AIMS For a better birth...

Family stories: putting them into the wider context

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By Alex Smith



My Grandmother Mary

My maternal grandmother, Mary Hannah Alberta Patchett, born at home in 1896, was so small at birth that her family always said they could have put her in a pint pot. She seemed very proud of this fact. Neonatal intensive care units did not exist in those days and tiny babies were raised, or died, at home. Until the advent of the NHS, many people could not afford hospital care, and in any case, its benefits were uncertain. Home nursing skills, guided by a nurse, handy woman, or the older women in the family and neighbourhood, were mastered very quickly and people knew what to do. They did not feel helpless.

My 1930s motherhood book[1] is very reassuring.

To care for a premature baby demands exceptional thoroughness and devotion. Given these, a little knowledge and plenty of common sense, almost any baby who is really complete and alive at birth can be safely and successfully reared in an ordinary home, with ordinary equipment, no matter how tiny they may be.

The care instructions include the use of a clothes basket if the cradle has not arrived. This is lined with brown paper and flannel and warmed with three hot water bottles of an exact temperature. The crib is

screened from draughts but a window kept open at all times while the baby is in bed. An incubator is *"not necessary nor desirable"* because, without plenty of fresh air, *"baby cannot possibly thrive"*. The author suggests cutting very simple clothes from a sheet of gamgee tissue (a roll of cotton wool between two layers of gauze) and not to undress and redress the baby more than once every three days *"until baby is over 3½ lbs in weight"*. Though guidance is given for "*artificial feeding"*, if needs must, "*mother's own milk"* is considered "*never so vital"*.



Rolls of gamgee tissue

The distant memory of this knowledge of the care of tiny babies has been carried into common parlance with idioms such as 'being wrapped in cotton wool', and 'still wet behind the ears', which premature babies are. The self-reliance and competence required to care for a premature baby is illustrated in Anne Glover's account of the premature birth of her grandmother's second baby and Alison Bryan's account of her mother's birth in 1942. Indeed, a great uncle of mine, born in the late 1800's, had the life-long nickname 'Tiny' on account of having been born very early.

Of course, historically, not all mothers or babies survived childbirth and the mortality rates were much higher than today. However, things may not have been as dreadful as historians would have us believe. Catherina Schrader (1656-1747)[2] was a Dutch midwife who left records of each of the 4000 births she attended between 1693 and 1745, 95% of which were spontaneous and without intervention. Analysis of her figures shows her maternal mortality was 4.6 in a 1000 (comparable with the UK up until 1935) and her perinatal mortality 54 in a 1000. It is hard to compare these figures with today's because it is likely that different criteria were used, but they show that, in her practice, around 99.5% of mothers and 95% of babies survived the birth.

To set this into context we should know that Catherina attended: breech and transverse-lie births; cases of placenta praevia and cord prolapse; twin births[3]; births of babies with mothers who were well into their forties; births of babies with conditions not compatible with life (less seen today because of therapeutic abortion); and babies stillborn or close to death because of rhesus incompatibility. Her figures align with those of Martha Ballard[4], an 18th century midwife working in the wilds of New England with no medical support other than her skills as a herbalist. In 27 years of practice Martha lost only 5 mothers, none of whom died during the labour or birth itself. Two were from infection when scarlet fever was present in the house, two from what was probably eclampsia, and one is uncertain. Her perinatal mortality rate was the same as the UK's in the 30s. It is likely that Catherina and Martha were exceptional, but their records show what was possible with skilled care.

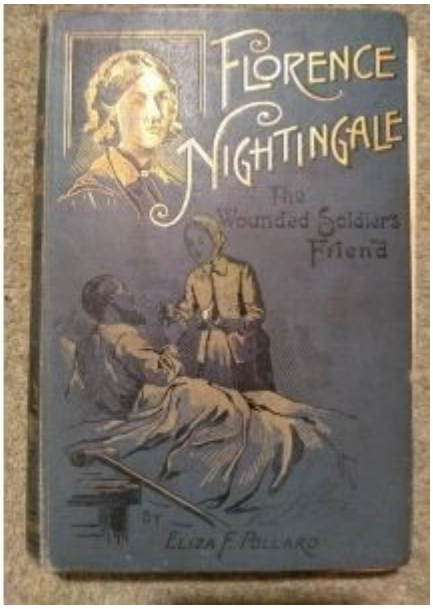
The maternal death rate in the UK throughout the second half of the 19th century and up until the mid-

