of nitrous-oxide to a fixed rate of 45 per cent “will be insufficient for some strong robust women,” but also believed that they had to “face these failures,” rather than allow midwives to vary the percentage, which could pose a greater risk to the patients. Maternal safety was the primary goal and the rate was adjustable only on physicians’ models.⁴² Obstetrical analgesics assisted parturient women, and their administration by midwives ensured medicalized practices reached a wide audience, but maternal and infant safety remained the priority.

By the end of the 1930s, the Central Midwives’ Board had authorised five nitrous-oxide inhalers for use by midwives: the Minnitt Gas-Air Analgesia Apparatus, the Walton Minnitt Gas-Air Apparatus, Queen Charlotte’s Gas-Air Analgesia Apparatus, Autogesia Self-Administered Gas-Air Apparatus, and the “Amwell” Gas-Air Analgesia Apparatus.⁴³ Although the Board itself did not recommend any one device as superior, the distribution of these apparatuses was not equal. The National Birthday Trust Fund efforts to distribute and study nitrous-oxide inhalers focused especially on the Minnitt Gas-Air Analgesia Apparatus, the Walton Minnitt Gas-Air Apparatus, and Queen Charlotte’s Gas-Air Analgesia Apparatus. The Minnitt Gas-Air Apparatuses were

⁴¹ TNA, Records of the Central Midwives Board, Analgesic apparatus: Chassar-Moir attachment, DV 11/2.

⁴² TNA, Records of the Central Midwives Board, Analgesic apparatus manufacturers: British Oxygen Company, DV 11/5.

⁴³ TNA, Records of the Central Midwives Board, Analgesic apparatus manufacturers: Dental Manufacturing Company, DV 11/6.

especially promoted by Lucy Baldwin who worked with Lady Rhys Williams in a campaign “agitating that all midwives should have the necessary training and apparatus” to provide pain relief to parturient women.⁴⁴ Baldwin’s support of the Minnitt Gas-Air Apparatus was such that, in the late 1950s, it was proposed that a model—initially slated to be called the Birthday Trust Machine—be named “The Baldwin” in honour of Baldwin’s efforts in the distribution of analgesic apparatuses.⁴⁵

Examining two of the more widely used gas-air inhalers—the Minnitt Gas-Air Apparatus, and Queen Charlotte’s Gas-Air Analgesia Apparatus—identifies some of the elements designed specifically for midwives. Both of these inhalers were produced by the British Oxygen Company and bore many similarities, but there were some differences in their marketing and design for midwives that warrant addressing. The Minnitt was promoted by the National Birthday Trust Fund and the NBTF compiled extensive data on its efficacy and ease of use by midwives. The Queen Charlotte’s Gas-Air Analgesia Apparatus, on the other hand, is an excellent example of how these machines were designed to suit the specific needs of midwives in relation to portability.

⁴⁴ Wellcome Library, National Birthday Trust Fund, Queen's Institute of District Nursing Survey of the use of gas and air analgesia in rural areas, SA/NBT/H.2/2.

⁴⁵ Wellcome Library, National Birthday Trust Fund, Lucy Baldwin Nitrous Oxide and Oxygen Machine, SA/NBT/H.2/8.

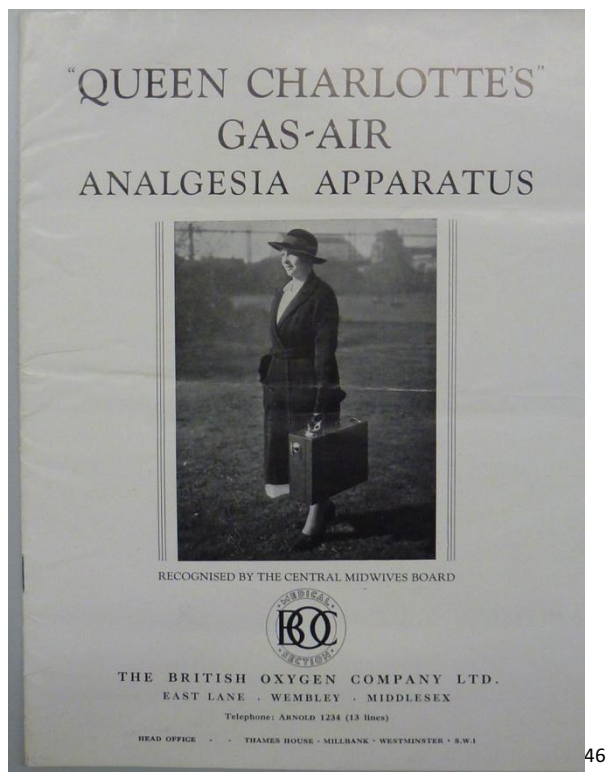


Figure 4: Queen Charlotte's Gas-Air Analgesia Apparatus (1937)

The Minnitt Gas-Air Apparatus, initially the Walton-Minnitt Gas-Air Apparatus, was named for Dr. R.J. Minnitt who, along with Dr. John Elam, was responsible for early testing of nitrous oxide inhalers in 1933–34. Minnitt and Elam were consequently able to demonstrate that gas-air inhalers had no negative effects on the mother's pulse, the foetal heart rate, or the oxygen content of the umbilical cord.⁴⁷ Both the portable and cabinet models of the Minnitt Apparatus were available either with or without the Chassar Moir "CM" attachment, which offered a higher dose of nitrous oxide than was delivered at the approved flow rate of 45 per cent, although not all features were

⁴⁶ Wellcome Library, National Birthday Trust Fund, Correspondence with suppliers of machines
Nov 1935–Jan 1946, SA/NBT/H.3/1.

⁴⁷ TNA, Records of the Central Midwives Board, Analgesic apparatus manufacturers: British Oxygen Company, DV 11/5.

available to midwives.⁴⁸ The higher dosage offered by the CM attachment was enough to cause some women to lose consciousness. Although both the portable and cabinet models of the Minnitt Gas-Air Apparatus met the requirements of the Central Midwives Board, the CM attachment was not approved by the Board; models that included this attachment were only approved for physician use.⁴⁹ The portable was 19 inches by 13 inches by 5¼ inches, and weighed 15 lbs—with most of the weight coming from the 100-gallon cylinder of nitrous oxide. The portable model was notably smaller than the cabinet model for use in hospital settings, which was over 2 feet tall and held two 200-gallon cylinders of nitrous oxide.

The Minnitt model was available as both a portable and hospital model, and the doctor's model with Chassar Moir attachment was suitable for minor surgery as well as obstetrical analgesia. The Queen Charlotte's Gas-Air Analgesia Apparatus, however, was designed specifically for midwives, which illustrates the midwife's centrality to these developments in obstetrical technology. First sold in 1937, the Queen Charlotte was available in two models, depending on the midwife's needs. The light-weight Model A weighed only 9lb 2oz. Measuring 11½ by 7½ by 5½ inches, Model A was extremely portable and had the advantage that it could be used with any size of cylinder and could work with either of the two valve types available on cylinder models in the United

⁴⁸ TNA, Records of the Central Midwives Board, Analgesic apparatus: Chassar-Moir attachment, DV 11/2.

⁴⁹ TNA, Records of the Central Midwives Board, Analgesic apparatus manufacturers: British Oxygen Company, DV 11/5.

Kingdom.⁵⁰ The great drawback to Model A, however, was that neither the cylinder and key nor the face mask and tube were contained within the case and had to be transported separately. Model B, on the other hand, was in a larger case that could transport the cylinder and mask. Containing a 50-gallon cylinder, Model B weighed 18lbs 5oz and measured 16.75 by 12.5 by 5 inches. As explained in the sales literature, while it was larger and heavier than Model A, Model B was extremely portable: “its size and weight permit of it being carried as an attaché case or on the carrier of a bicycle.”⁵¹



Figure 5: “Queen Charlotte’s” Gas-Air Analgesia Apparatus Model “C” (1937)

⁵⁰ TNA, Records of the Central Midwives Board, Analgesic apparatus manufacturers: British Oxygen Company, DV 11/5

⁵¹ TNA, Records of the Central Midwives Board, Analgesic apparatus manufacturers: British Oxygen Company, DV 11/5

⁵² “Queen Charlotte’s” Gas-Air Analgesia Apparatus Model “C”. Wellcome Library. Photograph of gas/air machines. CMAC SA/NBTF/H3/2/2.

It was also possible to purchase Model C, which had the advantage of containing two 50-gallon cylinders within the case, but was notably larger and heavier than Model B. As they were designed specifically for midwives, none of the Queen Charlotte's models could be fitted with the Chassar Moir attachment that was reserved for physician use. Midwives' widespread use of analgesic apparatuses meant their involvement in obstetrical advancements included a marketing element. Sales literature from the British Oxygen Company for the Queen Charlotte's model is interesting for the fact it was marketed specifically to midwives. While the Minnitt also discussed doctor's models and its use in minor surgery, the Queen Charlotte was a symbol of the midwife's involvement in medical practice and technology. The CMB's authorisation was emphasised in a way that was not the case for the Minnitt. Furthermore, all photographs of the Queen Charlotte model stress the portability and show it being transported by midwives and the ease of attaching it to the rear carrier of a bicycle; the midwife's primary mode of transportation.



Figure 6: Midwife Transporting Analgesic Gas-air Machine by Bicycle (1937)

The language of the sales pamphlets also clearly show professional hierarchies and assumed gender differences. While the pamphlets for the Minnitt emphasise the mechanical benefits of the apparatus, and even offer diagrams and detailed explanations regarding the pressure of the cylinder and the design of the valve, the Queen Charlotte’s pamphlets focus on how “Simplicity marks the operation throughout.”⁵⁴

⁵³ Wellcome Library. Midwife transporting analgesic gas-air machine by bicycle. CMAC SA/NBTF H.3/2/2.

⁵⁴ TNA, Records of the Central Midwives Board, Analgesic apparatus manufacturers: British Oxygen Company, DV 11/5

Although midwives were not permitted to administer gas-air analgesia without completing authorised training, the machines themselves were designed for easy use by both the midwife and patient. The apparatus, including insertion of the cylinder, could be assembled in advance of going to a confinement. Once the midwife arrived, she only had to open the cylinder valve and hand the mask to the patient; the patient then inhaled the gas-air mixture as needed.

Wellcome Images ⁵⁵

Figure 7: National Birthday Trust Fund, Breathing Apparatus (circa 1940s)

The design of the apparatus was such that, in addition to the restricted ratio of nitrous oxide to oxygen, the patient was unable to inhale an excessive dose of the analgesic. The mask contained an air-hole and inhalation of the analgesic gas could only occur if

⁵⁵ Wellcome Library, National Birthday Trust Fund, Breathing apparatus: National Birthday Trust Fund, CMAC SA/NBT/H3/11.

the patient covered the hole with her finger. The purpose of this design was to ensure that “if for any reason the threshold of *anaesthesia* is approached, the patient will be rendered incapable of effectively occluding this hole, and air will be inhaled.”⁵⁶ Women intending to receive gas-air during their confinement were taught the principles of administration during their antenatal care. Such education particularly emphasised the need to time the inhalations for maximum relief. In a model without a Chassar Moir attachment, it took 20–25 seconds for the analgesic to have effect, thus mothers were taught to inhale the mixture before the contraction so that they would receive the maximum relief during the height of the contraction. The inclusion of analgesic training in antenatal education helped to make these obstetrical aids available to all—or at least most—mothers without compromising maternal safety.

The subsequent widespread use of gas-air analgesics—administered by midwives—represents an approach to medicalization that was intended for maternal benefit rather than medical convenience. The primary beneficiaries of the new apparatuses were the mothers themselves, a fact which can be seen in maternal and medical responses to the new gas-air analgesics. Following their distribution of analgesic apparatuses to rural and urban communities, the National Birthday Trust Fund conducted extensive surveys on the use of gas-air inhalers during labour and delivery. The Trust’s surveys were concerned with analgesics administered by midwives and nurses rather than by physicians. Data was collected on the number of instances where analgesics were used in nursing districts, and asked the association to indicate how

⁵⁶ TNA, Records of the Central Midwives Board, Analgesic apparatus manufacturers: British Oxygen Company, DV 11/5.

many of these cases were satisfactory and why certain cases were not satisfactory. In these surveys, the assessment as to whether the analgesic provided satisfactory relief was nonetheless at the discretion of the healthcare provider—not the patient—although there were also surveys that focused on patient experience. In the majority of cases, it was concluded that the analgesic relief was satisfactory. Most of the institutions provided data on 10–20 cases and usually listed one or two cases that were “not completely satisfactory” and occasionally indicated that a case was “not satisfactory.”⁵⁷ In nearly every instance where they provided particulars as to why the case was not satisfactory, lack of patient co-operation was cited as the cause. There were a few cases where the problem was a long and complicated delivery, but, overwhelmingly, unsatisfactory cases were those in which the patient was deemed “un co-operative,” “nervous,” or “hysterical.”⁵⁸ The responses do not indicate what the patient said or did that was uncooperative, nervous, or hysterical.

While this data from district nursing associations and affiliated institutions provided an assessment of effectiveness from the clinician’s viewpoint, data was also collected that provided more detail for each case and focused on the patient’s perspective. In 1946 the Birthday Trust conducted a survey at Hertfordshire County Hospital on the efficacy of analgesic inhalers. Analgesia use was assessed for over two hundred deliveries. Midwives and nurses were required to provide the following

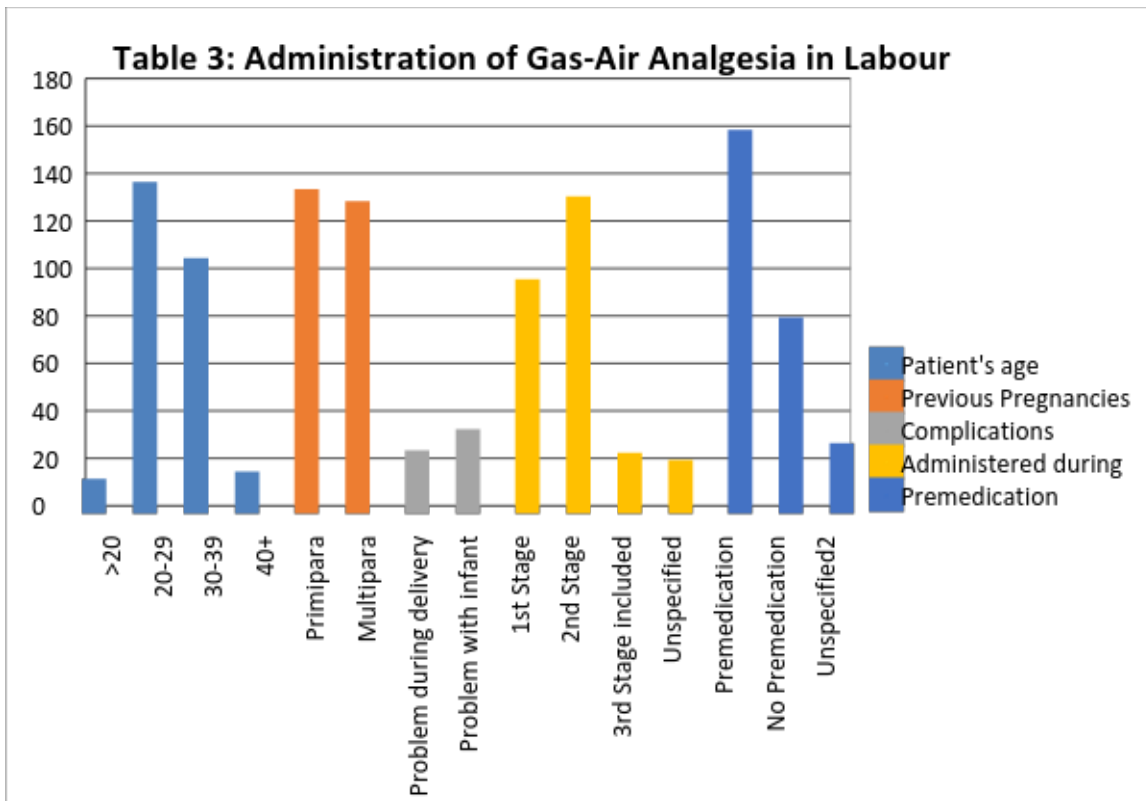
⁵⁷ “Reports on incidence of use of machines by District Nursing Association with comments on effectiveness: 6 monthly reports, Feb 1939–Dec 1951,” Wellcome Library, National Birthday Trust Fund, SA/NBT/H.2/3.

