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WOMEN, HEALTH AND POLITICS, 1919 - 1939: PROFESSIONAL
AND LAY INVOLVEMENT IN THE WOMEN'S HEALTH CAMPAIGN

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S U M M A R Y

This thesis analyses the aspirations and achievements of the lay women who were active in the campaign to improve women's health, and of those women who sought entry into paid occupations in the health services.

After an introduction, Section One is intended to place the substantive data in context. Middle-class women's enthusiasm for voluntary work and the terms on which women entered national politics are discussed. These issues are used to illustrate the effects the maintenance of rigid social-class divisions had on the unity of the women's movement and the implications for the future of the movement of the decision to seek entry to the public domain on the grounds that women could make a unique contribution.

Section Two is devoted to the lay women. First, the effect of the maintenance of rigid social-class divisions on the women's health campaign and on women seeking a career in the health services is discussed. Secondly, the consensus between both middle-class and working-class women, the medical profession and the Ministry of Health on the need to extend medical services is analysed, revealing an eagerness to follow technical advice which affected the strategy of the lay campaign and meant support for women workers in the health services was often circumspect. Thirdly, the reasons for the collapse of this consensus in the 1930s are discussed. This section is concluded with an assessment of the lay women's health campaign and a discussion of the impact the campaign had on women health workers.

In Section Three, women's position as paid employees in the health services is analysed, and three occupations, midwifery, medicine and health visiting, have been selected. Difficulties these women encountered establishing themselves in paid employment, and their status and their relations with male colleagues and with the Ministry of Health are assessed. The differences between these three occupations, which prevented a sense of solidarity and an identification with the goals of the women's movement, are discussed. Their achievements during the period are assessed, and the effects of the medicalisation of childbirth and the increasing involvement of the state in maternity and child welfare are investigated.

A fourth, concluding section draws these strands together. The lay women's health campaign and the goals and tactics of the women health workers are related to the maintenance of the existing social-class divisions, the ideological splits within the women's movement and the persistence of barriers preventing women from competing on equal terms with men in the public domain. Although the number of women working in the health services increased dramatically and women's place in these services was assured, women generally remained in subordinate positions, excluded from the prestigious and lucrative posts, while they achieved only a statutory presence on decision-making bodies.

A B B R E V I A T I O N S

BMA	British Medical Association
<u>BMJ</u>	<u>British Medical Journal</u>
CMB	Central Midwives' Board
CMO	Chief Medical Officer
FWG	Fabian Women's Group
HMSO	His Majesty's Stationary Office
LCC	London County Council
LGB	Local Government Board
MOH/MOSH	Medical Officer(s) of Health
MP/MPs	Member(s) of Parliament
MWF	Medical Women's Federation
NCMCW	National Council for Maternity and Child Welfare
NFWI	National Federation of Women's Institutes
NLH	National League for Health, Maternity and Child Welfare
NUSEC	National Union of Societies for Equal Citizenship
NUTG	National Union of Townswomen's Guilds
NUWSS	National Union of Women's Suffrage Societies
<u>PP</u>	<u>Parliamentary Debates</u> , Commons, Fifth Series
PRO	Public Records Office
QIDN	Queen's Institute of District Nurses
SJC	Standing Joint Committee of Industrial Women's Organisations
SMA	Socialist Medical Association
Soc.MOSH	Society of Medical Officers of Health
TUC	Trades Union Congress

WCG	Women's Co-operative Guild
WFL	Women's Freedom League
WPHOA	Women Public Health Officers' Association
WSI	Women Sanitary Inspectors' and Health Visitors' Association
WSPU	Women's Social and Political Union

C H A P T E R O N E

INTRODUCTION

During the early years of this century the particular health problems of women and the possibilities for extending and improving the medical care given to women during pregnancy and childbirth and to newborn babies and infants were debated with many new services being introduced. Women played a role in these developments as recipients of care, as campaigners for facilities and services and as workers in the evolving health services. A considerable volume of knowledge has been accumulated on women's role in the campaigns to extend services, but little research has been done on the women who sought paid work in the health services. The aim of this thesis is to analyse the aspirations and the role of women working in the health services during the 1920s and 1930s, and to relate their experience to the conduct of women active in the campaign to extend maternity and child welfare services. This is the period when the services on which the National Health Service was later to be based were developed.

Prior to the twentieth century, it was accepted that child-

birth could be dangerous and that many of the complaints associated with childbirth were inevitable. Efforts were made by charity workers to relieve the distress of individuals, and, from the mid-nineteenth century, home visiting became popular. This philanthropy, however, was restricted to short-term practical solutions.¹ No long-term solutions were sought, and little attempt was made to improve the general health of women, or to consider the underlying cause of physical suffering.