1930s was roughly 1 in 200.[5] [6] Everyone would have known, or known of, a mother who died. 55% of these deaths were from infection, with another 42% caused by bleeding, convulsions, and illegal abortion.[7] Infection was (and still is) much more likely from a hospital or doctor-attended birth (there was a mortality rate of about 85 in 1000 for the lying-in hospitals of that time), but mortality plummeted following the introduction of the first antibiotics. By today's standards the idea of 1 in 200 mothers dying is appalling, but when you consider that this figure included women of *all* risk groups: women with undiagnosed or untreated medical conditions such as heart disease, diabetes, rickets or preeclampsia[8]; women with no recourse to antibiotics or safe surgery; women having very large families; women living is abject poverty; and almost all women being attended at home by a midwife who by today's standards would be considered 'untrained', the fact that 99.5% of mothers survived childbirth in the care of these two women is a remarkable testament to traditional midwifery and the inherent safety of birth.

In Leap and Hunter's book 'The Midwife's Tale'[9], an oral history of midwifery, the community midwives interviewed (working in the decades before the NHS) reported seeing very few maternal deaths as women with really severe problems were referred to hospital by then. One midwife who had attended 4000 births saw only one woman die. This mother had given birth in hospital and had developed complications after she had come home. There are tales of midwives attending the home birth of triplets (without a doctor present as *"it would have frightened the patient"*), the home birth of twins born 24 hours apart (the second baby was in a good position…*"so why worry!?"*), and the home birth of a 21st baby. One midwife from Wales attended 200 births and didn't have to transfer a single mother into hospital – including the one caesarean carried out with the help of the GP (who she later married). The mother refused to go into the hospital...but that is a longer story. Another midwife describes how a baby, born at 30 weeks and weighing only two and a half pounds, was successfully cared for at home. However, childbirth, and the various medical or surgical procedures employed, did leave their toll.

In my own family story there were two maternal deaths that are remembered. My 4'11" maternal great great grandmother, Elizabeth, safely gave birth to thirteen children between the years of 1862 and 1889. (The records show that she once spent a week in jail for *disorderly conduct*. I like to think that this may have been a little holiday for her.) Elizabeth's ninth baby, Benjamin, died aged two; the others all survived to lead full lives. However, her young daughter-in-law, Emily, died from puerperal septicaemia following the birth of her baby in 1906, my Uncle Hector. I just remember Uncle Hector. We have a picture of his beautiful mother, and we also have a book, a book about Florence Nightingale, that was awarded to Emily at school in 1891 for gaining 135 out of 150 marks. I feel a strange sense of maternal pride and sadness whenever I think of this. Hector's Auntie Martha (a favourite great aunt of my mother's) helped raise Hector, and my Nanna, as a girl, remembers pushing him up and down the road in his wicker pram. The extended family must have been a God-send in times of birth and death.





Elizabeth and her husband with my great grandmother and her little daughter (my Nanna) to the left of the picture, and Auntie Martha to the right.

My paternal great grandmother Mary Anne, had eleven children. Her first pregnancy in 1880 was with twins. One was stillborn and the other, Mark John, died at three days old. The other nine children thrived, but sadly, Mary's youngest daughter Dorcas died in 1920 one month after the birth of her own twins. Apparently she had always had a bad heart and the cause of death is given as ulcerative endocarditis and pulmonary embolism. The babies survived and one stayed with my grandmother until arrangements were made for their adoption within the wider family.





Picture 1: One of the baby twins with my father and auntie. Picture 2: Great grandma Mary is on the left.

For hospital and doctor-attended births, the eventual acceptance of hand-washing in the late 1880s

saved countless maternal lives[10], and the improved living conditions of people from 1900 onwards made a vital contribution to lowering mortality and morbidity rates[11]. Medical breakthroughs in the 20th century also made a real difference. Antibiotics in the late 1930s further reduced mortality from infection. At around the same time, ergometrine was introduced to help control excessive postpartum bleeding.[12] Blood transfusion reduced mortality for women who did haemorrhage, and blood transfusion combined with improved anaesthesia made surgery a viable option in emergencies.[7] Legal abortion, however conflicted we may feel about this, has saved countless maternal lives,[13] and Anti-D medication, introduced in the 1960s, meant that women who were rhesus negative no longer had a string of stillbirths after their first child.[14] This last advance meant that I was able to have five healthy children, whereas my older friend Dorothy, determined to provide a sibling for her daughter, experienced the death of her second-born at three days (she wasn't allowed to see him) and then four stillbirths of term babies. Brilliant and welcome as they are, none of these medical advances require the mass hospitalisation of birth we see today.

