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A brief history of district midwifery

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The majority of the oral history quotes come from interviews carried out by the author. The interviewee is identified by their initials. They are discussed in more detail in McIntosh (2012)[1] and McIntosh (2014).[2]

By Tania Staras (formerly McIntosh)

[One] patient said, 'I've got Sister's tea.' I said 'Tea?' 'Oh yes, she only drinks Earl Grey' My midwife wouldn't go to the back door. You know some farmhouses; they don't actually use the front door. 'I'm not the tradesman,' she said. They were quite bossy in some ways, but it was accepted.

(DS interview)

As soon as the midwife's bike appeared, I sent the young one two doors up to fetch the cup and saucer. She was the only woman on the road with a matching cup and saucer … we all borrowed it for visitors. I would run and wipe the lavvy seat … I had four boys you see … the old man would push his paper down his waistcoat and slip over the back fence to next door, he was really terrified of the midwife. I'd be left to face the music.[3]

Introduction

These two brief stories give a snapshot of how midwives were viewed by women and families in England between the 1940s and 1970s. They were powerful, respectable, bossy and a bit scary. They are not the only stories – midwives were also remembered as kind and caring. But they give us a strong sense of how midwives were seen and of how they saw themselves.

This paper explores the work of district midwives in England between 1948 and 1974. This seems like a very specific group of people and a very specific time but it allows us to consider what made maternity care tick in the post war period. It also gives us an idea about why the home-based model of care struggled to endure. The paper focuses on the working lives of midwives in this period and then considers their relationships with those around them: general practitioners and most importantly women and families.

Background

As long as there have been women giving birth, there have been other women looking after them. In England the title of 'midwife' became legally protected after 1902 when the first Midwives Act was passed.[2] This meant that to describe herself as a midwife a woman (and it was always a woman – men were legally barred from midwifery between 1902 and 1979[4] when the law was challenged) had to have been trained, examined and her name entered on the Midwives Roll held by the governing body, the Central Midwives Board. Midwifery had been formalised in this way as it was increasingly felt that midwives had the capacity to 'sell' public health messages at a time of concern for infant and maternal well-being. There was also a drive to 'professionalise' midwifery, making it a suitable career option for middle-class women.[5] Most midwives worked 'on the district' – in their local communities – because that is where the majority of babies were born. After 1936 some local authorities began to pay their district midwives a salary (prior to this they had been reliant on case fees, not always easy to collect in poor communities) and in some areas went so far as to provide housing, bicycles, uniforms, and headed-note paper.

In 1948 the National Health Service [NHS] commenced work, offering 'healthcare free at the point of need'. The midwifery services fell under the umbrella of the NHS but their organisation remained the same as it had been since the mid-1930s. The 'tripartite' system of care, as it was called, meant that women could receive care from their district midwife through the local authority (who also ran antenatal and postnatal clinics); from their General Practitioner [GP] (who now contracted their services to the NHS); from hospital-based services, including midwives and obstetricians. Some women had care from just one of these bodies, while others moved through the system and might have had care from their district midwife and a GP who might then have referred them to hospital.

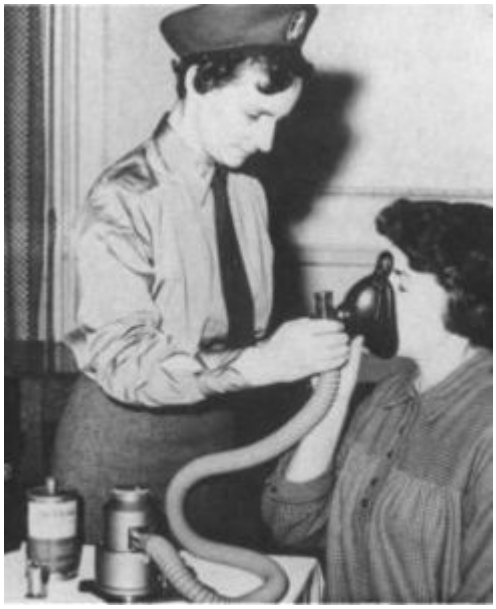
Despite the proportion of hospital births rising from around 30% in the late 1940s to 98% by the early 1970s, the system endured.[6] In 1974, however, midwifery care changed for good. Local authorities no longer employed district midwives or ran clinics or welfare centres. Their work was subsumed into the