Governments played little part in this work. Although medical officers of health (MOsH) were being appointed, their principal task was to deal with sanitation and public nuisances and not to provide health and welfare services for the individual.² However, as governments became aware of the advantages of maintaining a physically-fit nation, the reluctance to provide services for the individual began to wane. The state of the army recruits during the Boer War aroused fears of a decline in physical well-being. Two means of reversing this trend were proposed: a policy to encourage the fit to bear children, and a programme to educate mothers in the care of their children. The Inter-departmental Committee on Physical Deterioration, set up after the Boer War, advocated an anthropometric study, the medical inspection of school children and the education of mothers, as well as further factory legislation and measures intended to improve the environment.³ The public's attention was drawn to the need to protect the infant, and, from the early years of the twentieth century, the infant welfare movement grew dramatically. Steps were taken to ensure that babies received suitable nourishment

and centres were set up where mothers could obtain advice on the care of their babies. Regular inspection of infants was recommended.⁴

At the same time, theories of evolution and population growth were discussed. Fears of a declining population reinforced the desire to save foetal and infant life. Some of those anxious to improve the quality of the race advocated contraception for those regarded as physically unfit for child-bearing.⁵ Meanwhile, the middle classes were being encouraged to believe that childbirth was an imperial duty.⁶ Attention was given to measures necessary to make childbirth safer, and to reduce foetal mortality.⁷ Medical research was undertaken into the relationship between the foetus and the mother.⁸ By the end of the First World War, the government accepted that the state had a duty to ensure that all mothers had access to maternity and child welfare services.⁹ One aspect of women's health and welfare had become a matter of public interest. This desire to aid mothers and thereby help children stimulated debates on the benefits likely to accrue from the use of contraceptives to space births, and on the merits of economic assistance or services in kind for expectant and nursing mothers.

Historians have shown interest in this major shift in public policy. The first histories of the evolution of the maternity and child welfare services described the process as one of steady progress towards the goal of a complete midwifery service, supplemented by ancillary services and by a scheme to educate mothers.¹⁰ Recently, this interpretation has been challenged in the light of the various aims of the interested parties and conflicts over priorities, administration and fi-

nance.

My earlier research into the Ministry of Health's policy with regard to maternal mortality in the 1920s and early 1930s reveals that the Ministry was unsure of the measures to adopt, and was often constrained by financial considerations. When the Ministry was set up in 1919, one of its principal spheres of interest was maternity and child welfare. Taking its lead from the medical profession, the Ministry presumed that the object was to save life, and, as the infant mortality rate was beginning to decline (see Table One), attention was directed towards maternal mortality.¹¹

The Ministry, however, found that there was no simple solution. There was a lack of agreement within the medical profession over clinical priorities, while others pointed to the effects of hard manual labour, poverty and bad housing. Janet Campbell, a senior medical officer in the Maternity and Child Welfare Department at the Ministry, produced reports on the training of medical students and pupil midwives.¹² She then went on to produce two reports designed to isolate the principal causes of death in childbirth, and to suggest ways to alleviate the problem.¹³

Despite the information amassed by Janet Campbell, little positive action was taken at an official level to implement her recommendations. Meanwhile, leading members of the medical profession, the British Medical Association (BMA) and the Midwives' Institute, as well as women's organisations were producing schemes for a national maternity service.¹⁴ A desire to forestall any concrete proposals from these bodies prompted the Ministry in 1928 to set up departmental committees, one to

investigate the training and employment of midwives, and, a second, the causes of maternal mortality and morbidity.¹⁵ These committees recommended the creation of a national maternity service, but the recommendations were not implemented, owing to economic restraints and an anticipation of differences of opinion between the professional groups with a vested interest.¹⁶ No improvement in the mortality rate was evident until late in the 1930s, and the dramatic fall in maternal mortality did not occur until the 1940s.¹⁷ During the 1930s, the government, having first aroused national concern over the maternal mortality rate, found it desirable to try to divert attention away from the problem, and to minimise its significance.¹⁸

It is to be expected that women's organisations would take a keen interest in the development of health and welfare services. Women's groups were becoming more common, and a number took special interest in the health and welfare of women and children in the home. The Women's Co-operative Guild (WCG) was founded in 1883, and the Fabian Women's Group (FWG) in 1908, while the first Women's Institutes were started during the First World War. Moreover, there is evidence that women could organise an effective political campaign. During the nineteenth century, the campaign organised by Josephine Butler for the repeal of the Contagious Diseases Acts gives an indication of how successful a group of women could be in conducting a political campaign.¹⁹ Marian Ramelson argues that, by their actions, Josephine Butler and her colleagues were able

to force a line of action on a government which

was basically reluctant to take it.²⁰

There is also evidence that male members of parliament were aware of the potential political power of women.²¹ It would seem probable that, with the vote, women would be in a stronger position to launch political campaigns.