⁵⁸ “Reports on incidence of use of machines by District Nursing Association with comments on effectiveness: 6 monthly reports, Feb 1939–Dec 1951,” Wellcome Library, National Birthday Trust Fund, SA/NBT/H.2/3.

information about the patient's case: whether nitrous oxide or Trilene was administered, the age of the mother, how many previous confinements she had experienced, whether or not premedication was used, the stage in labour when analgesia was administered, the length of time of administration, the midwife's assessment of pain relief, the outcome of the delivery and the status of the baby upon birth. In addition to this extensive statistical data, patients were asked to provide remarks on their experiences with gas-air analgesia. Both the official statistics and the patient remarks reveal much about the efficacy of this form of analgesia.

The breadth of patients surveyed and the size of the sample group demonstrates that there were very few factors that influenced the efficacy of gas-air inhalers. The vast majority of mothers expressed satisfaction with the medication, but these women have very little in common otherwise, as this graph indicates:⁵⁹

⁵⁹ All cases for this survey came from Hertfordshire County Council. "Reports on use of different gas and air machines by individual patients at the Wellhouse Hospital, Hertfordshire," Wellcome Library, National Birthday Trust Fund, SA/NBT/H.2/4.



The one aspect of perinatal care common to the patients surveyed is that most women received analgesic medication prior to receiving gas-air analgesia. Twice as many women received gas-air analgesia following earlier medication—most commonly a mixture of chloral hydrate and potassium bromide—than did women who had not received any medication prior to the gas-air. The pre-medication may have increased the efficacy of the gas-air analgesia. In 231 out of the 254 cases nitrous oxide was the only form of gas-air administered, although Trilene was administered in 10 cases and a combination of nitrous-oxide and Trilene in another 13 cases. In situations when both nitrous-oxide and Trilene were administered the nitrous-oxide was always administered

first and then the patient was switched to Trilene, which some midwives reported as being the consequence of nitrous-oxide failing to adequately treat the pain.⁶⁰

Of the 254 mothers surveyed, only three expressed dissatisfaction with the analgesia. A 22-year-old primipara tried nitrous oxide for 5 minutes during the second stage of a labour that culminated in a “normal” delivery and “satisfactory” infant, but felt that the analgesia “did not help the pains very much,” while a 33-year-old with one prior pregnancy felt it was “not too effective until actual birth.”⁶¹ In the third case, a 21-year-old woman with no prior deliveries received 35 minutes of nitrous oxide during the second stage of a “normal” delivery with a “satisfactory” infant. This woman did find the pain relief “very good indeed,” but also expressed “after effects not so good.”⁶² In the remaining 251 cases mothers all expressed sentiments such as “I think it is wonderful how it helps you”; “completely eliminated all pain after first two inhalations and each successive one”; “I experienced immediate relief though quite aware of what was happening”; and “I feel the gas saved my life, it was wonderful.”⁶³ It is telling that women expressed such positive sentiments even when the infant faced serious complications and possibly death. A woman whose infant was asphyxiated at birth reported “gas dulled the pain,” while a woman whose infant was stillborn declared “it was wonderful, I was so relieved.”⁶⁴ The emotional aspect of these delivery

⁶⁰ Wellcome Library, National Birthday Trust Fund, SA/NBT/H.2/4.

⁶¹ Midwives used either “normal” or “satisfactory” to describe infants who displayed no health problems at birth. Wellcome Library, National Birthday Trust Fund, SA/NBT/H.2/4.

⁶² Wellcome Library, National Birthday Trust Fund, SA/NBT/H.2/4.

⁶³ Wellcome Library, National Birthday Trust Fund, SA/NBT/H.2/4.

⁶⁴ Wellcome Library, National Birthday Trust Fund, SA/NBT/H.2/4.

complications did not change the fact that women felt that the inhalation of gas-air during labour was a positive experience.

In the survey from Hertfordshire County Council, the point in labour when administration occurred does not appear to have affected whether women felt adequate relief from the analgesia. These reports show that 92 women received analgesia during the first stage of labour, while 127 received it during the second stage. While this case study suggests that administration during the second stage of labour was as beneficial as administration during the first stage, other districts did not always agree with this assessment. Gloucester District Nursing Society felt that there were “Much better results when the administration is commenced during the 1st stage.”⁶⁵ The records from the NBTf do not indicate why analgesia was most effective if it was first administered during the first stage, but modern studies on pain in childbirth indicate that the first stage and transition from the first stage to the second stage are usually far more painful than the second stage (the delivery of the infant).⁶⁶ While there were differing opinions on when to administer analgesia to provide the most effective relief, overall it was felt that the primary reason results were either unsatisfactory or not completely satisfactory was because the patient was being uncooperative, although there is no definition of what constituted an uncooperative patient.⁶⁷ Results from the

⁶⁵ “Reports on incidence of use of machines by District Nursing Association with comments on effectiveness,” Wellcome Library, National Birthday Trust Fund, SA/NBT/H.2/3.

⁶⁶ Jacqueline Wolf, *Deliver Me From Pain: Anesthesia and Birth in America* (Baltimore: Johns Hopkins University Press, 2009), 42.

⁶⁷ Wellcome Library, National Birthday Trust Fund, SA/NBT/H.2/3.

survey suggest that the fixed nitrous oxide to oxygen ratio on a midwife's apparatus had no notable impact on whether gas-air was effective.

Other studies showed similar results to the surveys done by the NBTf. In the late 1940s, the Committee on Analgesia in Midwifery also conducted surveys on the use of gas and air analgesia in both domiciliary and hospital settings. These surveys were completed as part of a project to design a Trilene inhaler that would be suitable for use by midwives in a domiciliary setting. As with the surveys from Hertfordshire County Hospital, this study provided results based on a wide range of ages, number of previous births, and time and duration of the analgesia. Additionally, the Committee's study looked at the efficacy of analgesics in labour at home versus labour in hospital, and, in the case of hospital births, whether or not the analgesic pethidine was used in addition to the nitrous oxide or Trilene analgesic.⁶⁸ Based on data for 295 women who received nitrous oxide, and 329 who received Trilene, during labour at home, the doctor or trained midwife determined that 92 per cent of mothers had complete or adequate analgesic relief from nitrous oxide, and 96 per cent of mothers received complete or adequate relief from Trilene.⁶⁹ The mothers themselves reported similarly. Of those who received nitrous oxide, 97 per cent found they experienced no pain or tolerable pain, and 99 per cent of mothers who received Trilene experienced either no pain or tolerable

⁶⁸ Pethidine hydrochloride is a synthetic opioid analgesic and muscle relaxant that was introduced as an obstetrical analgesic in the early 1940s. It was considered to have the same analgesic effects as morphine with a lower risk of decreased respiration. Walter Spitzer, "Obstetric Analgesia with Pethidine," *British Medical Journal* 1, 4335 (February, 1944): 179–181.

⁶⁹ TNA, Records of the Central Midwives Board, Analgesia in Childbirth Bill, DV 6/10.

pain.⁷⁰ In cases of labour in hospital, mothers and the supervising medical professional reported a similar range of pain relief to that of home births. Portable analgesic apparatuses meant that medicalized birthing practices did not always require a shift to hospital-based births. The addition of pethidine to nitrous oxide did slightly increase the analgesic effect, but pethidine had negligible effects when added to Trilene.⁷¹ This study, which was produced as part of a broad study on analgesia as it connected to the Analgesia in Childbirth Bill, is noteworthy as it shows that effective pain relief could be provided in a domiciliary setting and provided by a midwife. The nitrous oxide and Trilene inhalers designed for use by midwives had limitations compared to the physicians' models for hospital use, but, as these figures show, these limitations had no notable effect on the efficacy of analgesic relief.

The demonstrated effectiveness of gas-air analgesics, as well as the campaigns to encourage their widespread use, must be considered in relation to the regulation of medication and its subsequent effect on the midwife's professional status. The establishment of certificates in anaesthesia and analgesia has been discussed in relation to developments in these analgesics, but these certificates can be contextualized within the broader history of drug regulation and professional autonomy. In England and Wales, the administration of drugs was regulated under the *Dangerous Drugs Act* (1920). While the CMB outlined specific rules, the *Dangerous Drugs Act* dictated regulations for all professions. Initial versions of the *Act* did not specifically address midwives, a significant absence. The *Dangerous Drugs Act* of 1920 was specifically

⁷⁰ TNA, Records of the Central Midwives Board, Analgesia in Childbirth Bill, DV 6/10.

⁷¹ TNA, Records of the Central Midwives Board, Analgesia in Childbirth Bill, DV 6/10.

concerned with drugs that had high addictive properties, hence the name. The first act addressed the regulation of raw opium; medical opium; cocaine and ecgonine and their salts; morphine and its salts; diamorphine (heroin) and its salts; and any preparation, admixture, extract or other substance containing one-fifth per cent or more of morphine or one-tenth per cent or more of cocaine, ecgonine or diamorphine.⁷²

Midwives were not permitted to carry or administer any of these drugs—indeed, at this point, they were only permitted to carry antiseptics—and only medical practitioners and dentists were considered authorised persons under the 1920 Act.

In spite of the fact that midwives were excluded from the 1920 *Dangerous Drugs Act*, the question of whether midwives should be permitted to carry medication—including opium and opium derivatives—was frequently raised in *Nursing Notes and Midwives Chronicle* in the early 1920s. While acknowledging the risks associated with such medications, many of these articles and opinion pieces argued for the benefits of allowing midwives to administer certain medications. They also pointed out that, while certain medications were prohibited under the Act, “the proper administration of drugs by midwives is not forbidden in the rules. The question of whether any particular administration was proper would come under the head of proper or improper treatment in general.”⁷³ Some argued that midwives should be educated in the administration of medications regularly used by obstetricians—even if they were not used by midwives themselves.

⁷² Great Britain. *Dangerous Drugs Act s 1*, ch 3 (1920), London: Stationery Office.

⁷³ “The Administration of Drugs by Midwives,” *Nursing Notes*, (January 1920), 4.

The teaching of drug familiarity would ensure that midwives understood the nuances of medication and their potential domino effect where prescribing one drug can contribute to the need for further intervention; essential knowledge even if they could not administer all medications. For example, chloroform could be dangerous because it brought about inertia and a dangerous slowing of labour. Consequently, pituitary extract, which stimulates uterine contractions, was introduced to reduce the number of cases where physician interventions such as forceps use or caesarean section were required to safely deliver the mother. Pituitary extract itself posed its risks and was contraindicated in many cases, including “obstructed labour, maternal heart disease, severe anaemia, high blood pressure, or if the foetal heart sounds are weak or infrequent.”⁷⁴ In part because of these risks, it was believed that midwives should be familiar with the administration of pituitary extract—and its possible side effects—so that they could adequately assist an obstetrician by observing any possible dangerous symptoms. Such an argument was part of a larger view that midwives should be trained in the “method of administration, action and indications of drugs used in an emergency.”⁷⁵ Discussions about pituitary extract also demonstrate some of the complexities of the medicalization of childbirth. Chloroform was introduced to reduce the pain of labour, but it resulted in uterine inertia and potentially dangerous labour and pituitary extract was introduced to offset the side-effect of chloroform. The training of midwives in analgesics and anaesthetics thus included midwives in the medicalization

⁷⁴ M. Olive Haydon, “Pituitary Extract in Obstetrical Practice,” *Nursing Notes*, (March 1920), 28.

⁷⁵ Haydon, “Pituitary Extract in Obstetrical Practice,” 28.

of childbirth, but also ensured that their practice became increasingly medicalized as each medical intervention created a need for further interventions.

While British midwives were undeniably included in this process of increased reliance on medical technologies and medication during labour and delivery—which in turn enhanced their professional status—midwives and physicians adopted these medicalized practices for different reasons. Midwives were included in the medicalization of birth to assist mothers and ease pressure on physicians. Their elevation in professional status was a benefit, but not a goal, of this process. Physicians, on the other hand, believed in the medicalization of birth for personal, as well as professional and medical, benefits. The personal and professional motives of physicians in Ontario have been outlined in earlier chapters, and in this respect physicians in the United Kingdom were not entirely divorced from the perspectives and approaches evident in Ontario. Significantly, their personal and professional motives often supported trained midwives, but the administration of drugs during childbirth is one area where personal convenience was arguably placed at the forefront. As Dr. Laphorn Smith wrote in *Nursing Notes* (1921), the benefits of administering morphine during labour was that *he* was more likely to have a full night's sleep: "I have, for many years, been accustomed to prescribe a mixture of bromide of soda, 30 grains to the dose, and ½ grain morphine sulph., to be taken every four hours as soon as labour begins Instead of being called up every hour or two, I have spent many hundreds of nights in bed by the help of this prescription."⁷⁶ Dr. Smith does address the benefits of morphine for

⁷⁶ Laphorn Smith, "The Use of Morphine in Labour," *Nursing Notes* (May 1921), 51.

expectant mothers, but, in placing his convenience ahead of the patient's response, we do see early signs of how ideas about the medicalization of childbirth differed between midwives and physicians even as both involved in increasingly medicalized practice. Such examples show the complexities of professionalization and medicalization, but do not diminish the midwife's significance in these developments.

Throughout the first half of the twentieth century, changes to the regulations in the UK indicate that midwives were gradually being acknowledged as medical practitioners capable of administering appropriate drugs to parturient women. In particular, their certification in gas-air analgesia, and later their approved administration of medical tinctures, including specified dosages of medical opium—only permitted to medical practitioners and dentists under first editions of the Act—confirm this larger “inclusion” of midwives in the medicalization of childbirth. By the 1948 edition of the Act, midwives who had notified their local supervising authority of their intent to practice were “authorized to be in possession of, and to administer, medicinal opium, tincture of opium and pethidine (1 methyl-4-phenylpiperidine-4-carboxylic acid ethyl ester) so far as is necessary for the practice of her profession or employment as a midwife.”⁷⁷

Midwives were also permitted to carry some medications not covered by the *Dangerous Drugs Act*: general antiseptics; a preparation approved by the Local Supervising Authority for introduction into the child's eyes; cardiac and respiratory stimulants; a preparation of ergot for intramuscular injection; and sedatives and

⁷⁷ TNA, Records of the Central Midwives Board, Correspondence and Papers, Drugs: acts, circulars, regulations, 1920–1959, DV 11/52.

analgesics all fell under the category of drugs which “should ordinarily be carried by a midwife in addition to aperients.”⁷⁸ There were conditions placed on this authorisation, such as the need to keep an up to date drugs book and the ruling that she was not allowed “possession of a quantity of pethidine exceeding the quantity which would be required for the administration of two hundred milligrams to each woman whose case of pregnancy is entered in the said personal register of cases.” Even with these conditions, however, the new *Dangerous Drugs Act* permitted midwives much greater medical autonomy than was possible in early decades of the *Midwives Act*. While officially still only permitted to work autonomously in cases of normal childbirth, the changing definition of normal childbirth also expanded and redefined the midwife’s scope of practice.