NHS and run by hospitals. In some ways this seems logical; there was now one employer for all NHS midwives and having them together meant that training and rotas were easier to organise. However, the system had huge consequences that endure today. District midwives (called community midwives after 1974) were employed by an organisation that increasingly had risk as its focus. The idea of home-based midwifery and a social model of care was much harder to maintain when the focus was on acute and hospital care. Many very experienced district midwives left the service in 1974 rather than work under the new model. For those who remained, their work revolved almost entirely around antenatal clinics and postnatal visits. Home births were vanishingly rare in many areas.

There is a sense that the period between 1948-1974 was a golden era for the social model of midwifery care. This idea has gained traction through the TV series 'Call the Midwife' that focuses on the midwife as part of their community. The rest of this paper explores the work and relationships of district midwives and considers to what extent they were actually part of their communities. The evidence comes from oral histories of women and midwives, from midwifery case books and from local and national policies.

The working life of the district midwife

By 1948 all midwives working in England were trained[7] – the practice of the untrained 'handywoman' or 'woman who did' died out after lingering well into the 1930s. The modern district midwife was held in high esteem by local authority employers. No longer seen as ignorant or dangerous, as midwives had been viewed by the medical profession before 1902, she had a high level of autonomy in her work. By virtue of their training and practice, midwives were competent and confident to care for uncomplicated cases but also to manage, single-handedly, situations that could make modern hospital midwives reach for the emergency buzzer. In an era before scanning, every labour was to a certain extent a journey into the unknown. Midwives delivered breech babies, twins, premature babies, and those with congenital abnormalities. They were allowed to offer nitrous oxide for pain relief (although the equipment was heavy and cumbersome – it was only practical for midwives who had cars to transport it in) and after 1959 were able to give pethidine.



They did not suture however, and prided themselves on birthing a baby over an intact perineum where possible; otherwise, the GP had to be called out. One midwife recalled how this felt:

Or if she [the patient] was torn the doctor would come and stitch her up. Nowadays they don't seem to bother at all if the mother gets torn. In those days it was a terrible disgrace if you had a delivery and the mother was torn. It just wasn't done. It was bad midwifery; it was bad nursing to get a tear and you, you know, if you sent for a doctor you were almost apologetic that the mother was torn.[8]

In dire emergencies the Flying Squad could be summoned. Mandatory in all areas after 1948, this service was provided by local hospitals and consisted of a doctor, midwife, anaesthetist, and equipment to manage transfusions and other emergencies at home. Flying squad records suggest that most callouts were for post-partum haemorrhage and that only in the rarest of cases were women transferred to hospital.[9]

The confidence to work alone and to manage complex cases was instilled in pupil midwives. During this period, training consisted of two parts – the first in hospital and the second on the district. Only with both parts was a midwife qualified to take on a district role. One midwife recalled how pupils were thrown in the deep end:

Then when you came on the district, you went with a midwife and then she would choose cases and say "you go there and I'm there if you want me"...I did it as well but you have to be sort of confident in your student really and she has to be confident in you, and then you delivered them alone.

(DS interview).

Delivering the baby was not the end of the midwife's work. Postanal care was seen as essential, and given the number of visits, was time-consuming.

We used to do two visits [a day] for six days in the community...if they had stitches we had to go for six

days and swab them down. But if they hadn't then it was twice a day for three days, and then daily for ten days we looked after them.

(MB interview)

There are many stories of midwives staying up all night with births and then still doing a full load of visits the next day. Sometimes midwives worked in pairs, occasionally even living together to support each other. However, the caseloads and the intensity of work took its toll on the workforce. Through the period there were reports and inquiries looking at the workload of midwives and the professional exhaustion and attrition that followed. The Stocks committee in 1949 commented that

[The midwife] is unable to give sufficient time and attention to her mothers and babies, too busy to be calm, too pressed to enjoy her work'.[10]

In district work the limits to the midwife's role were set only by her 'physical endurance'. Although there was never a marriage bar in midwifery as there was in other professions such as teaching and the civil service, in practice the work precluded midwives from getting married and having families of their own. One midwife, interviewed by Leap and Hunter,[11] commented: "I often wish I'd had a baby...yes...but there it was...I chose the profession." For some midwives, the people they worked with became their families. A district midwife who worked in Sheffield in the 1940s explained, "you never really got the feeling that baby was yours until you delivered it on the district".[12]

District midwives prided themselves on their expertise, autonomy and on their resilience in the face of very heavy workloads. The baby boom in the 1940s and another spike in the 1960s meant that midwives recalled rushing from case to case.