Some socio-historical work published during the 1970s suggests that, during the inter-war period, women were not an effective voice, encouraging the belief that the feminist movement died after the 1918 franchise victory, to re-emerge in the 1960s. Elizabeth Wilson, for example, in an analysis of women's contribution to the development of the welfare state, remarks

The thrust of feminism wavered between the wars, partly because it was believed that with the vote women had achieved emancipation.²²

Sheila Rowbotham also detects a decline in feminism at this time, suggesting that the propaganda of the cinema and literature encouraged women to emphasise their femininity.²³ Ruth Adam's history of women's place in society supports this assessment, as her analysis of this period focuses on changing moral values and emphasises entertainment and fashion.²⁴

More recently, however, this interpretation has been challenged. Dale Spender reveals that her assumption that there was no significant women's movement between the suffrage victory and the emergence of the feminist movement in the 1960s was dispelled following interviews with some of the feminists of the inter-war period and a perusal of Time and Tide, a feminist journal which began publication in the early 1920s.²⁵ Attention has been paid to the various strands within the women's

movement, providing an explanation to account for the split in the movement following the 1918 franchise victory. Olive Banks, in a study of the development of the women's movement both in this country and in the United States of America, has located three intellectual strands within feminism, dating from the eighteenth century, which, she argues, were based on Evangelicalism, the Enlightenment and communitarian socialism.²⁶ It is not surprising, therefore, that whilst many women desired the right to vote, and were willing to work together for this end, there were divergent opinions on how this voting power should be utilised, with some women seeing the victory as an end in itself.²⁷ Moreover, it is evident that there have been conflicts over priorities. Sally Alexander reminds us that there has always been a dilemma within the women's movement over how to balance a plea for equality with an assertion of sexual difference.²⁸ Barbara Caine provides evidence of this division within the women's movement in a discussion of the conflict in the nineteenth century over the relative importance of suffrage and political issues as compared with sexual and moral ones, which led a group of suffragists to refuse to support the agitation against the Contagious Diseases Acts, despite their disapproval of the Acts, because they thought the suffrage campaign should have priority over all else.²⁹

Indeed, as the suffrage campaign had been a long and, at times, violent struggle, it is perhaps inevitable that impetus should wane after the immediate victory had been won. It was seen as the end of a phase: Ray Strachey, for instance, one of the leading participants and one of the first candidates

for parliament, although recognising that other changes were required before women achieved true emancipation, regarded the franchise victory as the conclusion of a phase in the history of the women's movement.³⁰

There had always been those women who did not want to emphasise sexual differences or to raise the question of maternal function, believing this would place claims for equality in jeopardy.³¹ This division remained after the 1918 franchise victory, with some wanting to campaign for equal rights with men in the job market, with equal pay for equal work, and others who thought this type of equality would be meaningless unless women's contribution in the home was recognised, and women were given a measure of economic independence based on this contribution.³² The desire to re-assess the aims of the women's movement in the wake of the suffrage victory highlighted the split within the movement.

Jane Lewis discusses the new feminism proposed by Eleanor Rathbone in the 1920s, which challenged the ideas of those feminists who sought merely to ape men. Lewis refers to Rathbone's desire to promote measures likely to raise the status of the mother, but points out that her humanitarian zeal outweighed her desire to expose the reality of women's social and economic position, and thus family allowances were advocated as an ameliorative social reform.³³ Banks also remarks on a division within the British women's movement, although she regards the principal matter of controversy to centre around the debate over the need for protective legislation for women working in industry.³⁴ Neither author, however, scrutinises the implications for the health campaign of

the division within the women's movement. Research for this thesis focuses on the split within the women's movement, indicating that it had a significant effect on the conduct of the women's health campaign, which in turn had an influence on the women who sought careers in the health services.

The part played by women in the campaign for health and welfare services during the 1920s and 1930s has been scrutinised recently by a number of authors. It is evident that these matters were of paramount importance to many women. Indeed, Banks goes so far as to say that, during this period, feminism was synonymous with welfare.³⁵ Most research has focused on particular issues or events, and, while each author acknowledges women's part in the health and welfare campaigns, the conclusion is that women lacked power and were often unable to achieve their goals.

The history of maternal and infant welfare has been subjected to detailed scrutiny by Lewis.³⁶ The aim of her research project was to discover why particular maternity and child welfare services were adopted and whether they accorded with the needs of the recipients. Lewis describes the way in which the desire to improve women's health arose initially out of the campaign to save infant lives. Government officials and the relevant charitable organisations aimed to benefit the infant, but attention was focused on the mother, as it was believed that her ignorance or neglect was responsible for much infant suffering. Consequently, the need to educate the mother was asserted.³⁷ Lewis investigates the demands made by women's groups, and reveals that these were often at variance with the Ministry. Women were concerned with morbidity as well as

mortality, and maintained that death and ill-health were not simply medical matters, as poverty, housing, heavy manual labour and the spacing of children were likely to be relevant. She argues that these women were aware that childbirth could not be separated from other aspects of women's lives.³⁸

Lewis's investigation of the campaigns initiated by lay women led her to conclude that these women were not able to convince the government to confront the problem of welfare in its widest sense. Furthermore, she states that women did not challenge the prevailing belief in the centrality of the motherhood role, and were satisfied to concentrate their attention on the extension of the maternity and child welfare services.³⁹

Similar conclusions can be drawn from a study, focusing specifically on working-class women during the inter-war period by Charmian Kenner.⁴⁰ This study encompasses women's campaigns not only for health services, but also for better housing and considers their endeavours to cope with unemployment and the resulting poverty. Kenner emphasises the difficulties encountered by working-class women and the lack of sympathy they received from the professional health workers.