The most significant change to medication regulations were those surrounding the administration of anaesthesia and analgesia. I have briefly outlined the certificates in anaesthesia and analgesia as part of a midwife’s beneficial involvement in medicalised birth, but a closer look at these changes illustrates their overall impact on midwifery practices during these years. Having established the regulations that depended on special courses in analgesia and anaesthesia, the Board became responsible for approving institutions intending to provide such courses. There were training requirements, although the particulars of the courses were left to the design of the individual institution. Initially the Board only felt it appropriate to grant permission

⁷⁸ TNA, Records of the Central Midwives Board, Central Midwives Board: Rules of Conduct, Nineteenth Edition (1947), “Notices Concerning a Midwife’s Code of Practice,” DV 3/19.

to institutions that had co-operated with the Royal College of Obstetricians and Gynaecologists on their report, but, beginning in the 1930s, the Board surveyed and approved—either provisionally or outright—numerous institutions across the country. The new approvals increased access to midwives seeking education in the administration of anaesthesia and analgesia. In December 1936, the Board granted five institutions the right to instruct in the use of gas and air analgesia: Wellhouse Hospital, Barnet; Leicester City General Hospital; Leicester Municipal Maternity Home; Royal Victoria and West Hants Hospital; and Nightingale Home (Royal Derbyshire Nursing Association).⁷⁹ Throughout the late 1930s and the 1940s the Central Midwives' Board approved numerous institutions from across England and Wales. While many were located in urban centres, the approved institutions offered training in most parts of the country. The process was such that, by the end of 1950, 199 institutions had been approved in the instruction of gas and air analgesia.⁸⁰ Even as many functions of the Central Midwives' Board decreased during the Second World War, the approval of training institutions remained a priority; 40 institutions were approved at seventeen of the twenty-one meetings held during the War.⁸¹

The legislation and accessibility of training are key to this study of medicalization; however, while the Board emphasized midwife instruction in gas and air analgesia, such an emphasis did not immediately translate into a rapid increase in

⁷⁹ TNA, Records of the Central Midwives Board, Central Midwives Board: Minutes, (December 3, 1936), DV 1/14.

⁸⁰ TNA, Records of the Central Midwives Board, Central Midwives Board: Minutes (1936–1939), DV 1/14–DV 1/16.

⁸¹ TNA, Records of the Central Midwives Board, Central Midwives Board: Minutes (1939–1946), DV 1/16.

midwives with this additional training. Initially, in spite of efforts by the NBTF, few midwives completed the analgesia and anaesthesia certificate. In 1945 there were 71,857 women certified on the Midwives' Roll. Of these 16,680 indicated their intent to practice in 1945.⁸² Meanwhile, as of January 1st 1946, only 3,046 midwives had completed certification in gas and air analgesia; it is not known whether all of these 3,046 midwives were practicing in 1945.⁸³ Even if all midwives with gas-air training intended to practice, over 80 per cent of practicing midwives would not have completed this certification. Between 1946 and 1947, however, changes to the training requirements of midwives led to a rapid increase in the number of midwives certified in gas-air analgesia. Shortly before the introduction of the *National Health Services Act*, the Central Midwives Board altered the training requirements of midwives to mandate that "a pupil-midwife shall receive theoretical and practical instruction in the administration of nitrous oxide and air analgesia."⁸⁴ Such instruction was to include "3 lecture demonstrations by a specialist anaesthetist, one of these lectures to include the emergencies of anaesthesia and the care of the unconscious patient," and required the pupil-midwife to administer gas-air analgesia from an approved apparatus to a minimum of 15 patients in labour.⁸⁵ The effect of this regulation was such that the

⁸² TNA, Records of the Central Midwives Board, Central Midwives Board: Roll of Practising and Non-practising Midwives, Aanenesen to Zipfel, DV 7/47.

⁸³ TNA, Records of the Central Midwives Board, Analgesic apparatus training: number of certificates issued to midwives, DV 11/11.

⁸⁴ TNA, Records of the Central Midwives Board, Central Midwives Board: Rules of Conduct, Nineteenth edition (1947), Section B 17(b), DV 3/19.

⁸⁵ The pupil midwife was required to complete this qualification during the second period of training, during which time the pupil midwife was expected to "attend and take responsibility for not less than 20 women during labour"; however, the rules do not

number of midwives certified in gas-air analgesia doubled in a year. By March 1947, 6,432 midwives had received certificates in the administration of nitrous oxide and oxygen.⁸⁶ Within a few years this number had more than tripled, and by end of the period covered there were 23,010 certified midwives proficient in gas and air analgesia: 13,172 of the 18,800 certified midwives who intended to practice during 1950–51 were proficient in gas and air analgesia.⁸⁷ The changes in regulation and training that accompanied these advancements in obstetrical technology indicate the centrality of the midwife to childbirth in the United Kingdom and show how such developments helped transform trained midwives into a largely autonomous branch of the medical profession fully involved in medicalization. The inclusion of midwives in medical advancements, including drug administration, is a key example of the correlations between medicalization and professional autonomy. While this study of regulation addresses how midwives interacted with the British medical system, it is also worth examining the role of British midwives in the International Midwives' Union, as this participation demonstrates that midwives not only utilised medical advancements in their practices, but were also active members in organisations concerned with the training of midwives and advancements in obstetrics.

stipulate whether these labours may overlap or whether the pupil was expected to attend a total of 35 labours during the second period of training. TNA, Records of the Central Midwives Board, Central Midwives Board: Rules of Conduct, Nineteenth edition (1947), Section B 14(b), 17(b.i, b.ii), DV 3/19.

⁸⁶ TNA, Records of the Central Midwives Board, Analgesic apparatus training: number of certificates issued to midwives, DV 11/11.

⁸⁷ TNA, Records of the Central Midwives Board, Ministry of Health Working Party on Midwives: Board papers and correspondence, DV 6/7.

Many midwives in England joined the International Confederation of Midwives (ICM), which was founded in Belgium in 1919 and had over 1,000 members from over twenty countries by the 1930s.⁸⁸ The ICM held a congress every second year throughout the 1920s and 1930s—with upwards of 600 midwives in attendance—to discuss the training and duties of midwives.⁸⁹ Their active role in the advancement of maternal health and safety shows the professional and social influence of midwifery in Europe. This organisation valued the training of midwives and believed midwives needed a minimum of “two years residence in a Maternity Hospital, and a supplementary year of study of child welfare and public health,” and that no more midwives should be trained than were needed in the country.⁹⁰ Not surprisingly, the organisation promoted home births and midwife-assisted births. This ideology received support from physicians who participated in the conferences. As Professor Dael (first name unknown), professor of obstetrics at Ghent University in Belgium, declared at the opening speech for the 1938 Congress in Paris, “Confinements at home should be encouraged by governments on account of their medical, social and ethical advantages. The presence of a midwife at every confinement should be legally imposed, even when a doctor is in attendance.”⁹¹ Although the organisation did not have any official standing, its persistence, publications, and interaction with the medical community is a noteworthy example of

⁸⁸ At the 1938 meeting in Paris there were 65 English midwives in attendance. Wellcome Library, International Confederation of Midwives, Communications of the International Midwives' Union 1932–1939, SA/ICM/R/1.

⁸⁹ Wellcome Library, SA/ICM/R/1.

⁹⁰ Wellcome Library, SA/ICM/R/1.

⁹¹ Wellcome Library. Communications of the International Midwives' Union. Professor Dael's Speech at the Eighth Congress. SA/ICM/R/2/1.

the professionalization process for European midwives. Such status, and independent participation in an international arena, was not possible for nursing and women's organizations in Ontario. While organizations such as the National Council of Women of Canada did support midwifery, none were able to break through the political and social stronghold of organized medicine in Ontario.

These interconnected stories of medical technology and the professionalization of midwifery are crucial to the period's larger concerns surrounding maternal health and mortality, childbirth practices, and access to healthcare. Furthermore, the professional autonomy gained by midwives through their access to analgesics and certain medications is noteworthy for the fact it was widely recognised as a benefit to the medical profession and externally created with support from numerous medical organisations. The National Birthday Trust, which supported midwives but was not officially connected to midwifery, engineered support from the Central Midwives Board and the Royal College of Obstetricians and Gynaecologists to find an obstetrical analgesia suitable for use by midwives. These efforts by the NBTF, CMB, and RCOG were instrumental to two important changes to British midwifery in the 1930s: the introduction of gas and air analgesics designed specifically for midwives, and changes to midwifery regulations in relation to anaesthesia, analgesia, and obstetrical drugs. Both of these changes ensured that the medicalization of childbirth in Britain was not synonymous with either physician-attended birth or hospital-based birth. They also helped to create a relatively autonomous midwifery profession that was able to assert its growing autonomy through organisations such as the International Confederation of

Midwives. Cumulatively, all of these issues helped to ensure that midwives were central to maternal health practices and policies in Britain. This centrality will become particularly apparent in the discussions relating to maternal and infant health and mortality as midwives were key agents in the attempts to reduce maternal and infant morbidity and mortality rates.

5 **“NEED OUR MOTHERS DIE?” THE GREAT DEPRESSION AND STATE CONCERNS ABOUT MATERNAL AND INFANT MORTALITY**

The professional measures enacted in Ontario and Britain at the turn of the twentieth century—while strikingly divergent—were intended, above all, to reduce maternal and infant mortality rates. In both instances, the changes did reduce maternal mortality; however, neither tactic was as fruitful as was hoped. Furthermore, on both sides of the Atlantic, the problems of maternal and infant mortality became all the more apparent after the staggering losses during the First World War. These concerns about maternal and infant deaths culminated in the 1930s; they were exacerbated during the Depression, although the correlations between poverty and mortality were not acknowledged until the 1940s. During the 1930s, the government of Ontario, alongside and frequently in partnership with the Canadian federal government and its public health and welfare agencies, as well as the government of Great Britain, conducted newly-rigorous studies to ascertain the leading causes of such high mortality rates. Their studies produced similar results; however, as the history of midwifery in each nation amply demonstrates, their responses to the research diverged. Britain opted to increase midwives' access to medical science and technology, whereas Ontario opted to push medicalization through physician-controlled hospital-births.

While health officials in Ontario were certainly concerned about the maternal mortality rate in the province, most studies on maternal mortality addressed provincial variations while treating the issue as a national concern because the socio-economic

impact of maternal mortality affected the nation and the programs that operated at a federal level. As Alberta's deputy minister of health, Dr. M.R. Bow, explained in a 1930 article in the *Canadian Medical Association Journal*:

As a public health authority has pointed out, 1,314 deaths of women [across Canada], and the chronic invalidism of several times this number, constitute a much graver problem than an equal number of deaths among the general population, since these maternal deaths involve the disruption of homes, the future welfare of dependent children, and other sociologic and economic factors which the State is sooner or later called upon to deal with.¹

The leading causes of maternal mortality in Canada were thoroughly addressed in a 1925 study by Dr. Helen MacMurchy, which was presented at the Medical Services Conference in Ottawa in 1927.² This report was credited for reducing the maternal death rate by 178 deaths between 1930 and 1931 (after adjustments to allow for variations in the birth rate): "It is generally believed that this saving of Mothers' lives has come about in consequence of the work of the Division of Child Welfare and especially the Report on Maternal Mortality in Canada, completed on October 28th, 1927, and published January 31, 1928, in which we had the personal co-operation of the Dominion Bureau of Statistics, the Provincial Authorities, Voluntary Societies, two thousand members of the medical profession and others."³ Ten years after MacMurchy's study, a committee of the Division on Maternal and Child Hygiene, as part of the Canadian Welfare Council, produced a follow-up study addressing the leading causes of maternal

¹ M.R. Bow, "Maternal Mortality as a Public Health Problem," *Canadian Medical Association Journal (CMAJ)* 23, 2 (August, 1930): 169.

² "Maternal Mortality Survey," *Second Conference on Medical Services in Canada*, House of Commons, March 28th, 29th, 30th, 1927 (Ottawa: F. A. Acland, King's Printer, 1928), pp. 146–49.

³ LAC, *Health branch, Department of National Health and Welfare*, RG 29 Vol 23 File 21-1-1.

and infant mortality in Canada, and placing the Canadian situation within a broader international perspective. The results of this study were disseminated in the 1935 publication, *Need Our Mothers Die?* This study provided statistics on the leading causes of maternal mortality by province, while also addressing factors such as marital status. Provincial maternal and infant mortality rates were correlated to provide a national portrait of their incidence.

One of the report's findings was that marital status had a significant influence on maternal mortality. Statistics from 1926–1933 show that, throughout this period, the maternal mortality rate of unmarried mothers was often double that of married women.⁴ In relation to the provincial birth rate, very few unmarried women gave birth each year, which means their high maternal death rate did not drastically increase the overall death rate. In 1930, across the country, Canada had a maternal death rate of unmarried women of 12.0 per 1,000 live births, which was the highest it reached during this study.⁵ In the same year, however, only 8,059 of Canada's 234,495 births, or 3 per cent, constituted "illegitimate" live births.⁶ Consequently the unmarried mortality rate of 12.0 only raised the national maternal mortality rate from 5.6 for married women to

⁴ "Maternal Mortality of unmarried women in Canada, 1926–33," *Need Our Mothers Die?*, 39.

⁵ The data in in this study does not provide the provincial breakdown for the maternal mortality of unmarried women and most of the available figures are national rather than provincial. "Maternal Mortality of unmarried women in Canada, 1926–33," *Need Our Mothers Die?*, 39.

⁶ "Summary of Births, Marriages, Deaths and Natural Increase by Provinces," *The Canada Year Book 1932* (Ottawa: F.A. Acland, Printer to the King's Most Excellent Majesty, 1932) 115.

5.8 for both married and unmarried women.⁷ Needless to say the unmarried mortality rate varied by province—as did the illegitimate live birth rate—and in Ontario the mortality rate of unmarried women was notably high: 8 per cent of maternal deaths were those of unmarried women.⁸ The average number of births in Ontario (1926–1930) was 68,703; given that Ontario had an average maternal mortality rate of 5.8 in the same period, that means approximately 32 unmarried women died in childbirth each year and their maternal death rate was almost twice that of married women.⁹ The potential causes of this high death rate were not discussed in detail, but the report did speculate “that the assurance of early social services and provision of maternal care to unmarried mothers may play not only an admittedly definite role, but a greater part than has been generally recognized in the correction of a high maternal death rate, in Canada.”¹⁰ In short, unmarried mothers were likely to keep their pregnancies “hidden,” availing themselves of medical services only at the last minute, if at all.

In the aftermath of *Need Our Mothers Die?* antenatal care to prevent maternal and infant deaths was increasingly emphasized in other publications, both professional and public. As MacMurchy admonished,

The undiminished and increasing seriousness of the neonatal death toll, the unchanged incidence of the stillbirth rate, and the continuing high incidence of maternal deaths due to preventable causes, indicate that in spite of some measurable progress in prenatal care, due to public and professional education

⁷ “Maternal Mortality of unmarried women in Canada, 1926–33,” *Need Our Mothers Die?*, 39.

⁸ *Need Our Mothers Die?*, 38.

⁹ “Summary of Births, Marriages, Deaths and Natural Increase by Provinces,” *The Canada Year Book 1932*, 114; *Need Our Mothers Die?*, 38; “Maternal mortality rates in Canada and the Provinces during the years 1926–34,” *Need Our Mothers Die?*, 11.

¹⁰ *Need Our Mothers Die?*, 38.

and co-operation, the immediate challenge of this decade is for public health education to the need of more adequate measures of maternal welfare.¹¹

There was an understanding that education and antenatal care were the key methods of reducing maternal and infant mortality rates. The effectiveness of antenatal care as a means of reducing maternal mortality rates cannot be disputed. In 1938, a few years after the publication of *Need Our Mothers Die?*, the maternal mortality rate for all of Canada was 4.2 per 1,000 births, but the maternal mortality rate for obstetric cases under the supervision of Victorian Order Nurses was only 1.5.¹² Such support of antenatal care arrived late in the interwar years, however, as initially it was not a factor emphasised in public health. As the Advisor in Nursing for the Rockefeller Foundation expressed in a 1927 article in *The Canadian Nurse*: “in Canada, we refuse to consider maternal care an essential, indeed a foremost, concern of the public health authorities.”¹³ One year later, the Superintendent of the Victorian Order of Nurses for Greater Vancouver argued that, on a federal level, there was not enough emphasis on antenatal care and that both the public and many trained nurses were ignorant of the benefits: “The importance of pre-natal supervision is not yet realized by the general public or even by many of the nurses.”¹⁴ While Canada’s focus on maternal care may have been delayed compared to some countries, by the 1930s the emphasis turned to promoting antenatal care.

¹¹ *Need Our Mothers Die?*, 11.

¹² Libraries and Archives Canada, Victorian Order of Nurses for Canada MG 28 I 171 vol. 6.6.

¹³ Mary Beard, “Department of Public Health Nursing: Midwifery in England: Part 1,” *The Canadian Nurse* (February, 1927), 91.

¹⁴ Margaret Duffield, “The Necessity of Pre-Natal Work,” *The Canadian Nurse* (April, 1928), 199.