I've delivered three babies in a night. I've worked all day and then during that night I've literally gone out, delivered a baby, come home, just got back into bed again, the phone rings, go out. And that's the most I've done is three confinements in one night.

(BR interview)

The idea that district midwives could cope with anything was important to their self-image. They saw themselves as tough, knowledgeable, and having ownership of families and births. Inevitably this sense had an impact on relationships with women and families.

Relationships with women

Most people know that 'midwife' means 'with woman' (from the old English). The word carries the sense that midwives support and nurture women during pregnancy and the postnatal period and particularly during labour and birth. Traditionally midwives were drawn from their local communities and their knowledge was gained through attending births and giving care. As we have seen, in post-war England the situation was very different. Midwives were trained, increasingly used medical terminology and specialist equipment, wore uniforms, and drove to visits. They were no longer obviously 'with woman' in

the sense that they were the same as them – they were now set apart and saw themselves, and were seen by families, as educated professionals. As the stories at the beginning of this paper show, midwives expected to be treated with respect by women. Midwives saw themselves as at the heart of their communities, but also powerful within them. The evidence suggests that to a certain extent women accepted this relationship, but also that they subverted it. One midwife recalled that women were not afraid to ask things of their midwives:

But when I first came on the District I had a Council Morris Minor and then I got my own bright yellow Ford. The other midwife, Johnson, she had an orange car. So they'd ask you sometimes to park down the side street because they didn't want the neighbours to know they were pregnant.

(DS interview)

This story is partly about social beliefs about pregnancy, but also reminds us that midwives were, in many ways, servants of the women they cared for. This is most clear in relation to place of birth. Women giving birth at home were very much the centre of their experience, whatever the midwife might believe. Women chose if and when to call for the midwife, whether to attend clinics, and whether to be out when the midwife dropped by postnatally. Evidence from casebooks suggests that women would call midwives very late in labour or sometimes not until the baby was in the cot.[13]

The relationship between midwives and women was always one of negotiation and acceptance. What midwives across the period clearly found harder to manage was the growth of 'consumer' groups such as the Association for Improvements in Maternity Services (AIMS) and the National Childbirth Trust (NCT). These groups were created as a deliberate challenge to elements of the system of maternity care in the UK, although not necessarily to district midwives themselves. The impact they had, however, was to make midwives feel threatened because women increasingly had knowledge and a voice and would not always meekly accept the power of the midwife. Some midwives clearly felt that their status was under threat, "We were the professionals. I think women were just encouraged to have unrealistic expectations." (ST interview) The belief that midwives were professionals, and controlled knowledge is suggestive. Developments in care were not about what women needed and wanted; they were about the ownership and control of pregnancy by midwives.[14]

Relationships with GPs

The relationship between midwives and women was the central plank of their work, but they also worked with GPs and, increasingly, with hospitals. Before 1948, GPs and midwives had been in competition for maternity cases and fees. Now that midwives were salaried this was no longer the case, although GPs did get a fee for attending births, which meant they were keen to be there. Case books show that GPs attended many routine births when their presence was not required on clinical grounds. One midwife recalled what this looked like in practice:

And one GP, he was at the top of the hill, he used to like to come and give the girls chloroform for delivery. I mean at least he came out, but you got wise to this and sent for him too late. But he'd still get

his fee for coming. But I mean the mums didn't want...they want to be awake, even in those days they wanted to be with it for the delivery.

(MB interview)

This suggests that midwives felt they knew women, and what they wanted, better than doctors. Another midwife described how much more skilled she believed she was than the generalist GP:

I only ever had one [breech birth] to be truthful, it wasn't my patient, I was relieving for the midwife. Partway through the GP said … 'definitely breech, I'm just going back to the surgery'. I said, 'If you're going back to read about it, you needn't bother, I'll tell you what to do'. I think the GP was a bit … wouldn't be overjoyed with it myself but at least it all turned out alright.