More detailed work has been carried out on the birth control campaign and the campaign for the provision of family allowances. This indicates how other arguments were subsumed by eugenic and social welfare considerations. Audrey Leathard chronicles the emergence of the Family Planning Association.⁴¹ Her conclusions are similar to those of Peter Fryer, who, in the 1960s, surveyed the history of birth control.⁴² Both authors accord a prominent place to the part played by Labour women in the 1920s, but both make it apparent that birth control

was eventually justified because other bodies, notably the medical profession and the clergy, gave their approval, and birth control was recognised as a means of combating maternal mortality. Linda Ward, however, in a more recent study, refers to activity at the local level, the breaking down of prejudice against discussing birth control and the unintended consequences of the Local Government Act of 1929, which gave local authorities more autonomy.⁴³ She points out how feminist arguments in favour of birth control might well have been concealed in order to gain the support of men and to widen the appeal. Hence pragmatic arguments were used and reference was made to the benefits to maternity and child welfare and to the desirability of making knowledge available to all.⁴⁴ Meanwhile, John Macnicol's investigation of the family allowance campaign reveals how the feminist ideas of equal pay held by the early campaigners were submerged by desires to relieve child poverty and promote eugenic arguments. During the 1930s, the Family Endowment Society had close links with groups seeking to remove child poverty. Support also came from those who saw a need to keep the unemployment benefit below the minimum wage, and recognised that this required a re-organisation of social services.⁴⁵

Brian Harrison, in a provocative essay, published in 1981, argues that feminists did not influence the development of the health services during the hundred years preceding the Second World War. He discusses three possible ways in which such influence might have been exerted: the feminist sympathies of male doctors, the influence of feminists on the medical profession, and the impact of women doctors on the advancement of

knowledge, concluding that women were either ineffective or that changes were evident before women became active.⁴⁶

Harrison's thesis is substantiated by Ann Oakley's study of the development of ante-natal care, which charts the medical profession's assumption of control over pregnancy and child-birth.⁴⁷ This latter study has been published since completion of this thesis.

Taken together, there would seem to be an assumption in recent socio-historical analyses that women were not able to exert their influence on the development of government policy. This thesis does not seek to challenge this assessment, but rather to refine it through further investigation. The impact of the maintenance of rigid social-class divisions in society after 1918 and of the persistence of gender divisions in the family, coupled with a continuation of the prevailing attitudes to the aptitude of women and their role in society, merit further investigation. As noted above, these are issues which other authors have tended to overlook: much of the work on maternal health has not drawn out the conflicts engendered by pursuance of a welfare issue by women-only organisations. This thesis argues that such an analysis will contribute to a better understanding of the lay women's health campaign and will help to further our knowledge of the aspirations of those women who sought paid employment in the health services.

Research by Diana Gittins dispels the myth that working-class women were imitating middle-class practices when they began to limit family size in the 1920s and 1930s. Using oral and documentary evidence, Gittins argues that knowledge of birth control techniques depended on the opportunity to associ-

ate with other women, notably in the work place, and that the use of contraceptives was influenced directly by socio-economic circumstances.⁴⁸ Ward observes that, whereas middle-class women tended to use pragmatic arguments, such as the need for population control, to justify the dissemination of birth control information, working-class women were more likely to regard birth control as a means of helping mothers.⁴⁹ Similarly, middle-class and working-class women often demanded different maternity and child welfare services, and, when in agreement on the need for a particular service, their reasons for making the demand were often at variance.

It is important also to judge women's contribution with reference to the restraints which continued to be placed upon their political activity. Margaret Stacey and Marion Price have reminded us that the ability of women to organise a successful political campaign is limited owing to social circumstances peculiar to their gender. The newly-enfranchised women were faced with problems which were not encountered by the male working class. Stacey and Price argue that there were three factors, peculiar to women, which inhibited their ability to gain political power. First, they point out that, although women had won the right to vote, nothing else had changed: all other social institutions and the power structure remained the same. Moreover, they examine not only the public domain, but also the private domain of the family, and argue that relations within the family were not amended.⁵⁰ Secondly, they argue that women, although they had a common material base, namely housework and family duties, were divided by the class position of their husbands, which determined the family interests.⁵¹

Thirdly, relating to the previous point, they consider the implications for women of the absence of any organisation, akin to the male working-class tradition of trade unionism, which could provide a political base.⁵² It is against this background that Stacey and Price set women's achievements.

It is evident that women's problems did not arise merely out of the difficulty of organising isolated women, with no tradition of association for a common end. A perusal of the literature of the women's movement reveals that there were other factors influencing women's ability to mount an effective campaign. Feminists encountered particular problems resulting from the manner in which they, and previous generations, had been socialised. Winifred Holtby, a successful novelist and journalist of the 1930s, commented

Educated to please, to attract, to console, a woman inevitably found opposition to current standards of value difficult. It demanded of her an almost monstrous repudiation of what she had always been told should be her nature.⁵³

Vera Brittain, another prominent feminist author of the inter-war period, expressed a similar idea. She pointed out

my generation of women was so resolutely trained in childhood to put persons before convictions that its members have never been able to pursue an impersonal idea without remorse