By the publication of the 1935 study *Need Our Mothers Die?*, it was certainly known to provincial and federal health officials in Canada that proper antenatal care could and did improve the maternal and infant mortality rates. It was not, however, clear what form antenatal and parturient care should take. The overarching question in *Need Our Mothers Die?* was “what is the ideal structure and system of perinatal care?” Dr. John Puddicombe, the Staff Obstetrician for the Division of Maternal and Child Hygiene in Ontario expressed in a 1934 report the centrality of antenatal care, yet doctors and health officials remained ambivalent about what that care entailed: “To the laity too frequently it means only a contract to be cared for at the time of confinement. To the medical men it may be as variable as the characters of those individuals who undertake the practice of midwifery.”¹⁵ For many physicians, antenatal care was not considered lucrative work and they were only in favour of providing such care to paying patients, which is why nursing organisations such as the Victorian Order of Nurses were responsible for providing most antenatal care. Yet physicians in Ontario also equated medicalization with physician-led care. The elimination of midwives and limiting the scope of practice for nurses would ensure professional and economic success. In light of this ambivalence—and at times conflicting opinions—towards antenatal care, organisations such as the Canadian Welfare Council sought to define its requirements. While nurses were permitted involvement in some antenatal and postnatal care, these organisations overwhelmingly promoted physician managed pregnancy and birth.

¹⁵ “The importance of prenatal care,” Libraries and Archives Canada, Child and Maternal Health Division RG 29 Vol 993 File 499.3.7 Pt 9.

In spite of the revelations about the causes of maternal mortality, figures from throughout the 1920s and 1930s show minimal variation in the maternal mortality rates in either Ontario or Canada. In the mid-1920s, the Canadian maternal mortality rate was approximately 6.4 per 1,000 births.¹⁶ This means that, for the 237,199 births that occurred in Canada between July 1st 1925 and July 1st 1926, there were 1,532 maternal deaths.¹⁷ Of these 1,532 maternal deaths, experts believed that approximately 1,000 were preventable, mostly through adequate antenatal care and medical—defined as physician—attendance at the delivery.¹⁸ Such beliefs in the importance of physician care before and during birth were emphasized in statistics that showed that “only 190 of the 1,532 dead Mothers had Pre-Natal Care.”¹⁹ Factors such as rural isolation were recognised barriers to antenatal care and physician, or even nurse, care at confinement, but these were not considered acceptable reasons for the high maternal death rate in Canada. Physicians and public health officials understood that proper antenatal care was the best way to reduce the maternal mortality rate, and finding ways to ensure the availability of such antenatal care was the top priority.

Most studies from this period focus on the benefits of antenatal care in relation to the maternal mortality rate. The burgeoning government advice literature made overt connections between antenatal care, maternal health, and saving infants.

¹⁶ *Need our mothers die?: a study made by a special committee of the division on maternal and child hygiene* (Council House, Ottawa: Canadian Welfare Council, December 1935), 1.

¹⁷ Helen MacMurchy, *Mother: The Little Blue Books National Series No. 3* (Ottawa: F.A. Acland Printer to the King's Most Excellent Printer, 1928), 2.

¹⁸ MacMurchy, *Mother*, 3.

¹⁹ MacMurchy, *Mother*, 18.

Although most of the major studies in both Ontario and Britain were focused on maternal mortality, national concerns about infant mortality and morbidity were significant. In 1940, physician Ernest Couture, director of the federal Child and Maternal Hygiene Division, published the first of many issues of *The Canadian Mother and Child*. As Dr. R.E. Wodehouse, Deputy Minister of the Department of Pensions and National Health, wrote in the foreword, “The health of mother and child depends on intelligent care, and *The Canadian Mother and Child* contains facts relating to infant and maternal hygiene which every woman should know. It is not a textbook but a ready reference which expectant mothers should keep at hand for their guidance.”²⁰ Couture argued that antenatal care was beneficial for both mother and child.²¹ Although he was willing to speak openly about how to manage pregnancy and delivery in cases where it was not possible to have physician supervision, he supported the overall medical commitment to physician supervised care as the best option. He contended that mothers “should remain throughout these months under the constant supervision of a medical man.”²² Other options were clearly considered inferior to physician-controlled care.

Physician dominance as the only avenue to maternal safety—and the subsequent argument that medicalized birth required physician attendance—is

²⁰ Ernest Couture, *The Canadian Mother and Child* (Published by authority of The Hon. Ian A. Mackenzie, Minister of Pensions and National Health, Ottawa, Canada, 1940) Foreword.

²¹ The correlations between antenatal care and infant mortality have been discussed in Mona Gleason’s recent publication: Mona Gleason, *Small Matters: Canadian Children in Sickness and Health, 1900–1940* (Montreal & Kingston: McGill-Queen’s University Press, 2013), 22–29.

²² Couture, *The Canadian Mother and Child*, 3.

apparent in studies on mortality rates in Ontario and Canada, as well as the professional discourses found in the *Canadian Association Medical Journal (CMAJ)*. Numerous *CMAJ* articles related to maternal and infant mortality and associated developments in obstetrics were published during the interwar years.²³ These articles, however, make it clear that physician concerns about midwifery were very different than those found in equivalent British publications such as the *British Medical Journal (BMJ)* and *Lancet*, both well known and likely read by many Canadian physicians. In contrast to the British belief that midwives were integral to effective maternity services, *CMAJ* contributors, all of them “medical men,” blamed midwives, including properly trained midwives in the United Kingdom, for maternal mortality.²⁴ Grant Fleming, physician and public health activist, denied any correlation between the use of midwives and low maternal

²³ Between 1920 and 1940 the *Canadian Medical Association Journal* published sixteen articles addressing maternal mortality on a provincial, national, and international level. *CMAJ* articles from this period not already discussed in this chapter include: W.W. Chipman, “Maternal Mortality,” *CMAJ* 34, 5 (May, 1936): 552–553; W.G. Cosbie, “Maternal Mortality,” *CMAJ* 43, 1 (July, 1940): 38–44; J.H. Duncan, “Maternal Mortality in Country Practice,” *CMAJ* 38, 6 (June, 1938): 550–552; J.R. Goodall, “Maternal Mortality,” *CMAJ* 21, 4 (October, 1921): 447–450; W.B. Hendry, “Maternal Mortality,” *CMAJ* 13, 4 (April, 1923): 252–254; Helen MacMurchy, “On Maternal Mortality in Canada,” *CMAJ* 15, 3 (March, 1925): 293–297; MacMurchy, “Maternal Mortality,” *CMAJ* 15, 9 (September, 1925): 941; MacMurchy, “Maternal Mortality in Canada,” *CMAJ* 17, 12 (December, 1927): 1434–1438; Presley A. McLeod, “Maternal Mortality From the Viewpoint of the Obstetrician,” *CMAJ* 42, 1 (January, 1940): 53–56; J.T. Phair, and A.H. Sellers, “Maternal Mortality in Ontario,” *CMAJ* 31, 6 (December, 1934): 655–658; Karl M. Wilson, “The Problem of Maternal Mortality,” *CMAJ* 34, 5 (May, 1936): 518–525; James Young, “An Address on Maternal Mortality from Puerperal Sepsis,” *CMAJ* 19, 2 (August, 1928): 227–233.

²⁴ W.W. Chipman, “Problems of Obstetrical Practice,” *Canadian Medical Association Journal* 13, 6 (June, 1923): 379–380.

mortality rates.²⁵ He argued this point even while acknowledging that countries with a low maternal death rate relied on trained midwives.²⁶ In addition to wholesale dismissal of midwifery services, such discussions never addressed the possibility of nurses using new technologies or directing advancements in medical science and technology to suit their specific needs. As shown in Chapter Two, nurses in Ontario often acted as de facto midwives—especially in rural areas where physicians were either unavailable or unaffordable.²⁷ Nevertheless, nurses were excluded from discussions about the use of technology in maternity services and their role was of trained professional rather than medical practitioner. Whereas *Nursing Notes and Midwives Chronicle* in Britain and *Irish Nursing News* were inundated with articles pertaining to anaesthesia and advancements in obstetrics, the only article in *The Canadian Nurse* on the use of chloroform by nurses discusses the detrimental effects of chloroform on major organs. The author does not even address if, or how, nurses should be permitted to administer chloroform.²⁸ Dr. Wesley Bourne, the physician who wrote this article for the enlightenment of Canadian nurses, published extensively on obstetrical anaesthesia in the *CMAJ*. His *CMAJ* publications discuss the roles of obstetricians and anaesthetists in the administration of analgesia and anaesthesia, but at no point does he make reference to nurses. Whereas British midwives were permitted to administer nitrous-oxide while working independent

²⁵ By the 1930s Grant Fleming was based in Montreal; however, earlier in his career he worked in Ontario.

²⁶ Grant Fleming, “The Future of Maternal Welfare.” *Canadian Medical Association Journal* 29, 2 (August, 1933): 162.

²⁷ The Canadian Medical Association Journal, 1920–1950.

²⁸ Wesley Bourne, MD, “The Administration of Chloroform in Obstetrics by Nurses,” *The Canadian Nurse* (November, 1930), 585–587.

of physician supervision, an approach that was viewed as beneficial to British physicians, Bourne does not address the possibility of nurses, much less midwives, even assisting physicians with medical technology or medication during childbirth.²⁹

Canadian nurses themselves officially supported the model of medically-managed childbirth that was dependent on physician control. The nurses' position may have been influenced by the fact that the elimination of midwives increased their professional responsibilities in pre-natal care, in assisting physicians at confinements, and in post-natal care; securing their positions if not their autonomous medical practice. Midwives quite simply did not constitute economic competition or professional rivalry in Ontario. Consequently, many nurses officially endorsed physician-dominated childbirth practices and joined doctors in blaming midwives for high maternal mortality rates. As one public health nurse asserted in their journal, "Registration and proper supervision of midwives have greatly reduced deaths among mothers, but in rural districts the untrained midwife is still common, and few mothers present themselves for medical examination in the early months of their pregnancy. Every expectant mother should 'book' with a doctor and with a nurse or certified midwife early in pregnancy."³⁰

Nurses were also involved in promoting physician-controlled birth at an official level. The Canadian Nursing Association (CNA) supported government programmes and

²⁹ Wesley Bourne and James W. Duncan, "Nitrous Oxide-Oxygen Analgesia and Anaesthesia in Obstetrics," *CMAJ* 11, 11 (November, 1921): 818–822; Bourne, "Anaesthesia in Obstetrics," *CMAJ* 14, 8 (August, 1924): 702–70; Bourne, "Vinyl Ether Obstetrical Anaesthesia for General Practice," *CMAJ* 33, 6 (December, 1935): 629–632; Wesley Bourne and AJ Pauly, "Thiobarbiturates in Obstetrics: Pentothal and Thioethamyl." *CMAJ* 40, 5 (May 1939): 437–440.

³⁰ Nan. B.D. Hendrie, "Department of Public Health Nursing: Preventable Maternal Mortality," *The Canadian Nurse* (May, 1926), 255.

was represented on the Committee on Maternal Care organised by the National Council of Women in 1929. By the 1920s the CNA's official stance indicated that the nurses were "opposed to any scheme for the training and licensing of midwives in Canada."³¹ While arguing for the elimination of midwives—or at least their reinstatement, since the legal elimination had long been effected nurses were urged to take part in the medicalization process without ensuring their contributions to the process:

Let us then as nurses, members of the best organized bodies of professional women in Canada, direct individual and concerted efforts to further the teaching of health to the children in the schools, to the young girls in Little Mothers' Classes, to the women in Home Nursing Classes. To see that more and better pre-natal clinics are established, and, more than all, never miss an opportunity to tactfully place before the prospective fathers and mothers the suggestion that the time to prepare for the dangers of child-birth is in the very beginning of pregnancy.³²

Such arguments do suggest that nurses partially promoted this model of medicalization for professional gain, if not professional autonomy. The establishment of antenatal care emphasized programmes such as the Little Mothers' Classes or Home Nursing Classes that increased the employment and status of Canadian nurses.³³

The issue of professional policy and practice is especially pertinent because one of the key factors influencing maternal mortality rates was the location of labour and delivery, and the comparative safety of home confinements. It was not until after the Second World War that hospital births became safer than home births. For most of the first half of the century, hospitals had higher maternal mortality rate than home births, a trend that was true not only in Ontario but also across Canada, in much of the United

³¹ E. Johns, "The Practice of Midwifery in Canada," *Canadian Nurse* (January 1925), 13.

³² Editorials, "Maternal Mortality," *The Canadian Nurse* (April, 1928), 174.

³³ Editorials, "Maternal Mortality," *The Canadian Nurse* (April, 1928), 174

States, and in Britain.³⁴ *Need Our Mothers Die?* determined that both puerperal sepsis rates and maternal mortality rates were higher in hospital births than in domiciliary confinements. The mortality rate was 5.3 versus 2.3 per 1,000 live births in hospital and at home respectively, while the deaths from puerperal sepsis were 1.7 in the institutional setting and 0.7 in the home setting, per 1,000 live births.³⁵ Urban maternal mortality rates were also higher than rural: 5.7 versus 4.7 per 1,000 live births, possibly due to a higher rate of hospital confinements in the urban setting.³⁶

In comparing the original study (1924–1925) with that of the mid-1930s, it is evident that the earlier study irrevocably established that maternal mortality in Canada was second only to that of tuberculosis as the leading cause of death for women aged 15–50. The leading causes of maternal death were puerperal septicaemia, haemorrhage, toxaeimias of pregnancy, dystocia, shock, and ectopic pregnancy.³⁷ The updated reports from 1935 showed that puerperal septicaemia, haemorrhage, and toxaeimias of pregnancy were still the leading causes of maternal mortality, and also that, between 1925 and 1935, the percentage of deaths they represented was virtually unchanged.³⁸ Toxaeimias of pregnancy could be diagnosed through urine analysis, which

³⁴ Several studies have shown that, in Ontario, home births were safer than hospital births until after the Second World War: Comacchio, *Nations are Built of Babies* (1993); David Gagan and Rosemary Gagan, *For Patients of Moderate Means: A Social History of the Voluntary Public General Hospital in Canada, 1880–1950* (Montreal & Kingston: McGill-Queen's University Press, 2002); Oppenheimer, "Childbirth in Ontario" (1983); Wendy Mitchinson, *Giving Birth in Canada: 1900–1950* (Toronto: University of Toronto Press, 2002).

³⁵ *Need Our Mothers Die?*, 18.

³⁶ *Need Our Mothers Die?*, 18.

³⁷ "The Department of Health Inquiry, 1925–26," *Need Our Mothers Die?*, 1–2.

³⁸ "Causes of Maternal Deaths," *Need Our Mothers Die?*, 5.

midwives in the UK were required to complete as part of their pre-natal visits.³⁹ Regular antenatal care also ensured a full patient history was recorded, as well as the pulse and temperature at each visit; information that helped ensure a parturient woman had the correct medical care during her delivery. Midwives in Britain were required to complete these tasks as part of antenatal care—and urge the patient “to seek advice from her medical attendant or at a Hospital or other similar Institution” if an abnormality was present.⁴⁰ Nurses in Ontario could have provided similar care, which is why patients who received VON supervision had lower mortality rates.

While the causes of maternal mortality remained essentially the same over the period covered by the reports, the mortality rates fluctuated notably. Results from the reports showed that between 1926 and 1934 the maternal mortality rate (per 1,000 births) in Ontario ranged from a high of 6.2 in 1930 to a low of 5.1 in 1932. These figures were close to the national averages—and in keeping with the national patterns—which ranged from a high of 5.8 in 1930 to a low of 5.0 in 1932 and 1933.⁴¹ *Need Our Mothers Die?* also addressed maternal mortality in other countries and assessed Canada’s international ranking.

³⁹ TNA, Records of the Central Midwives Board, Central Midwives Board: Rules of Conduct, Eleventh edition (1934), “Antenatal Care”, DV 3/11.

⁴⁰ TNA, Records of the Central Midwives Board, Central Midwives Board: Rules of Conduct, Eleventh edition (1934), “Duties to Patient” 16(c), DV 3/11

⁴¹ “Maternal mortality rates in Canada and the Provinces during the years 1926–34,” *Need our mothers die?: A Study Made by a Special Committee of the Division on Maternal and Child Hygiene* (Council House, Ottawa: Canadian Welfare Council, December 1935), 11.