(ST interview)

As with women, however, the power that midwives had could be more illusory than real. Doctors were set above them professionally. One midwife recalled trying to have a baby admitted to hospital, but the hospital refusing to take the referral unless it came from a GP. In describing the incident, midwife MB explained that the GP took her side and concluded that:

...the GPs did support you. We didn't get them out unnecessarily, but you knew they were there if you needed anything, and you really knew that you knew more about the situation than they did. But often it was the doctor who had to say...'

(MB interview)

Conclusion

This paper has explored community maternity care in the post-war period from the perspective of the midwives who delivered the care. Evidence from case books, reports and oral history suggests that midwives were proud of their status and their role at the heart of communities. They saw themselves as professionals on a par with GPs and set apart from women by virtue of their training and expertise. In reality, however, GPs and hospitals still controlled the way that district midwives were able to work. Relationships between women and midwives could be warm, supportive, and nurturing. However, there were often undertones of control by midwives and subversion by women which were brought more into the open as a consumer movement in maternity developed in the 1960s.

Many district midwives prided themselves on their resilience and capacity for hard work. It was only looking back that some realised that the nature of their work blinded them to the fact that maternity care was changing under their feet. The growth in hospital births meant that the main feature of their work – home births – was disappearing, leaving them with a diet of antenatal clinics and postnatal visits. A midwife who worked through the period commented that:

Once women went into hospital and booked under obstetricians, the midwifery profession started to decline. It was very easy with hindsight to see that. My generation of midwives has to bear the

responsibility for it but at the time we were just too busy getting on with our job to notice the erosion of our role.[15]

It is important not to use history to make glib connections to contemporary situations. However, the evidence suggests that the qualities district midwives were most proud of, their busyness and sense of difference, may have contributed to their decline as the landscape of care changed around them. And once birth lost its social and community connection it has proven very hard to recover.

District midwife just before the Second World War showing uniform and transport

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1 McIntosh T. (2012) A Social History of Maternity Care. Abingdon: Routledge

2 McIntosh T. (2014) '"I'm not the tradesman": a case study of district midwifery in Nottingham and Derby 1954 -1974' *Social History of Medicine*

3 Allison J. (1996) Delivered at Home. London: Chapman & Hal

4 Editor's note: While some midwifery training opportunities became available to men in the late 1970s, the amendment to the 1975 sex discrimination act that gave men a legal right to enter midwifery was not made until 1983 and did not come into effect until January 1st 1984. https://www.rcm.org.uk/news-views/rcm-opinion/2022/120-years-of-the-midwives-act-in-england-and-wales/

5 Dale P. and Fisher K. (2009) 'Implementing the 1902 Midwives Act: Assessing Problems, Developing Services and Creating a New Role for a Variety of Female Practitioners', Women's History Review 18, 427–52

6 MacFarlane A. and Mugford M. eds. (2000) Birth Counts: Statistics of Pregnancy and Childbirth. Volumes I and II. London: The Stationary Office

7 Editor's note: I would like to note that earlier midwives received training through apprenticeship and were often skilled and competent practitioners.

8 Oral history interview, Nottingham City library A75a–c

9 Editor's note: This article may be of interest to some. Lloyd H N (1948) DISCUSSION ON EMERGENCY OBSTETRICAL SERVICE (THE FLYING SQUAD) - ITS USE AND ABUSE https://journals.sagepub.com/doi/pdf/10.1177/003591574904200101

10 Stocks Report (1949) Report of the Working Party on Midwives (page 17)

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

12 Mathers H. and McIntosh T. (2000) Born in Sheffield: A History of the Women's Health Services, 1864–2000. Barnsley: Wharncliffe Books (page 122)

13 McIntosh T. (2013) 'The Concept of Early Labour in the Experience of Maternity in Twentieth Century Britain', Midwifery, 29, 3–9

14 Editor's note: This is a gloriously bold and contentious statement, but I have heard it said before by midwives who have made a study of these things.

15 Christie D and Tansey E, eds. (2001) 'Maternal Care', Wellcome Witnesses to Twentieth Century Medicine. Volume 12. London: The Wellcome Trust (page 14)