Sometimes I grip the chair in impotent rage because one woman could do so little, and all women were cursed with such an infinite capacity for resigned endurance.⁵⁴

Women who carried out surveys into the lives of working-class women referred to the difficulty such women faced in visualising an alternative, when there was little time for contemplation

or opportunity for witnessing an alternative life style.⁵⁵ Likewise, many women believed the majority of the morbid conditions associated with childbirth to be inevitable, and, therefore, something that must be born with fortitude, as long as it did not actually prevent the continuation of their work.⁵⁶

An analysis of women's role in the health campaign as well as their place as paid workers in the health services requires recognition of these factors. Their achievements must be placed in the context of the discussion of the future of the women's movement following the franchise victory, and assessed with an awareness of the tradition amongst many middle-class women to regard voluntary welfare work as a valid task for which they were well-qualified to undertake with the supervision and guidance of the generally male technical experts. This analysis of the impediments to united action seeks to place the gains achieved in perspective, while at the same time providing a basis on which to understand not only the aspirations of women entering the health services as paid employees but also the hostility of many male members of the health professions.

In order to facilitate analysis of the data, the thesis is divided into sections. Chapter Two, which comprises Section One, is intended to place the subsequent data in context. It traces the entry of women into the public domain from the mid-nineteenth century, drawing out the divisions between women over the aims of the women's movement and illustrating the way in which social-class divisions hindered the development of a united women's movement. In Section Two, the lay women's health campaign is analysed, to explore the effects of social-

class divisions on the campaign and to analyse the consequences of a failure to challenge the prevailing attitude to a woman's role in society coupled with a ready acceptance of the efficacy of medical solutions to the problems associated with pregnancy, childbirth and the care of young children. This should contribute to an understanding of lay women's attitude to the role of women working in the health services as paid employees. Section Three deals with women in paid employment in the health services. Although there were common problems and experiences faced by all women seeking paid employment outside the home, women entering employment in the health services encountered a number of specific problems, which varied according to the nature of the work and whether the occupation was classified as suitable for middle-class or working-class women. Women doctors, midwives and health visitors have been selected for investigation.

The major data sources have been the journals published for maternity and child welfare workers and the medical profession and the journals of women's organisations. Publications discussing women's maternal role, their health and their role in society have been consulted. The files of the Ministry of Health were perused as well as its published material. The reports of women's organisations and professional bodies have been examined. Of particular value has been the archival material on the WCG,⁵⁷ the FWG and the Medical Women's Federation (MWF), which has revealed information these bodies did not choose to make public. In addition, the work of some of the leading feminists, notably Vera Brittain, Winifred Holtby, Dora Russell and Virginia Woolf, has provided a valuable insight

into the women's movement during this period. These women, who were brought up before the First World War, had personal knowledge of women who lived in Victorian Britain, and, therefore, were aware not only of the immense changes which had been effected by women, but also recognised the barriers which remained to hinder women's participation in the public domain.

From the outset, in order to gain a better insight into the aspirations and objectives of the women's organisations, particular issues or years were not selected for investigation as this would require some prejudging of the debates. Instead, each issue of the journals was consulted to obtain an understanding of the principal topics raised, and to obtain a feeling for the period and for the tensions between the disparate groups. Adopting this approach precluded the collection of oral evidence or data from the regions. It is argued that a contextual study is required, as previous work in the field has not sought to focus on these issues. More detailed information on sources and on the research method is given in Appendix Two, and the affiliations of the journals frequently used in the text are given in Appendix Three.

It is hoped that this study will complement the work already done on the factors influencing social-policy decisions and will contribute to an understanding of the activities of women in the inter-war period.⁵⁸ An investigation of the divisions within the women's movement and the recognition of class and gender divisions in society has led to a fuller understanding both of women's achievements in the health campaign and of their status as employees in the health services. It is argued that, owing to class and ideological differences,

women were able to unite on only a limited number of issues. It is acknowledged that the maintenance of the existing gender order affected not only women's ability to enter the health services as paid workers, but also affected their attitude and that of their male colleagues to their place within the health services. Lay women played a prominent part in the campaign to improve women's health, but their deference to medical expertise contributed to the way in which the health services evolved, and helped to reinforce the place of women in society. Moreover, the strategy adopted by those women who obtained paid employment in the health services enabled them to secure a place, but one that reinforced the existing views of women's attributes and place in society and one that ensured that many women entered jobs which were always supervised by the generally male medical elite.

These data and this interpretation may contribute to an appreciation of the gains and the pitfalls that have been encountered in the continuing struggle for women's emancipation, and may provide a case history relevant to the campaigns of the contemporary women's movement.

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S E C T I O N O N E

INTRODUCTION

The manner in which women entered the public domain had a significant effect on both the organisation of the lay women's health campaign and on the way in which women sought employment in the health services. This chapter, therefore, seeks to draw out the principal factors which affected these lay women and the women health workers. First, attention is focused on the importance of philanthropy to middle-class women, showing the way in which these women wished to work with mothers and babies and how this interest led them to seek a place on statutory bodies and in politics. At the same time, however, they failed to challenge male domination at the executive level and readily followed the lead of the medical profession. Secondly, the divisions between the equal-rights feminists and the welfare reformers is discussed, to account for the way in which the women's health campaign came to be dominated by those seeking to improve maternity and child welfare services, to educate women in childcare and household management, and to promote measures likely to lead to improvements in child health. Thirdly, as social-class divisions were responsible for a fragmentation of the maternity and child welfare campaign and were apparent within the various branches of the health services, evidence is presented to show how women tended to assume that social stratification was inevitable and immutable.