**Table 4: Trend of maternal mortality in Canada and certain other countries
maternal deaths per 10,000 live births**

Country	1921	1922	1923	1924	1925	1926	1927	1928	1929	1930	1931	1932	1933
Australia	47	45	51	55	56	53	59	60	51	53	55	56	51
Belgium	57	53	56	57	50	62	57	60	62	52	49	48	51
Canada	47	50	49	52	50	57	56	56	57	58	51	50	50
Chile	79	80	74	61	61	58	58	59	78	68	75	71	84
Czechoslovakia	37	34	32	31	33	34	36	42	43	41	41	43	48
Denmark	20	20	26	23	24	26	31	27	32	35	35	26	36
England and Wales	39	38	38	39	41	41	41	44	43	44	41	42	45
Finland	33	30	31	35	29	32	30	30	36	33	30	29	..
France	..	..	..	..	24	25	29	29	30	27	25	26	..
Germany	49	50	52	53	50	49	52	55	55	54	51	53	..
Greece	73	72	85	88	67	59	61	66	71	58	56	56	..
Hungary	29	30	28	31	29	32	30	34	34	36	37	37	32
Irish Free State	50	57	48	48	47	49	45	49	41	48	43	46	44
Italy	26	25	27	32	28	26	26	28	29	27	28	30	..
Japan	36	33	34	31	30	27	28	28	28	27	27	25	25
Lithuania	..	..	..	49	59	56	50	50	57	60	62	55	61
Netherlands	23	25	23	24	26	29	29	34	34	33	32	30	32
Newfoundland	..	72	66	104	39	47	51	36	56	53	64	52	45
New Zealand	51	51	51	50	47	42	49	49	48	51	48	41	44
Northern Ireland	52	47	49	45	44	56	48	52	49	53	51	53	54
Norway	22	25	28	29	27	32	25	30	36	30	27	26	28
Salvador	57	46	50	57	50	56	63	56	53	48	56	65	..
Scotland	64	66	64	58	62	64	64	70	69	69	59	63	59
Spain	51	49	46	44	40	38	39	40	36	36	38	35	..
Sweden	27	25	23	24	26	29	28	33	38	35	37	34	..
Switzerland	55	51	46	48	43	44	37	44	46	43	44	44	46
Union of South Africa (Whites)	49	52	52	47	56	46	48	50	53	53	47	53	48
United States	68	66	67	66	65	66	65	69	70	67	66	63	62
Uruguay	33	27	27	25	25	30	22	24	24	31	24	..	24

Source: *Need Our Mothers Die?*, 15.

In every year of the study, Canada's maternal mortality rate was higher than the international average. Furthermore, the Canadian maternal mortality rate was notably higher than countries with which it associated itself. For example, in 1932, the year of the lowest mortality rate in both Ontario and Canada as a whole, the Canadian average was 50/10,000 live births. In the same year the average for England and Wales was 42/10,000 live births, New Zealand was 41/10,000 live births, Sweden was 34/10,000 live births, the Netherlands was 30/10,000 live births, and France was 26/10,000 live births.⁴² To look at this from another perspective, in 1932 there were 235,666 births in Canada and 66,842 births in Ontario.⁴³ With the 1932 mortality rates, this means that in 1932 there were 1,178 maternal deaths in Canada, of which 341 occurred in Ontario. If Canada and Ontario could achieve the same maternal death rate as England and Wales (42/10,000 live births) then in 1932 there would have been 990 maternal deaths across Canada and 281 in Ontario. In other words, there would have been 188 fewer maternal deaths across Canada and 60 fewer maternal deaths in Ontario if Canada had lowered its maternal death rate to match that of England and Wales. If it could match Sweden or the Netherlands—which were the countries Britain looked to when studying its own maternal mortality rate—the number of lives saved would have been greater still.

As well as these variations in the overall maternal mortality rates, *Need Our Mothers Die?* addressed the international variations in some of the leading causes of childbirth. This report showed that in 1927 in Canada 89.6 per cent of all maternal

⁴² "Trend of maternal mortality in Canada and certain other countries," *Need Our Mothers Die?*, 15.

⁴³ "Births, Deaths and Natural Increase in Canada, by Provinces and for each Sex," *The Canada Year Book, 1934–35* (Ottawa: J.O. Pattenaude, I.S.O., King's Printer, 1935), 176.

deaths were the result of puerperal causes, while only 10.4 per cent were from non-
puerperal causes. Conversely, the percentage of deaths in England and Wales attributed
to puerperal causes was 78.7, while 21.3 per cent of maternal deaths were the result of
non-*puerperal* causes.⁴⁴ Looking at these figures another way, for every 1,073 maternal
deaths in Canada 953 were from puerperal causes, while in England and Wales 844 out
of 1,073 deaths were attributable to puerperal causes. In the same year the Canadian
maternal mortality rate per 10,000 births was 56 (in Ontario it was 60), while the
maternal mortality rate in England and Wales was 41 per 10,000 births.⁴⁵ If one
considers these figures from another perspective they indicate that in Canada the
maternal death rate from puerperal causes was 50.12 per 10,000 births whereas in
England and Wales it was 32.27 per 10,000 births. This distribution suggests that, when
attempting to reduce the overall maternal mortality rate, Canada—and Ontario—
needed to focus specifically on puerperal causes. In other areas, however, the countries
were remarkably similar. In Canada (1927–1933), the average maternal death rate from
non-septic abortion was 1.6 per 10,000 births.⁴⁶ In England and Wales (1934) the
maternal death rate for non-septic abortion was also 1.6 per 10,000 births.⁴⁷ Even
allowing for a margin of error, it is apparent that non-septic abortion caused very similar
maternal death rates in both Canada and England and Wales. These figures include both

⁴⁴ “Assignment to puerperal and nonpuerperal causes by the United States and certain foreign countries,” *Need Our Mothers Die?*, 14.

⁴⁵ *Need Our Mothers Die?*, 11, 15.

⁴⁶ “Maternal mortality rates from certain causes in Canada,” *Need Our Mothers Die?*, 7.

⁴⁷ “Deaths from Abortion and Sepsis,” Loudon, *Death in Childbirth*, 112.

spontaneous or accidental abortion—now more commonly known as miscarriage—and induced abortion.

As emphasised in Chapter 3, there were perceived correlations between midwifery and abortion—both outside the realm of respectable medicine as well as outside the law. They also recognised that women would turn to illegal, untrained, midwives when seeking guidance in family planning.⁴⁸ In Britain the untrained and unregulated “handywoman” is often spoken of in the same derogatory tones applied to midwives in Ontario, but records from the Central Midwives Board show very few cases where midwives were charged providing abortions.⁴⁹ Although it is difficult to prove that midwives on either side of the Atlantic were helping women to procure abortions, the rates and risks of abortion—both accidental and induced—are an integral part of discussions surrounding maternal mortality in the first half of the twentieth century. While physicians, midwives, and women in the community all helped women to procure an abortion, physicians were “reluctant to break professional solidarity by giving legal testimony” against another physician.⁵⁰ Consequently, trials and public opinion were more likely to focus on female abortionists—the publicity associated with a trial could even result in an abortionist receiving an increase in the requests for her services.⁵¹

⁴⁸ Angus McLaren and Arlene Tigar McLaren, *The Bedroom and the State: The Changing Practices and Politics of Contraception and Abortion in Canada, 1880–1980* (Toronto: McClelland and Stewart Limited, 1986), 139.

⁴⁹ Although there were thousands of cases brought before the CMB in the first half of the twentieth century, there were only twenty-five instances of women facing charges for providing drugs to procure an abortion. TNA, Records of the Central Midwives Board, Central Midwives Board: Minutes, Board Minutes 1905–1951, DV 1/2–DV 1/17.

⁵⁰ Barbara Brookes, *Abortion in England, 1900–1967* (London: Croom Helm, 1988), 27.

⁵¹ Brookes, *Abortion in England*, 139.

In light of public perception and a degree of collusion within the medical community, it was easy for contemporaries to assume that midwives were performing abortions.⁵² Regardless, maternal deaths from abortions, both spontaneous and induced, were one of the concerns expressed by governments in relation to maternal mortality rates. As suggested in the writings on working-class culture by historian Lucinda McCray Beier, induced abortions were more likely to be sought out by married women than unmarried women.⁵³ Statistics suggest, however, that a higher percentage of unmarried women attempted self-induced abortions. In his seminal work on maternal and infant mortality, Irvine Loudon points out that “In a survey of 2,665 cases of abortion admitted to hospital between 1935 and 1950, 2,350 were married women, 303 were single, and 12 were widows,” and it was estimated that as many as 90 per cent of these were induced abortions.⁵⁴ Based on these figures, at this particular hospital, approximately 13 per cent of abortion cases were single women. Numerically the overwhelming majority were married women. During this same period, however, the percentage of illegitimate maternities ranged from approximately 4.2 to 6.6 of all maternities.⁵⁵ The 13 per cent of abortion cases for single women was therefore two to three times the rate of illegitimate maternities. In sheer number, more married women

⁵² In her writings on working-class health culture, Lucinda Beier discusses the fact that many working-class women seemed to be aware of how to obtain an abortion. While her interview subjects make some mentions to druggists and doctors assisting with abortions the vast majority of abortionists were unqualified women who were likely to help poor families who already had many children born close together. Lucinda McCray Beier, *For Their Own Good: The Transformation of English Working-Class Health Culture, 1880–1970* (Columbus: The Ohio State University Press, 2008), 246–251.

⁵³ Beier, *For Their Own Good*, 247.

⁵⁴ Loudon, *Death in Childbirth*, 266.

⁵⁵ Loudon, *Death in Childbirth*, 266.

sought out abortions, but a much higher percentage of single women aborted their pregnancies.

The relevance of these abortion rates from England and Wales are fairly obvious to maternal mortality concerns. In the broader scope of this transnational study, however, their relevance is found as much in their existence as in the implications of these numbers. In Ontario and across Canada reports on maternal health were far less focused on abortion than was the case in Britain. Even *Need Our Mothers Die?* conceded that “in most countries the practice of both abortion and contraception has increased or at least has become far more openly discussed.”⁵⁶ The contributors to *Need Our Mothers Die?* recognised that the failure to discuss abortion was a problem as it meant that the existence of induced abortion was not recognised. Based on the international evidence, it was therefore determined that “abortion must be regarded as associated with considerable danger to health,” due to problems including high rates of sepsis, and in light of these concerns “Instruction should be given at prenatal clinics as to the dangers of abortion and the importance of seeking medical advice at once, should it occur, while special hospital facilities should be provided because of the potential sepsis of such cases.”⁵⁷ These studies and statistics therefore drew attention to problems that had previously been overlooked.

In addition to addressing issues related to contraception and abortions, Canadian health professionals were openly looking at mortality rates in other countries to ascertain what changes they could make. This focus meant that an examination of

⁵⁶ *Need Our Mothers Die?*, 143.

⁵⁷ *Need Our Mothers Die?*, 143.

data necessitated an acknowledgement of the correlations between midwifery and reduced maternal mortality rates. In 1932, the Netherlands—which relied on highly-trained midwives to assist mothers during pregnancy and birth—had one of the lowest mortality rates of 28 surveyed countries.⁵⁸ While the Netherlands had an impressively low maternal mortality rate, *Need Our Mothers Die?* also acknowledged that England and Scotland, which had lower maternal mortality rates than Canada, valued midwives and provided high levels of maternal care. These reports from England and Wales also recognized the connection between certified midwifery and improved maternal mortality—trained midwives were beneficial but ‘handywomen’ were detrimental.⁵⁹ At the time of the study, British officials in the Ministry of Health and Central Midwives Board were aware of the problems associated with ‘handywomen’, and the 1936 *Midwives Act* removed provisions for these uncertified midwives in the year following the publication of *Need Our Mothers Die?*. Reports from the United States also addressed some of the benefits associated with midwifery care and “The New York Academy of Medicine Report” published in *Need Our Mothers Die?* acknowledged that midwives and home births would be beneficial. An analysis of 1,343 “preventable” puerperal deaths (1930–32) showed that only 2.2 per cent of these deaths could be charged to the midwife. Meanwhile, 61.1 per cent could be charged to the supervising medical professional and the remaining 36.7 per cent to the patient.⁶⁰ The New York Academy of Medicine’s report called for “adequate training, licensing and control of

⁵⁸ *Need Our Mothers Die?*, 74–75.

⁵⁹ *Need Our Mothers Die?*, 83, 115.

⁶⁰ “Maternal Mortality in New York City,” *Canadian Medical Association Journal* 30, 4 (April, 1934): 472.

midwives,” as well as the “necessity for the encouragement of home confinement where conditions are suitable and normal confinement indicated.”⁶¹

Given the fact that *Need Our Mothers Die?* acknowledged the benefits of midwifery in reducing the maternal mortality rate, the rejection of trained midwifery services in Ontario is particularly surprising. The report also acknowledged that, in Canada itself, there were areas where high quality maternity care was being provided without the supervision—or even the assistance—of physicians, as was the case in the Red Cross Outpost Hospitals, which offered nursing care to remote Canadian communities:

The Red Cross Outpost Hospitals which, faced with mothers in the difficult conditions of frontier life, have not only maintained an exceedingly low rate of hospital deaths, but have also, through their nursing services, handled large numbers of midwifery cases where it has been impossible to get a physician in these very remote areas. In nearly a thousand such cases there has been no maternal death.⁶²

Yet, in spite of this strong national and international evidence in favour of the use of midwives and/or trained obstetrical nurses, the Ontario and Canadian governments, strongly influenced by the Canadian Medical Association, continued to promote physician-attended birth as the best—and indeed only—option for expectant mothers.

The differing approaches to medicalized midwifery are particularly apparent when comparing studies on maternal mortality from either side of the Atlantic. During the first half of the twentieth century health authorities in Britain conducted studies on maternal and infant mortality similar to those produced in Ontario and Canada, such as

⁶¹“The New York Academy of Medicine Report,” *Need Our Mothers Die?*, 135–136.

⁶² *Need Our Mothers Die?*, 35.

Need Our Mothers Die?. As with many other areas of maternal health, however, the outcome of these studies was very different than was the case in Ontario. British health authorities did recognise the importance of physicians in improving mortality rates—which is why rules of the Central Midwives' Board emphasised the need to call for a physician in cases of abnormal labour or birth—but they believed that, in the majority of cases, mothers needed a trained attendant but not necessarily a physician. In her 1924 report on the causes of maternal mortality, acclaimed British physician Dame Janet Campbell (D.B.E, M.D., M.S.) viewed midwives entirely in a favourable light. When addressing the fact that midwives had significantly better mortality rates than physicians, she did add in the caveat “the restricted function of the midwife, which precludes operative interference, may have something to do with this. Moreover, midwives are engaged for presumably normal cases only, and although they encounter emergencies and abnormalities, the percentage of difficult cases likely to go badly must be less in their practice than in medical practice.” But at no point does she suggest that trained midwives are anything but beneficial in cases of normal birth.⁶³ Indeed she suggests that midwives might be safer than physicians in terms of the conveyance of infection, as they were less likely to have contact with septic cases in the course of ordinary practice.⁶⁴

In Canada, a 1917 study commissioned by Lady Aberdeen showed similar results: the physicians' high maternal mortality rates was caused by their spread of infection.

⁶³ Janet Campbell, *Maternal Mortality* (Ministry of Health, London: Published by His Majesty's Stationery Office, 1924), 32.

⁶⁴ Campbell, *Maternal Mortality*, 44.

This report, which was included in a *Canadian Medical Association Journal* article on British publications about maternal mortality, identified physicians as carriers of contagion. The Aberdeen study of maternal deaths—as cited in the *Canadian Medical Association Journal* (1929)—showed “that there were no deaths among the 445 midwife cases in which forceps were used by the doctors called in to assist. The view is expressed that the higher puerperal death rate in the practice of doctors is not necessarily due to trauma caused by instrumental interference, but is more likely to be due to contagion spread by carriers; and doctors were considered to be more liable to become streptococcal carriers than midwives.”⁶⁵ While health authorities did see a need to reduce maternal mortality rates, they did not consider midwives the root of maternal health problems.