With a gradual shift towards hospital over the middle decades of the 20th century, home remained a very normal place to give birth well into the 1960s. My petite mother-in-law gave birth to my husband at home one snowy Sunday morning in 1950. She remembers that the church bells were ringing. Help was summoned using the village telephone box. The telephone operator said, "Is that you Ron? Is the baby on the way?" Birth was a community event. The midwife duly arrived but rode away again on her bicycle saying that, as it was a first baby, it would take some time and she would call again at teatime. Not long after she had left, things progressed rapidly and my father-in-law was dispatched to fetch the sweetshop lady who had once been a nurse. While he was gone, the baby was born with only grandma in attendance. My mother-in-law shared her birth story with me a few times, and rather than focusing on the 'no midwife present' part, she always mentioned that she was walking around right up until the birth with her mother following behind trying to tempt her with a bowl of cereal. The homeliness and ordinariness of her account helped cement in me my utter and unshakeable belief that in the right environment babies usually just come out. Where else would they go?

Having attended home birth and home death, there is a strange comfort in the normalcy and ownership of the everyday surroundings, and of the life transitions themselves. In these situations I have experienced a really strong sense of connection with the past, as if all the women who had been there before me were sharing their support and wisdom. It really is true that what you need when a baby is being born is towels, hot water and faith. In 1981 I was issued with a list of requirements for my planned home birth:

- 1 hand bowl
- 2 jam jars
-

Supply of clean newspapers

- Saucepan and lid
- 1 large jug
- 1 jug ½ pint
- 2 boilable pudding basins
- 2 forks
- Supply of clean mackintosh sheeting

I rather thought that the midwife had plans to make me a celebratory omelette. Having gathered everything as asked, none of it was used. My baby was born before they had time to boil a pudding basin. I kept the list though, because, for me, it epitomises the everyday and timeless ordinariness of childbirth.

Author Bio: Alex is an editor for the AIMS journal. She remembers birth stories from her grandmother's time and before, all the way through to those of her great grandchildren.

1The Motherhood Book. (1930) The Amalgamated Press, Ltd., London

2Dunn P M (2004) Catherina Schrader (1656-1746): the memoirs of a Friesian midwife. Archives of Disease in Childhood -- Fetal & Neonatal Edition, November. https://bmj.altmetric.com/details/556365

3Co-editor Salli Ward's memory: "My dad, born at home in 1927, was a twin. The story was he came out the wrong way round (feet first) and had to be pushed back in and told to come out the right way. He lived to be 85, though his twin sister died of the hospital superbug in her 70s."

4Ulrich L T (1991) A Midwife's Tale: the Life of Martha Ballard Based on Her Diary, 1785-1812. Vintage

5Chamberlain G. (2006). British maternal mortality in the 19th and early 20th centuries. Journal of the Royal Society of Medicine, 99(11), 559–563. https://doi.org/10.1258/jrsm.99.11.559

6Loudon I. (1986). Deaths in childbed from the eighteenth century to 1935. Medical history, 30(1), 1–41.

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7Irvine Loudon, Maternal mortality in the past and its relevance to developing countries today,*The American Journal of Clinical Nutrition*, Volume 72, Issue 1, July 2000, Pages 241S–246S, https://doi.org/10.1093/ajcn/72.1.241S

8 Author's note: Preeclampsia (previously referred to as Toxaemia) is not a modern disease but its cause is still not known. Current theories remain theories. Bell (2010) outlines the history of the condition: Bell M. J. (2010). A historical overview of preeclampsia-eclampsia.*Journal of obstetric, gynecologic, and neonatal nursing : JOGNN*, *39*(5), 510–518. https://doi.org/10.1111/j.1552-6909.2010.01172.x

9 Leap N. Hunter B. (1993) The Midwife's Tale. London: Scarlet Press

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11 Tew M. (1985). Place of birth and perinatal mortality. The Journal of the Royal College of General Practitioners, 35(277), 390–394.

12 Dunn P M (2002) Perinatal lessons from the past: John Chassar Moir (1900–1977) and the discovery of ergometrine. https://fn.bmj.com/content/87/2/F152

13 Haddad, L. B., & Nour, N. M. (2009). Unsafe abortion: unnecessary maternal mortality.*Reviews in obstetrics & gynecology*, *2*(2), 122–126.

14 Lundevaller EH, Edvinsson S. The effect of Rh-negative disease on perinatal mortality: some evidence from the Skellefteå region, Sweden, 1860-1900. Biodemography Soc Biol. 2012;58(2):116-32. http://umu.diva-portal.org/smash/get/diva2:359114/FULLTEXT01.pdf