C H A P T E R T W O

WOMEN'S ENTRY INTO THE PUBLIC DOMAIN

Women's experience as workers in the health services was affected by society's perception of a woman's inherent aptitudes and skills, which, it was argued, made her suited to caring, domestic tasks associated with mothers and children. The women's movement from the mid-nineteenth century often tended to reinforce this view of women by its willingness to campaign for rights because motherhood was an important task and women had special knowledge of household matters rather than because they were both adult citizens. At the same time, as Stacey and Price observe, this identification with the home tended to emphasise social-class differences between women, thus hindering the development of a united women's movement.¹ Those women who did not wish to be regarded as wives and mothers became isolated from the broader women's movement and tended to remain separate from the women's health campaign, with the result that the health campaign was dominated by those working for measures designed to reduce infant mortality, to improve maternal health and to help women in the home to provide better

care for pre-school children.

The definition of women as primarily wives and mothers, which resulted in a separation between welfare reformers and equal rights campaigners, and the maintenance of social-class divisions had a profound effect not only on the conduct of the maternity and child welfare campaign but also on women workers in the health services. Women entering the health services as paid workers were affected not only by their male colleagues' views on the place of women in health work, but also by their own socialisation, by the example of women who were entering other previously male institutions and by the expectations of lay women active in the campaign for improved welfare and medical services. Women's entry into the public domain in the nineteenth century and their experience in national politics are used as examples to illustrate the pressure placed on women to regard motherhood as central to their lives. Evidence of the split within the women's movement in the 1920s over the question of the direction in which the women's movement should go and the perpetuation of social-class divisions within the women's movement provide a basis for a further examination of the women's health campaign, to re-evaluate the contribution made by lay women and to reveal their attitude to women's role as paid workers in the health services.

Nineteenth-century Women's Entry into the Public Domain

Despite the Victorian men's desire to keep the home cushioned from developments in the outside world,² some women in the mid-nineteenth century began to seek entry into the public domain. First, women participated in the burgeoning

charitable work, secondly, they sought wider employment opportunities for single women and a better education service, and, thirdly, the suffrage campaign was launched.

Philanthropy provided the principal avenue for women to enter the public domain.³ These women were happy to emphasise the distinctions between men and women. Their particular concern was with mothers and babies, and visiting soon became an important part of their work. They sought to convey a religious message and to profer advice on hygiene and child care.⁴ This work formed the basis of the health visiting service, although the religious element was dropped when the state became involved in the provision of health visiting services.⁵

Many of the women involved in visiting and other aspects of charitable work took the work seriously and acquired expertise,⁶ but they tended to be active mainly at the local level. When national societies were formed, it was men who tended to fill the executive positions.⁷ From early in the twentieth century the voluntary societies became increasingly organised from London. Centralisation was advocated to overcome the problems of the duplication of services, to reduce administrative costs and to facilitate fund raising. In 1905, the National League for Health, Maternity and Child Welfare (NLH) was incorporated. This League represented eight organisations, including the Association of Infant and Maternity Centres and the National Association for the Prevention of Infant Mortality.⁸ In 1919, another organisation was formed under the auspices of the Red Cross. This was the National Council for Maternity and Child Welfare (NMCW) and included those societies already in the NLH plus five other bodies.⁹

The NCMCW had similar aims to the NLH. As the Council was set up in the same year as the Ministry of Health, it is evident that the voluntary bodies did not anticipate that their work would be superceded by the state. Indeed, after the First World War, these co-ordinating bodies assumed greater prominence, as the Carnegie Trust, one of the principal sources of funds for charitable work, decided to confine its payments to the co-ordinating bodies.¹⁰ Its influence was considerable. In 1928, when the Trust decided to fund the NCMCW, in preference to the NLH, the League was forced to disband.¹¹ Similarly, when local authorities began to take over the organisation of health visiting, the women visitors were placed under the male MOH.¹²

Some women did object to their subordinate position and lack of power, seeking election first as Poor-Law Guardians¹³ and then as councillors in local government,¹⁴ while others began to campaign for the vote.¹⁵ The women doing philanthropic work who sought involvement in administration and wanted the vote were not seeking a change in the type of work undertaken. F.K. Prochaska argues that they demanded the vote on the grounds that this would enable them to extend their domestic influence, and would force legislators to take into account the moral feelings of women.¹⁶ Women Poor-Law Guardians were commended for being good with children, for being able to place girls in domestic service, and for their thorough inspection of the domestic arrangements of the workhouses and of the clothing of the inmates.¹⁷ It seems probable that the majority of women working in this field were content with this opinion of their expertise. Similarly, women who sought to enter local

government argued that they should be there to represent the interests of the women and children who came under the control of the local council.¹⁸

Many of the women involved in philanthropy not only accepted a subordinate position but also endorsed the view that charities should promote self help. They relied upon short-term solutions, and, in line with government policy, concentrated attention on infants and the education of women in household management and child care.¹⁹ This policy, as will be discussed in Chapter Three, was perpetuated in the inter-war period and had a significant effect upon unity within the maternity and child welfare campaign.