Other factors contributing to maternal mortality, however, were comparable when addressing data from Ontario and the British Isles; notably, regional differences in British maternal and infant mortality rates were also apparent. Similar variations to those seen across Ontario and Canada were evident within the British Isles. During the 1911–1920 period, the maternal mortality rate in England was only 3.95, but in Scotland for the same period the maternal mortality rate was 6.0.⁶⁶ British studies on maternal mortality were concerned with these regional differences.

⁶⁵ A. D. Blackader, “Thoughts on Maternal Mortality: Being an Abstract of Papers and Discussions Which Have Appeared in British Journals During the Past Year,” *Canadian Medical Association Journal* 20, 6 (June, 1929): 657.

⁶⁶ Campbell, *Maternal Mortality*, 17.

Table 5: “Total Death Rates per 1,000 Births from all Causes connected with Childbearing”

Period	England	Wales*	Scotland	Ireland
1881–1890	4.64	6.10	5.45	7.07
1891–1900	4.96	6.94	4.72	6.60
1901–1902	4.43	6.89	4.95	6.21
1903–1910	3.75	5.26	5.30	5.45
1911–1920	3.95	5.43	6.00	5.17

*Wales includes Monmouth⁶⁷

It was also noted that regional variations were present within counties in Britain.

Industrial towns, particularly those concerned with textile trades, generally had the highest maternal mortality rates in England, and Wales—dominated by mining communities—also sustained high maternal mortality rates.⁶⁸ There are two likely explanations for the high maternal mortality rates in these areas: lack of hospital facilities and population density. The high rates of mortality, particularly from puerperal sepsis, in these industrial areas and mining communities could be explained by the fact that, as Loudon has found, the “high density of population and frequent septic wounds associated with a high rate of industrial accidents may have generated conditions favourable for the spread of streptococcal infection.”⁶⁹ Loudon also suggests that poor quality obstetric care could influence mortality rates in industrial communities, but the

⁶⁷ Janet Campbell, *Maternal Mortality* (Ministry of Health, London: Published by His Majesty's Stationery Office, 1924), 17.

⁶⁸ Campbell, *Maternal Mortality*, 17.

⁶⁹ Irvine Loudon, *Death in Childbirth: An International Study of Maternal Care and Maternal Mortality, 1800–1950* (Oxford: Clarendon Press, 1992), 252.

correlation between socioeconomic status and mortality rates is not as straightforward as might be expected.

Both Ontario and Canadian studies and British studies addressed the influence of socioeconomic status on maternal and infant mortality and correlations were often made between economic status and these death rates. Such correlations were not as strong as might be expected, and there were more factors at play than problems such as poor housing. The 1935 Canadian study on maternal mortality showed that housing and over-crowding, in and of themselves, might not directly contribute to the maternal mortality rate. Nonetheless, "it is... the greater danger of infection common in such conditions of life and the general debilitation too frequently found in the health of women living under such circumstances, which though they may not affect the death rate directly, affect the health of the mother and too often the life and health of the child."⁷⁰ British research also argued for indirect causes of maternal mortality in impoverished communities but concluded somewhat differently. While the chance of infection and general poor health were obviously important contributing factors, this research concluded that their relationship had more to do with the quality of birth attendant than either economics or living conditions.

Studies from communities throughout England showed instances where the maternal mortality rate of working-class communities was lower than that of middle-class communities. In the 1919–1922 period, the working-class community of West Ham

⁷⁰ *Need Our Mothers Die?*, 51.

in the East End of London had the lowest mortality rates in all England.⁷¹ This was a community with poor, overcrowded, living conditions. Another study from the 1920s of mortality rates in Leeds showed that the maternal mortality rate “for the city as a whole was 44.9 but the rate was 59.3 in the middle-class areas, and 30.1 in the parts inhabited by the working classes.”⁷² Similar statistics were found in Glasgow and Aberdeen in the late 1920s and early 1930s, which also showed that the mortality rate of cases delivered by midwives—who predominantly attended to working-class women—were half that of cases delivered by a physician.⁷³ Part of this difference can be explained by Dame Campbell’s argument that midwives were prohibited from attending risky cases that inevitably had higher mortality rates. This factor alone, however, does not explain the difference. It is likely that, as was the case of hospital births in Ontario at this same time, for numerous reasons physician-attended births were more dangerous than births attended by trained midwives and that the quality of the attendant was more important than housing conditions. Certified midwifery made quality care affordable, which in turn made the attendant’s professional quality more apparent than the patient’s income.

Where socioeconomic factors do affect mortality rates becomes clear in examining the different rates attributed to trained midwives and handywomen. Handywomen, both untrained and unregulated, had far higher mortality rates even when they worked in conjunction with a physician. The transition from handywomen to trained midwives, however, was a slow process in many working-class communities. As I

⁷¹ Campbell, *Maternal Mortality*, 12.

⁷² Loudon, *Death in Childbirth*, 244.

⁷³ Loudon, *Death in Childbirth*, 244.

have already discussed, many working-class women preferred handywomen to trained midwives. At the same time, midwives were unlikely to receive an adequate salary in these impoverished communities when charging on a case-by-case basis made it easier for the handywoman to persist. This problem was faced by many countries promoting midwifery, which is why “in the sparsely populated district the midwife is paid a public subsidy to bring her income from private cases up to a minimum fixed by the state.”⁷⁴ The Central Midwives Board and Ministry of Health discussed the possibility of similar programmes to reduce the work of handywomen in Britain.

Support for the role of midwives in the reduction of maternal mortality in Britain also came from the Midwives Institute, as discussed in the previous chapter. During interwar discussions about maternal mortality rates, the Midwives’ Institute remained adamant that midwife-assisted childbirth was the best option for expectant mothers. As they noted in a 1936 report in favour of establishing a salaried midwifery service to improve the economic standing of midwives, “It is beyond dispute that the midwife tends to keep normal cases normal. Normal cases as conducted by midwives show the lowest maternal death rates in the country.”⁷⁵ Correspondence and reports on how salaried midwives could prove beneficial to the maternal mortality rate also addressed the continuing problem of untrained and unregulated handywomen who, at the time of Midwives’ Institute report, persisted. The changes to the *Midwives Act* in 1936 removed provisions for handywomen, and salaried midwives could allow midwives to work in

⁷⁴ *Need Our Mothers Die?*, 75.

⁷⁵ TNA, Ministry of Health, Scheme for the reform of midwives services: circulation of report to elected associations, etc. (1936), DV 55/651.

communities that otherwise would not provide adequate employment. Given the inferior care provided by the vast majority of handywomen it was relevant to maternal mortality rates—and the status of midwives—that the elimination of the handywoman would mean that two thirds of all births would be available for trained midwives.⁷⁶

In both Britain and Canada—including Ontario—as these studies all pointed out, there was a notable reduction in maternal mortality rates when women received antenatal care and medical supervision during labour and delivery. The distinction, however, is that countries with trained midwives considered them suitable medical attendants during most pregnancies and deliveries. Furthermore, international studies on maternal mortality, including the Canadian publication *Need Our Mothers Die?* recognised that mortality rates tended to be lower in countries that relied on trained midwives. The lowered rates in relation to midwifery reflected the accessibility of affordable obstetrical care as much as the quality of care offered by trained midwives, but physicians and health professionals in Ontario refused to see the benefits of including trained midwives or obstetric nurses. As a result, the structure of antenatal care and advice offered to expectant mothers differed greatly on either side of the Atlantic. The role of professional midwifery was prominent in advice literature which reflected the midwife's position in medicalization in Britain. As I will show in the following chapter, the advice literature shows the starkly different approaches to medicalization on either side of the Atlantic; differences that resulted not only in a different medical model but also in the very approach to pregnancy and birth.

⁷⁶ TNA, Ministry of Health, Scheme for the reform of midwives services: circulation of report to elected associations, etc. (1936), DV 55/651.

6 **“THE FIRST SERVANT OF THE STATE”:
PROFESSIONAL DISCOURSES ON MATERNITY CONCERNS**

In their attempts to improve infant mortality rates as well as the health and welfare of mothers and young children, governments and local authorities in Britain, Ontario, and Ottawa published advice literature intended to guide expectant mothers about their central role in raising them as healthy and loyal citizens. In both Britain and Ontario, there was a surge in these publications during the interwar years. Initially such concerns were prompted by the concerns that the war raised about the health status of citizens as well as the high mortality rates of young soldiers during the First World War. In Canada two thirds of all men who attempted to enlist under the Military Service Act were rejected as unfit for active duty.¹ In England, similar concerns about the deterioration of national health had arisen during the Boer War. A study from 1902 showed that only two out five recruits were healthy enough for active duty.² Faced with these obvious signs of poor health, especially within the working class, governments on both sides of the Atlantic embraced the principles of the scientific motherhood movement and promoted childrearing that was influenced by medical supervision,

¹ Cynthia Comacchio, *“Nations Are Built of Babies”*: Saving Ontario’s Mothers and Children, 1900–1940 (Montreal & Kingston: McGill-Queen’s University Press, 1993), 56.

² Alice Reid, “Birth Attendants and Midwifery Practice in Early Twentieth-Century Derbyshire,” *Social History of Medicine* Vol. 25, No. 2 (2012): 383.

opinion, and practice.³ These messages were disseminated in letters, pamphlets, and books provided to expectant families.

In England, advice literature was published in the form of pamphlets produced and distributed by authorities in local counties and boroughs, which followed similar boundaries as the Local Supervising Authorities that oversaw midwifery practice. In spite of the regional nature of these publications the message was uniform across the counties; leading physicians were responsible for many publications and all pamphlets and ephemera were monitored by the Ministry of Health. While the particulars of each publication did vary somewhat, these publications offered a unified national message on the importance of antenatal health, and guidelines for health care provision. This universality means that the multitude of English advice manuals was, in effect, a singular discourse oriented specifically to expectant mothers.

This chapter examines this English advice literature and comparable provincial and federal publications in Ontario from the same period. Although the administration of healthcare was under provincial jurisdiction, some of the most widely disseminated advice literature for expectant and new mothers in Canada was published at the federal

³ The connections between the scientific motherhood movement and national concerns have been addressed in literature on motherhood and childrearing in both Canada and other countries including the United States and the United Kingdom. This literature has shown that concerns about infant mortality led to the promotion of medicalized birth as means of reducing this problem that threatened both lives and the community. Dodd, "The Blue Books, Helen MacMurchy, and the Department of Health," 204; Angus McLaren and Arlene Tigar McLaren, *The Bedroom and the State: The Changing Practices and Politics of Contraception and Abortion in Canada, 1880–1980* (Toronto: McClelland and Stewart, 1986), 69; Rima D Apple, "Constructing Mothers: Scientific Motherhood in the Nineteenth and Twentieth Centuries," *Social History of Medicine* 8, 2 (1995): 162; Denyse Baillargeon, *Babies for the Nation: The Medicalization of Motherhood in Quebec, 1910–1970* (Waterloo: Wilfrid Laurier University Press, 2009), 51, 105.

level. When discussing Canadian advice literature, it is therefore not feasible to focus exclusively on Ontario. There are three main forms of advice literature in Canada that I will focus on here: the pre- and post-natal letters produced by the Child and Maternal Health Division; advice manuals for mothers, including the *Little Blue Books* series written by Dr. Helen MacMurchy; and advice literature produced by individual Canadian physicians. Each of these formats will be compared to the English publications to show how contrasting national healthcare policies can originate from common origins and to highlight how medical practice intersected with gender and professional politics.

In addition to the divergent definitions of medicalized birth, the approach to maternal education and the medical profession were strikingly different on either side of the Atlantic. In Ontario, where most of the prenatal literature was produced federally and referred to Canada, the ties between motherhood and nation-building were overt. This nationalism is evident in three elements of all the prenatal literature of the period: the mother is represented as 'the first servant of the state'; physician-supervised childbirth and childrearing practices are encouraged as being 'better for Canada'; and "scientific" hygienic practices were seen as necessary for the development of 'good Canadians.' These ties between healthy practices and nation-building were based on prevailing Anglo-Celtic middle-class concepts of "Canadian-ness": "Of course you will be particular about your toilet," MacMurchy asserted, "like a good Canadian."⁴ Such constructions of nationalism and citizenship permeated the literature, revealing middle-

⁴ MacMurchy, *The Canadian Mother's Book* (1927), 25.

class and professional aspirations of establishing Canada as a nation with a solid foundation of health.

In contrast to the approach seen in literature distributed in Ontario and across Canada, British advice literature did not make explicit ties between maternal health and nationalism.⁵ Following the Boer War, and in the years leading up to the First World War, British health officials were concerned with national health, particularly that of the working class. During these years health literature geared towards young women did make overt connections between personal health and national responsibility, considering girls to be “the future welfare of the nation.”⁶ The burgeoning emphasis on maternal health concerns in the interwar years suggests that the First World War heightened some of these national concerns and contributed to these programmes and the associated emphasis on the responsibility of the state in the creation of social services.⁷ In spite of these inevitable influences of the war, and the earlier trend towards using health literature to promote a nationalist agenda, maternal health literature from the 1920s and discussions amongst health officials do not make any such explicit connections. The motivations behind British publications seem to be tied,

⁵ The belief in the child as the future of the nation, which is an underlying but not overt theme in the British antenatal literature, has been discussed in several prominent works: Deborah Dwork, *War is Good for Babies and Other Young Children: A History of the Infant and Child Welfare Movement in England, 1898–1918* (London: Tavistock Publications, 1987); Shurlee Swain and Margot Hillel, *Child, nation, race and empire: Child rescue discourse, England, Canada and Australia, 1850–1915* (Manchester: Manchester University Press, 2010).

⁶ Hilary Marland, *Health and Girlhood in Britain, 1874–1920* (Houndmills, Basingstoke: Palgrave Macmillan, 2013), 189–196.

⁷ TNA, Ministry of Health, Scheme for the reform of midwives’ services: circulation of report to elected associations, etc. (1936), DV 55/651.

instead, to economic concerns based on the high infant and maternal mortality rates in working-class communities.⁸ Such publications were in keeping with the charitable work performed by organisations such as the National Birthday Trust Fund, which has been addressed in previous chapters. The other difference between publications distributed in Britain and in Ontario is their definition of medical supervision and intervention. In Ontario, advice literature allowed only for physician-supervised pregnancy, birth, and childrearing. British literature, meanwhile, advocated for the same levels of antenatal supervision and medical care throughout pregnancy and childhood, but allowed that such care could, in most conditions, be provided just as well by a certified midwife as by a physician.

MacMurchy's advice for mothers as established in the *The Little Blue Books* publication the *Canadian Mother's Book* situates her strongly within both the scientific motherhood movement, which advocated for medically managed motherhood, and the maternal feminist movement, which believed that motherhood was a woman's highest calling and developed social programs to protect that calling.⁹ These ideals of maternal feminism are present throughout *The Little Blue Books* with passages promoting the

⁸ Lucinda Beier's work on healthcare in working-class Lancashire demonstrates some of the socioeconomic factors that influenced maternal health as well as discussions on how housing conditions influenced home healthcare: Lucinda McCray Beier, "Expertise and Control: Childbearing in Three Twentieth-Century Working-Class Lancashire Communities," *Bulletin of the History of Medicine* 78,2 (Summer 2004): 379–409; Beier, *For Their Own Good: The Transformation of English Working-class Health Culture, 1880–1970* (Columbus: Ohio State University Press, 2008).

⁹ The interaction of physicians and maternal feminists in the promotion of "informed motherhood" is a point further examined by Dodd, who argues for a "relationship between feminism and professionalism in the interwar period." Dodd, "Advice to Parents," 204.

value of the mother as “the first Servant of the State.”¹⁰ Further ties between nation and the value of motherhood are seen when MacMurchy instructed families by guiding everybody to “help Mother please. That is the Canadian Way.”¹¹ This ideology permeated medical practice in Ontario and Canada. The connection between mothers and the nation was, as one report pointed out, evident in legislation: “the importance of the mother to the State is recognized in the fact that federal legislation justifies the physician in sacrificing the child for the sake of the mother.”¹² The emphasis on the national importance of helping the mother was in keeping with the belief that maternal and infant mortality rates were a national concern that needed to be addressed for the health of the nation.¹³

The pre- and post-natal letters originated in 1926 as a product of the federal government’s Child and Maternal Health Division.¹⁴ Delivered monthly to expectant and

¹⁰ Helen MacMurchy, *The Canadian Mother’s Book* (Ottawa: Department of National Health, Canada, 1936), preface.

¹¹ Helen MacMurchy, *The Little Blue Books Home Series: 8—How to Take Care of Mother* (Ottawa, F.A. Acland Printer to the King’s Most Excellent Majesty, 1922), 13.

¹² “Problems in Infant Hygiene and what statistics reveal” Libraries and Archives Canada, Child and Family Welfare MG 28 I 10 vol. 53 file 446.

¹³ The rise of these concerns about the health of the nation can be connected to the losses during WWI and the belief that pre-War life had left many men unhealthy. As Cynthia Comacchio addresses in *Nations are Built of Babies*, 68 per cent of all applicants for enlistment during the Military Service Act were rejected as unfit. In light of these statistics it was believed that the health of Canadian Men needed to improve. Cynthia Comacchio, *Nations are Built of Babies: Saving Ontario’s Mothers and Children, 1900–1940* (Montreal & Kingston: McGill Queen’s University Press, 1993), 56.

¹⁴ Established in 1920 as part of the Department of Pensions and National Health, the Child and Maternal Health division was initially the Division of Child Welfare. The Division was restructured and renamed numerous times during the early twentieth-century before becoming the Child and Maternal Health Division in 1945. For clarity and consistency with archival records I refer to it as the Child and Maternal Health Division throughout the entire chapter.

new mothers throughout pregnancy and the first year of the child's life, the letters provided parents with practical advice, guidelines of health development, and instructions regarding the need for medical care. This format was chosen as a means of dispersing antenatal advice to a scattered population, such as was the case in Canada during the interwar years.¹⁵ Physician-centred medicalization was one of the chief objectives of the Child and Maternal Health Division. In keeping with the promotion of physician-supervised birth, the Division also hoped to achieve physician dominated medicalization through the establishment of "adequate hospital facilities, health centres, and prenatal clinics within reach of all Canadian mothers."¹⁶ As was shown in Chapter Two, women in isolated communities were far less likely to have a physician's care during confinement because physicians might be too far away, or the weather too challenging, to arrive in time for the birth. In spite of the limited access to medical care faced by many parturient women, the pre-natal letters argued for the benefits of a physician's supervision throughout the pregnancy, delivery, and postpartum periods. This message reached a wide audience: with the support of such popular "ladies' magazines" as the *Canadian Home Journal* and *Chatelaine*, 58,000 sets of "Pre-Natal Letters" were distributed during the first five years of the programme, in both French

¹⁵ "The Situation, 1935," Libraries and Archives Canada, Child and Maternal Health Division RG 29 Vol 991 File 499.3.2 pt. 2. It should be noted that in the interwar years some Canadian women were isolated not only from the medical community but also from a network of family or friends who could provide them with some form of support during pregnancy and birth. For these women, the professional ideal of antenatal care and medical assistance during confinement was more of a dream than a reality. Nanci Langford, "Child Birth on the Canadian Prairies, 1880–1930," *Journal of Historical Sociology* 8, 3 (September, 1995): 280.

¹⁶ "1928 Report," Libraries and Archives Canada, Child and Maternal Health Division RG 29 Vol 992 File 499.3.7 Pt 6.

and English.¹⁷ Their national significance can be seen in the distribution rates; by 1934 the letters had reached one quarter of Canadian mothers.¹⁸ Although reception does not indicate acceptance and application, mothers expressed their appreciation for the advice—and the government’s interest in their welfare—in correspondence to the Division during these years.¹⁹

Such responses suggest that British physician Dame Janet Campbell was incorrect in her assessment that national campaigns, such as existed in Canada, would not be beneficial in Britain since “Many working women are not used to learning by means of studying printed papers, which are often unread or lost.”²⁰ Given Campbell’s status in maternal welfare circles in Britain, her lack of support meant that a similar antenatal and postnatal advice series was not developed for British mothers. At the same time, the ubiquitous pamphlets published across England suggest that—in spite of Campbell’s concerns—mothers were expected to learn by studying printed literature, much of it medically written and published under state authority.

Campbell’s 1924 report on maternal mortality indicates that not all British physicians endorsed the benefits of instructional literature, but pamphlets produced by local health authorities were, nevertheless, widely available. The campaigns, however, were markedly different from the Canadian approach in terms of both distribution and guidance for parturient women. British advice literature for expectant mothers was

¹⁷ LAC, Child and Maternal Health Division, RG 29 Vol. 992, File 499.3.7 Part 5.

¹⁸ Comacchio, *Nations Are Built of Babies*, 97.

¹⁹ Comacchio, *Nations Are Built of Babies*, 103.

²⁰ Janet Campbell, *Maternal Mortality* (Ministry of Health, London: Published by His Majesty's Stationery Office, 1924), 89.

organised locally, and each community or borough received its own pamphlets offering suggestions to expectant mothers, fathers to be, and new families. Many of the topics covered in these manuals are the same as those disseminated in Canada. Both the pre- and post-natal letters in Canada and the British publications advised mothers about proper hygiene during pregnancy and in preparation for confinement. They provided guidelines for infant care during the critical first weeks of life, and also offered an outline of normal patterns of development. In both countries, making such scientific advice available to expectant mothers was seen to be imperative for healthy pregnancy, maternity and infancy.

The pre-natal letters offered Canadian mothers advice tailored to each month of pregnancy. Detailed in their descriptions, the letters provided mothers with medical guidance and practical advice on how to prepare for confinement and motherhood, as well as instructions on the preferred protocol in regards to medical supervision and care. The letters emphatically promoted physician-controlled pregnancy and birth and stressed the need for regular medical attention from a physician. As indicated by the advice in the prenatal letter for the third month of pregnancy, “we hope that you have already chosen your doctor and are receiving his regular supervision and advice.”²¹ In spite of the limited access to medical care in many communities there was no alternative presented to the model of physician supervised pregnancy and birth.

There was a limited reaction against the consistent failure to recognize that, for many Canadian women, physician-attended births were simply unattainable. In 1934

²¹ LAC, Child and Maternal Health Division RG 29 Vol 992 File 499.3.7.

Huilota Dykeman, Director of Public Health Nursing Service for New Brunswick, wrote to Dr. Puddicome at the Canadian Council on Child and Family Welfare with concerns that were applicable to most rural areas of the country. As Nurse Dykeman stated, there were many mothers who were attended by the “old woman” of the village as they were unable to access a physician’s care due to either distance or lack of funds. Dykeman was adamant that she did not intend to promote midwifery, but asked whether, in light of the situation, “would it not be possible to include one page in the series stating briefly what the mother should expect in the woman who attends her at delivery, especially in the matter of cleanliness, the drops in the baby’s eyes and the immediate care of the baby.”²² These letters show a schism between the endorsed medical practices and the reality of many Canadian women’s lives by offering advice—and promoting a narrow definition of medicalization—that could not be followed in many cases.

The Canadian support for physician supervised pregnancy highlights one of the striking differences between Canadian and British advice literature; the role (or exclusion) of the midwife in medicalized childbirth. In 1920, Dr. J.W. Ballantyne, an internationally recognized obstetrician, wrote a pamphlet for British women in which he treated the certified midwife as equal to the physician in providing antenatal and perinatal care. Throughout his publication all guidelines for the mother instruct her to speak to her “doctor or midwife.”²³ Such endorsement of midwives was in keeping with his views surrounding the importance of medicalized pregnancy and birth, and his role

²² LAC, Child and Maternal health Division RG 29 Vol 992 File 499.3.7.

²³ J.W. Ballantyne, M.D., *Hints to the Expectant Mother on her Health (for her own sake and for that of her expected baby)* (London: Women’s Co-operative Guild, 1920).

in the promotion of antenatal care.²⁴ Published a few years earlier in 1914, his book *Expectant Motherhood: Its Supervision and Hygiene* can be read as an argument for medically managed pregnancy and birth.²⁵ In the preface to the publication Ballantyne clearly places midwives as part of the transformation of childbirth in the early twentieth century:

the surgeons and physicians found out how to give them more help than the midwives could furnish, and gradually a great many confinement cases passed into the hands of members of the medical profession; then came the days of the women doctors and (for normal cases) of the certified midwives, and once again it was open to women in labour to be attended, if they so chose, by those of their own sex, possessed now, however, of skill and knowledge not before available.²⁶

While Ballantyne acknowledged the personal reasons why an expectant mother might choose a midwife or female physician, his emphasis is on the fact these attendants provided high-quality medical care. Ballantyne's support of midwives in cases of normal pregnancy was by no means unusual in Britain. In all the literature presented to expectant mothers, the section on preparation for confinement implies that a mother would deliver at home, and clearly acknowledges the probability that it could just as easily be either a doctor or midwife attending her. Instructions for labour include such advice as "the doctor or midwife should be sent for," and passages referring to the care offered by midwives indicate that the midwife was considered equal to the physician in

²⁴ Ballantyne's teachings surrounding the importance of antenatal care were considered "the most epoch-making feature of the twentieth century in obstetrics." A. Louise McIlroy, "The Progress of Obstetrics in the Present Century," *Irish Journal of Medical Science*, 3, 11 (1928): 691–694.

²⁵ Marika Seigel, *The Rhetoric of Pregnancy* (Chicago: The University of Chicago Press, 2014) 35–50.

²⁶ J.W. Ballantyne, *Expectant Motherhood: Its Supervision and Hygiene* (London: Cassell and Company, Ltd., 1914), Preface.

normal births.²⁷ When comparing Ballantyne’s endorsement of midwives to the attitudes in Canadian advice literature, it is worth noting that Ballantyne’s status—and support of midwifery—were well-respected by the Canadian medical community even though Canadian physicians expressed a markedly different view on midwives. A couple of years after the publication of Ballantyne’s *Hints to the Expectant Mother on her Health* the *Canadian Medical Association Journal (CMAJ)* published an editorial endorsing Ballantyne’s work on prenatal care and describing him as “one of the men particularly well worth meeting.”²⁸ Its author recognised the contribution of the British Midwives’ Acts to the advancement of public health.

This editorial from *CMAJ* also touches on one of the key reasons why British physicians felt confident about supporting trained midwives without compromising their own professional status. In 1911, the *National Insurance Act* for England and Wales was introduced to help secure the economic status of physicians; it meant that physicians no longer had to rely on obstetrical work for income.²⁹ Such economic security helps to explain why British advice literature valued midwives as competent practitioners, and key actors in medicalization, rather than representing them as professional competitors. In Ontario, where physicians lacked such economic security, advice literature showed ardent support for physician-supervised pregnancy and birth. There were, however, a

²⁷ TNA, Ministry of Health, *Maternal Mortality: Advice to Expectant Mothers* (leaflets issued by Local Authorities), MH 55/679.

²⁸ “Ballantyne and the New Midwifery,” *Canadian Medical Association Journal* 13, 6 (June, 1923): 441.

²⁹ Reid, “Birth Attendants and Midwifery Practice,” 381.

number of problems with directing women towards doctors for antenatal and parturient care.

While Dr. Helen MacMurchy stated in the *Canadian Mother's Book* that expectant mothers could approach a physician with the confidence that “the right kind of Doctor will not be trying to make money out of you, but will ask only a reasonable fee,” the physician’s fees were an insurmountable obstacle for many families.³⁰ Between problems associated with safety and accessibility the physician-centred model of medicalized motherhood was not the infallible option that was presented to mothers and health workers in the interwar years. Furthermore, the physician-centred approach not only delayed the widespread implementation of medicalized birthing practices in Canada, it also was partially responsible for the persistence of untrained attendants.

At times there was a grudging acceptance of this persistence, and there is some evidence that MacMurchy’s advice on “what to do if the baby arrives before the doctor” was used as instructional midwifery. In 1937, the wife of an Anglican missionary wrote to the secretary of the Division of Maternal and Child Hygiene with the following request: “Some years ago Dr. MacMurchy issued a little pamphlet, on exactly what to do if you had to deliver a baby without a doctor’s help. For 5 years we have been near a doctor and I am going back to where I will have to take up a certain amount of midwifery work again. The little pamphlet was splendid. I translated it into Cree at one

³⁰ Helen MacMurchy, *The Canadian Mother's Book: The Little Blue Books Mother's Series No. 1* (Ottawa: F.A. Acland, Printer to the King's Most Excellent Majesty, 1927), 14.

time. I only had one copy and I have lost it. Can you get me one?"³¹ The woman's letter was forwarded to Dr. Heagerty in the Department of Pensions and National Health. Rather than suggest that a missionary's wife should not be performing midwifery, Dr. Heagerty offered practical suggestions. He was unable to find a copy of MacMurchy's *Supplement to the Canadian Mother's Book*, but suggested that "as the applicant is going to do midwifery work she might get in touch with the Victorian Order of Nurses and endeavour to be present at a few confinements as she would learn a great deal in that way. I have no doubt that she would be able to obtain a text book which would give her valuable information."³² Even within the public health hierarchy, realism about women's conditions of life dictated that, even while physician assisted birth was the only officially condoned policy, untrained women in isolated communities had to act as midwives. If maternal and infant safety were to be the essential goals, it was better to provide such untrained midwives with appropriate information. As such, while MacMurchy adamantly favoured physician-controlled childbirth, she was ultimately compelled, as were many other doctors, to acknowledge the reality faced by many women in Canada and to provide some medical direction to suit that reality. The costs in maternal and infant lives might otherwise prove too high.

In addition to these national publications for expectant mothers and new families, there is one publication, *Dr. Dafoe's Guidebook for Mothers*, that is far less known but nevertheless deserves recognition. Although this "guidebook" was neither a

³¹ "Correspondence, 1937" LAC, Child and Maternal Health Division RG 29 Vol 991 File 499.3.2 pt 2.

³² "Correspondence, 1937" LAC, Child and Maternal Health Division RG 29 Vol 991 File 499.3.2 pt 2.

national nor a state publication, it was written by an Ontario physician of celebrity status, and is significant in the way that it reflects many of the dominant views about maternity and childrearing. In 1934, the Dionne quintuplets were born near Corbeil, Ontario, approximately 350 kilometres North of Toronto. Their mother, Elzire Dionne, was attended during her delivery by two Franco-Ontarian midwives and local physician Dr. Alan Dafoe. The work of the midwives, however, was greatly overshadowed by that of Dr. Dafoe. Not only did Dafoe receive all public credit for the unprecedented successful birth and survival of all five babies, the midwives later felt excluded from the Dionnes' lives. William Herbert Alderson of the Canada Red Cross Society and Northern Ontario Relief Commission testified in court, as part of a trial regarding the advertising rights of the five sisters, that "the midwife, Madame LaBelle, has since complained bitterly to me saying that although she was present at the birth she had not been permitted to have access to the children at any time after that prior to the opening of the Hospital in September, 1934."³³ The midwife's role was thus overshadowed by that of the physician.

In addition to identifying the midwife as a crucial actor in medicalization—not overshadowed by the physician—British manuals offered far more reassuring advice than the Canadian literature. This difference in tone is apparent throughout the publications: expectant mothers in Ontario were given advice based on the idea that motherhood was a national as well as a personal duty, and that, since the stakes were so high, they should be careful of mistakes. British advice literature was more affirming,

³³ Archives of Ontario (AO), F 4392-58, B236444, *St. Lawrence Starch Company Fonds, Dionne Quintuplets Files*, File 8.

attempting to reassure mothers of their innate maternal abilities without inspiring fear. A 1938 report for the Ministry of Health examined the literature to ensure that “most of the pamphlets and booklets are reassuring.”³⁴ Indeed, mothers were often advised that “Child bearing is a very natural healthy process. With care you can produce a normal healthy baby with no danger to yourself.”³⁵ This heartening approach is markedly different than what is generally put forward in the Canadian literature.