Women in other spheres also focused on mothers and infants, readily acknowledging their differences from men. Consequently, women's groups emerged from the Co-operative Society and the Fabian Society. From the outset, the WCG aimed to address domestic issues and in particular the problems encountered by mothers endeavouring to cope on a budget which was sufficient only for day-to-day expenses.²⁰ Childbirth quickly became one of the major topics.²¹ Guildswomen sought representation in local government specifically to speak on behalf of mothers with young children. The FWG was concerned principally with women's social welfare and political rights.²² The FWG, unlike the WCG, was London based and middle class, but in common with the WCG it took an active interest in the welfare of mothers and babies.²³ Its recommendations were for cash benefits rather than welfare services favoured by the WCG,²⁴ but both organisations made it plain that women merited special consideration because of their maternal role. Moreover, both

argued that healthy children were a national asset and that childbirth was a service to the state.²⁵

This readiness to acknowledge maternity was shared also by the women's trade unions, which began to appear in the 1870s.²⁶ The leaders of these early trade unions for women tended to be middle class, as they had the time and the money to attend meetings and to travel away from home.²⁷ Many believed that, ideally, in view of their responsibility for childcare and household management, married women should not have to work outside the home. They, therefore, supported protective legislation for women working in industry. This was a widely held belief in the early twentieth century.²⁸ Ways were sought to enable women with young children to remain in the home,²⁹ and this remained a major consideration during the inter-war period. For example, in 1919, at the League of Nations Labour Conference in Washington, the two Labour women delegates voted against a motion advocating the provision of crèches in factories on the grounds that efforts should be made to enable women to remain at home with their young children.³⁰ In the same year, Gertrude Tuckwell, a prominent trade unionist, writing on women's employment in a Labour Party pamphlet, argued that women should not be discriminated against on the grounds of sex, but she stipulated that it should be remembered that women did have a disability.

Women have been called to bear a double burden, and to meet the claims of both work and home. They must continue to fulfil their greatest function of mothers and home-makers. Our recommendations have to safeguard this while seeing that it does not interfere with their position of equality in the labour market.

We lay down two principles: that no bar should

be placed on women's work which is not imperatively dictated by the demands of the race and the health and well-being of mother and child, and that when it is proved that work is injurious to maternity, any prohibition should carry with it adequate compensation for the lost wage. To do otherwise is to penalise motherhood.³¹

She advocated, therefore, the payment of pensions to mothers, to enable them to fulfil their dual responsibilities. Ten years' later, similar arguments were used by the Labour Woman, the journal for women supporters of the Labour Party, in a leading article, following a radio debate between Marion Phillips, the Chief Woman Officer of the Labour Party, and Elizabeth Abbott of the Open Door Council, a group which campaigned specifically for an end to all restrictions placed on the employment of women and which opposed any legislation designed to make special provision for the needs of mothers.

Finally, there is one question which those who oppose protective legislation constantly set aside. This is the fact that girls are potential mothers and that married women in employment are sometimes expectant and nursing mothers. With regard to the girls some special attention is necessary to the conditions of their employment in order that their physical development may not be damaged and cause pain and suffering and even death in the future. With regard to the latter, it is essential that care should be taken to protect both mother and child from any harm that might result from industrial employment too near the time of birth or too soon after.³²

Those seeking further employment opportunities for middle-class women stressed the distinct contribution that a woman could make. This was particularly evident amongst those women who joined the medical profession. Banks refers to Elizabeth Blackwell, who, in a series of lectures given in London in 1859, stressed the special contribution women could make to medicine, because of their ability to subordinate the self to

the welfare of others.³³ Regina Morantz argues that women justified their entry into medicine on the grounds of propriety and morality. Medicine was seen as a natural extension of women's sphere, and particularly suited to their character, as it required qualities of self-sacrifice and empathy. Medical women, it was hoped, would glorify motherhood and would be the professional allies of wives and mothers.³⁴ These arguments were necessary for women to obtain entry to all-male occupations and institutions, but, subsequently, they could be used against them, when women sought to establish equal pay and equal opportunities for promotion. These themes will be taken up again in Section Three.

Women in National Politics

The desire to draw on women's responsibility for the home and knowledge of domestic matters was especially evident amongst the majority of women who sought an active role in national politics. The women candidates at the 1919 general election emphasised their interest in women and children.³⁵ The candidates referred to their experience as wives and mothers, and discussed the advantages of having experts on household matters in parliament. This applied not only to Conservative women, with a background in voluntary social work, but also to the Labour women who had entered politics through their trade-union work. Mary MacArthur, for instance, often had her young daughter on the platform with her while campaigning.³⁶ Mrs. H.A.L. Fisher, writing in the Daily Sketch, summarised women's attitude to their role in the plans for post-war reconstruction.