There are two corresponding explanations as to why the Canadian advice was less reassuring and more dogmatic than the British, both relevant to the different historical circumstances of the two nations. In Canada, a young, sparsely-populated and insecure nation having to come to terms with a large immigrant population, concerns about national identity and citizenship melded with similar concerns within the dominant class, of whom physicians were an important sector. Thus the promotion of a particular, class, “race” and gender-defined ideal Canadian melded with the promotion of physician-controlled pregnancy, birth, and childrearing. Canadian literature reinforced the benefits of physician control by instructing mothers to turn to their socially superior male physicians for every aspect of pregnancy. British literature was just as ardent in its endorsements of safe pregnancy and birth, but did not elevate and sanctify the physician’s indispensability: doctors were considered vital in medical emergencies of pregnancy and childbirth, but common developments could be dealt

³⁴ “Note on Booklets and Pamphlets supplied by Mrs. Tennant to the Minister of Health, 25/3/38,” TNA, Ministry of Health, *Maternal Mortality: Advice to Expectant Mothers* (leaflets issued by Local Authorities), MH 55/679.

³⁵ “Denbighshire County Council Ante Natal Clinics: Hints to Expectant Mothers,” TNA, Ministry of Health, *Maternal Mortality: Advice to Expectant Mothers* (leaflets issued by Local Authorities), MH 55/679.

with as readily, and possibly more efficiently, by nurses and trained midwives. In the *Canadian Mother's Book*, MacMurchy instructed expectant mothers to contact their physicians for all concerns regardless of their severity: "Having a good Doctor, you will have good medical advice and care all through your pregnancy, and help for any ailment, small or great."³⁶ In contrast, British literature stated that medical advice could be obtained at welfare centres and women only needed to contact a doctor if "one of the following DANGER SIGNALS appears: Bleeding from any part; persistent vomiting; headaches; giddiness or disturbance of sight; puffy face or swelling of the feet or hands; discharge or sores of any kind; less urine than usual; definite pain in any part; persistent sleeplessness; obstinate constipation."³⁷ British advisors endorsed medically-managed pregnancy, but—except for cases of emergency—they did not contend that "normal" pregnancies required constant physician supervision.

While most of these examples have focused on major medical aspects of pregnancy and childbirth, British and Canadian advice literature had a common approach in preparing for the practicalities of childbirth. For all the prominence of nationalism, medically managed birth, and attitudes towards motherhood, at their core the Canadian pamphlets, letters, and books of this period were produced to offer expectant mothers useful and practical advice. Much of the advice did reflect this intention. Mothers (and, to a much lesser extent, fathers) were advised on how to have a comfortable and healthy pregnancy and how to prepare for the baby's arrival.

³⁶ MacMurchy, *The Canadian Mother's Book* (1936), 11.

³⁷ *Health & Happiness for Baby*, TNA, Ministry of Health, Maternal Mortality: Advice to Expectant Mothers (leaflets issued by Local Authorities), MH 55/679.

MacMurchy offered detailed guidance, instructing mothers not only on what items the baby would need, but also by providing a precise list of what the mother should prepare for a home confinement. This list was extensive and specific. Mothers were informed that the doctor and nurse would need items such as “Abdominal binders, two, each 2 yards unbleached cotton, 18 inches wide, sterilized...Pads, small, sterilized, 4 dozen...Tape, narrow bobbin tape, one piece... The tape should be cut the right length (8 inches) for tying the cord, sterilized and enclosed in a sterile envelope till needed. Have four.”³⁸

While British advice did not offer such detail, mothers were nonetheless provided a list of basic requirements for a home confinement, also emphasising the importance of sterilisation. Mothers were warned that “It is a great mistake to think that anything is clean enough to soak up discharges during and after labour. Soiled things contain dangerous germs, which are likely to set up puerperal fever. Whatever is to be used should be well boiled beforehand and should be burned immediately after use.”³⁹ Regardless of the somewhat differing tone and emphasis of some of the instructions, all of these publications offered mothers, especially first-time mothers, the kind of necessary advice that made the literature valuable, which is likely why such letters and manuals had wide distribution rates with an apparently generally positive reception.

³⁸ MacMurchy, *The Canadian Mother's Book* (1938), 58–59.

³⁹ *Advice to Expectant Mothers* (1936) p 2, TNA, Ministry of Health, Maternal Mortality: Advice to Expectant Mothers (leaflets issued by Local Authorities), MH 55/679.

The publications also gave advice regarding the mother's diet, and clothing for both the mother and the baby. In both *The Canadian Mother's Book* and some of the British literature, mothers were provided with lists of what clothing infants would need, and some even included knitting patterns for baby's clothes designed to be suitable up to one year of age.⁴⁰ Mothers were instructed regarding what clothes were ideal during pregnancy to accommodate the bodily changes that would occur, including suggestions for supporting a growing belly as needed. The city of Manchester provided mothers with pamphlets and patterns for preparing three different types of underclothes to be worn during pregnancy: a breast sling, which was essentially a rudimentary brassiere; a maternity belt to support the belly and lower back; and suspender braces to avoid the circulation problems posed by garters or suspender belts.⁴¹ Mothers on either side of the Atlantic could create an entire maternity wardrobe and layette based on the instructions in these publications.

Some of the advice in Canadian literature was also very patronizing, as it assumed that the mother was incompetent without expert intervention. Without such guidance, the mother would be unable to adhere to appropriate standards. For example, the prenatal letter for the fourth month of pregnancy told women that they had to dress without letting their appearances slide: "You will be much more

⁴⁰ MacMurchy, *The Canadian Mother's Book* (1927), 36–63; *To Mothers and Fathers: How to keep yourselves and your children well and strong*, p 19, TNA, Ministry of Health, Maternal Mortality: Advice to Expectant Mothers (leaflets issued by Local Authorities), MH 55/679.

⁴¹ "Breast Sling," "Corporation of Manchester Maternity and Child Welfare Department: Maternity Belt," "Corporation of Manchester Maternity and Child Welfare Department: Suspender Braces," TNA, Ministry of Health, Maternal Mortality: Advice to Expectant Mothers (leaflets issued by Local Authorities), MH 55/679.

comfortable and cheerful if you give the necessary attention to your clothing. To go around in a wrapper has a depressing effect upon both you and your family.”⁴² Both Helen MacMurchy and the pre-natal letters told expectant mothers about the importance of rest during pregnancy, and advised that they avoid using a machine or treadle sewing machine, an important household duty for many women.⁴³

This sort of advice reinforced ideas about physician dominance and implied that, without guidance from approved experts, mothers would be unable to care for themselves properly during the critical time of pregnancy, with sorry results for themselves, their infants, and the nation. From the outset, experts admonished mothers not to rely on the advice of friends and family, especially any that contradicted with instructions from their physicians: “As we grow older we learn to appreciate that at such times it is advisable to turn for advice and help to those who have knowledge and experience...Disregard the advice of well-meaning friends and neighbours if it differs from the advice of your family doctor.”⁴⁴ The traditional network of support consisting of female family members and friends, it was argued, was now irrelevant, outmoded, and perhaps even harmful. Only the experts, especially physicians, could advise effectively and thereby ensure the best results for all concerned.

⁴² “The fourth prenatal letter,” LAC, Child and Maternal health Division RG 29 Vol 992 File 499.3.7 Pt. 4.

⁴³ Helen MacMurchy, *Sterilization? Birth Control? A book for family welfare and safety* (Toronto: The Macmillan Company of Canada Limited, At St. Martin’s House, 1934), 33; “The fourth prenatal letter,” LAC, Child and Maternal health Division RG 29 Vol 992 File 499.3.7 Pt. 4.

⁴⁴ “The first prenatal letter,” LAC, Child and Maternal Health Division RG 29 Vol 992 File 499.3.7

Ultimately, the advice proffered in this literature both built upon and expanded public, and especially professional, concerns about maternal and infant mortality. Advice literature, medical supervision and “scientific” standards of hygiene were delivered as the essential maternal education that would best help to reduce the maternal and infant mortality rates. Understanding the literature’s purpose explains why certain approaches were favoured while also revealing some of the problems of a reliance on physician-produced maternal education to solve the larger problems. The Canadian literature was adamant that physician-controlled pregnancy, with an emphasis on hospital deliveries, was the best option and the definition of medicalization. But, as I have shown in an analysis of this literature and throughout this project, many Canadian women did not have access to a physician’s services, and even those that did were not necessarily in safer hands—particularly not if the medical care included hospitalisation.⁴⁵ Physicians in Ontario actively promoted medicalized pregnancy, childbirth, and hospital births because that approach had the benefit of applying “modern science” to the problem of maternal and infant welfare while also expanding their social influence and strengthening their professional interests. This message was emphasised in spite of the clear evidence, discussed in the *Canadian Association Medical Journal*, that trained midwives could hasten the process of medicalization.

As I have shown, the tone of the messages in the Canadian literature was designed to instil fear as a means of convincing new mothers to bow to the superior

⁴⁵ According to *Need Our Mothers Die?*, the puerperal mortality rate was 5.3 per 1,000 live births in a hospital, but only 2.3 for home births. Similarly the death rates from puerperal sepsis in a hospital setting were 1.7 per 1,000 live births, but only 0.7 for home births. *Need Our Mothers Die?*, 18.

knowledge of the—mostly male—professionals, to whom even the medically-trained nurses and midwives must bow. Given the inherent problems in the message promoted in these interwar publications it is necessary to question whether such approaches actually addressed the problems of maternal and infant mortality, as they were clearly intended to do. The exclusion of midwifery and trained obstetrical nursing were detrimental to Canadian mothers, many of whom had few or no options regarding physician care. Furthermore, even in the interwar years, physicians and policy makers had evidence that clearly showed that such exclusions only benefitted the physician dominance. There was a genuine need to reduce the maternal and infant mortality rates, and the health care workers responsible for these publications were seeking to address that need, but there is no escaping the promotion of physician dominance as the forceful message delivered in these works.

7 CONCLUSION

The medicalization of childbirth in Ontario and the British Isles, while studied extensively, has not previously been addressed as a transnational comparison. On both sides of the Atlantic maternity care in the late-nineteenth-century was largely unregulated and seldom provided by trained medical professionals. By the middle of the twentieth century, childbirth had been overwhelmingly medicalized in both regions. Yet the process of medicalization, and even the resulting medicalized model, were strikingly different. While physicians and health authorities in Ontario proposed a model that placed medical care and advancements firmly in the hands of physicians, in the British Isles trained midwives were integral to advancements in maternity care. These differences were not incidental. This comparative study offers an alternative view of medicalization that questions why physicians in Ontario advocated for medically-supervised childbirth while simultaneously ensuring that such a system was impractical at best. The official elimination of midwives—unofficially many untrained midwives worked throughout the first half of the century—was done in the name of medical progress and maternal safety, but both of these were delayed by the very regulations that were supposed to promote them.

The alternative model suggested by this comparative study of medicalization, consequently, is one in which—as the British example demonstrates—trained midwives were fully participant in the advancements in obstetrics and antenatal care.

Medicalization occurred far more rapidly when midwives were integrated into the

process. Furthermore, the regulation and training of midwives improved maternal and infant health and lowered mortality rates. The resulting system, while not without problems, offered widespread medically-managed birth. In Ontario, the impracticality of physician-managed birth meant that official policy was often different from the lived-experience. In the British Isles, the regulation of midwifery, training grants for midwives, and the emphasis on replacing handywomen with trained midwives all helped ensure the application of official policy.

While divergent trajectories in the medicalization of birth are prominent in a comparison of policy and practice in Ontario and the British Isles, the interconnected aspects ensure that such a comparison is not merely a hypothetical observation and theory. In Ontario, physicians and healthcare workers were often acutely aware that policy and practice in Ontario were markedly different than was the case in the British Isles—and much of Europe. When establishing the Victorian Order of Nurses (VON) in the late nineteenth century, Lady Aberdeen initially hoped to include trained midwives but was unable to, due to opposition from physicians. Nevertheless, maternity care, including obstetrical nursing during confinements, represented a significant portion of VON services. Officially these nurses were prohibited from attending confinements without a physician, but there is evidence that nurses were the primary attendant at births where the physician either could not arrive in time or was never called—physicians' services were prohibitively expensive for many women.¹ In such instances, there are obvious parallels between the work of visiting nurses in Ontario and certified

¹ LAC, Victorian Order of Nurses, MG 28 I 171 Vol. 6, House of Commons Special Committee on Social Security, File 6.

midwives in Britain. Furthermore, nurses in Ontario were themselves aware of some of the benefits of trained midwives. Nursing organisations such as the VON endeavoured to improve patient services and reduce maternal and infant mortality rates and studied alternative models of care. Articles in the *Canadian Nurse* show that nurses in Ontario were aware that countries which employed trained midwives often had lower maternal mortality rates. They also addressed some of the other benefits offered by maternity services that included certified midwives.² Such articles should not be interpreted as evidence that the majority of nurses in Ontario would have been in favour of introducing trained midwives, but it does highlight the need for a comparative analysis: medical professionals in Ontario were aware of some of the drawbacks of a physician-centred model of medicalization.

The primary discourse on the medicalization of childbirth focuses on health and safety, and, to a lesser degree, professionalization. On both sides of the Atlantic, improving infant and maternal morbidity and mortality rates were the impetus for their changes to perinatal care. This transnational comparison, however, shows that improved morbidity and mortality rates were not the only benefits of including trained midwives. The establishment of trained midwives as regulated medical professionals allowed them to participate in obstetrical advancements, including the administration of analgesia and certain other drugs, which made medicalized care available to a significantly higher percentage of women. The regulation of midwives in Britain limited their practice, and there were a number of circumstances under which they were

² Mary Beard, "Midwifery in England: Part 1," *Canadian Nurse* (February 1927), 89–94.

required to call for a physician's assistance, but their training and employment were viewed as beneficial to physicians rather than as competing or inferior care. In Ontario, it was not only untrained (illegal) midwives who were barred from such developments: trained nurses were not allowed access to the same range of medicine and medical technologies as was available to midwives in Britain. Such contrasts are illustrated not only in regulation, but also in contemporary publications. While the British journal *Nursing Notes and Midwives Chronicle* and the Irish journal *Irish Nursing News* both published extensively on midwives' administration of analgesics and other drugs, the *Canadian Nurse* rarely addressed these same developments. Nurses in Ontario received a high-level of training, but professional regulations ensured their exclusion from many aspects of medicalization.

The advice literature targeting expectant mothers helps to explain some of the motivation behind these divergent approaches. Ostensibly, literature from Britain and Ontario covered many of the same topics: the importance of antenatal care; nutrition during pregnancy; breastfeeding; preparing for a home confinement; and general advice on what to expect during pregnancy, birth, and the first months of an infant's life. The tone of the literature, however, was markedly different. Advice literature from Britain was written to provide reassurance for mothers, discussed trained midwives as ideal attendants for normal births, and provided guidance that did not invoke a nationalist agenda. In contrast, much of the literature available to mothers in Ontario used a combination of fear and ideas of national duty to convince mothers of the benefits of a physician-supervised pregnancy and birth. An analysis of the literature shows that

physicians in Ontario lacked the professional and economic security experienced by their British counterparts. While this alone does not explain the divergent approaches to medicalization, it does illustrate that physicians in Ontario had a professional and financial interest in excluding trained nurses and untrained midwives from many aspects of perinatal care.

This comparative study calls into question the definition of the medicalization of childbirth, which in Canadian history has been defined as a physician-centred process. In Britain, regulated midwifery allowed for rapid medicalization that was not dependent on physician dominance. Midwives provided quality medical care, including access to certain drugs and technology, to the majority of women, often in their own homes. This model removed the economic, social, and practical barriers that prevented many women in Ontario from accessing a physician's care. Furthermore, it improved maternal and infant mortality and morbidity rates. Certain aspects of this model, such as midwives attending the majority of deliveries on bicycles, would not have been practical in Ontario where the population was lower and far more dispersed. Expanding the scope of nurses' practice, however, would have made many of these developments available through the extensive maternity care offered by Victorian Order Nurses. The transnational differences are highly significant since the decision in Ontario to promote physician-centred medicalization was made with the knowledge that alternative models could be safer and more accessible. The British medical system still reinforced gendered and professional hierarchies, but did so in a way that made obstetrical advancements available to nearly all mothers.

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