Just when all the energies and brains of the political leaders of the world are needed to re-build distracted and shattered Europe upon a sure basis, we at home are demanding that our domestic problems shall be similarly solved and similarly put upon a secure basis.

Here, then, is surely where we women can help

As the women say at citizenship meetings, housing, babies, motherhood, child welfare, plans for looking after the boys and girls in their off times - these are our jobs.

And we mean to see what we can do to get them dealt with along what our experience makes us believe are the right lines.³⁷ (*italics in original*)

Elizabeth Vallance and Pamela Brookes observe that the majority of women who stood for parliament regarded their candidacy as an extension of their role as wives and mothers, while many had a background in welfare work for women and children.³⁸ This opinion is corroborated by an article written by Margaret Bondfield, a trade unionist and Labour politician, for the Vote, the journal of the Women's Freedom League (WFL). She claimed that it was important for women to be in parliament to deal with housing and health matters, and anticipated that, with a 'strong body of women' in parliament, there would be proper facilities for maternity and child welfare.³⁹ The Labour Woman urged women to tackle the problems of home life, as they were the experts.⁴⁰ Home and Politics, the Conservative Women's journal, also carried articles propounding the centrality of the role of wife and mother.⁴¹

Although a women's party was never a viable proposition, the women members of parliament (MPs) did tend to recognise a common bond, perhaps enhanced by the hostility of some male MPs and the cramped and difficult conditions under which women MPs had to work.⁴² Lady Astor, the first woman MP, believed that

she should represent all women and children and not just those in her constituency.⁴³ Some women candidates expected to get votes from women regardless of their political affiliation,⁴⁴ while some women refused to stand against another woman.⁴⁵ There are examples of women voting against their party on specific issues.⁴⁶ Meanwhile, separate women's sections within the political parties seemed practical as women needed to develop political skills, to build up their confidence and required a forum in which to discuss issues of particular interest to women which previously had not been on the political agenda at the national level.⁴⁷ Both the Labour and Conservative women's sections claimed that their sections were vital in order to attract new women supporters.⁴⁸

The Attitude of the National Political Parties to Women

This emphasis on a woman's role as wife and mother and her knowledge of domestic matters provided women with a justification for entry into the public domain which was accepted by the men already established in this domain. Research on women's entry into national politics has shown how the political parties presumed that women would confine their activities to this sphere. The Conservative Party summarised its view of women's role in politics, declaring

the advice and opinion of the homemaker are as complementary to those of the bread-winner. Such co-operation has, in fact, become urgently necessary, since legislation concerns itself increasingly with domestic life, and the child is viewed as an asset to the State. The problems of a changeful time need the co-operation of the woman, who sees them from the kitchen and nursery window, with the man, who looks through that of an office or workshop. Help and counsel, too, are due from that

large body of women who do social service, paid or unpaid.⁴⁹

The leaders of the principal parties directed election appeals specifically to women, highlighting domestic issues.⁵⁰

There was an assumption, particularly in the Conservative Party, that women, because of their domestic interests, would be more active at the local level. A pamphlet produced specifically for women urged them to participate in local government and emphasised the importance of women councillors, but when referring to national politics it was assumed that a woman's participation required her merely to vote.⁵¹ The Labour Party, however, showed little enthusiasm for creating women officials of the Party. When the Women's Labour League merged with the Labour Party under the 1918 constitution, the Vote described the amalgamation as

a marriage of the old sort - resulting in the subservience and economic dependence of the wife.

It noted that women found it difficult to attract the chairman's eye at conferences.⁵² Similarly, Sheila Lewenhak points out that women were invariably represented by men at the national level in the trade union movement even in the unions in which they were the majority of the membership.⁵³ Selina Cooper, who had been prominent in Labour politics in her home town of Nelson since the beginning of the twentieth century, was one of those who failed to be selected as a parliamentary candidate. She asserted that the attitude of the trade unions made it virtually impossible for a Labour woman to be selected to stand for a Northern industrial city.⁵⁴ In 1925, articles appeared in Time and Tide accusing the Trade Union Congress (TUC) of

attempting to exclude women members.⁵⁵ Consequently, there was little chance of a woman trade unionist being sponsored, although Leah Manning, who represented the teachers' interests, was an exception.⁵⁶

Kenner found that women in the unemployed workers movement suffered a similar fate: women were delegated to deal with issues affecting the home, and were more active at the local level than at the national level.⁵⁷ This, however, was not so relevant as far as parliamentary representation was concerned, as communist-led groups were largely excluded from the Labour Party during the 1920s and 1930s.

The Co-operative Party was also reluctant to adopt women candidates. The WCG report for 1919-20 revealed that thirteen branches had tried unsuccessfully to have women adopted as Co-operative Party candidates.⁵⁸ Again, in the report for 1929-30, readers were informed that a deputation had gone to the leaders of the Co-operative Party to complain that it was the only party without a woman MP.⁵⁹ After Eleanor Barton, one of the leading Guildswomen, had failed to be elected for Kings Norton in 1922, the Central Committee of the WCG decided to find a 'safe' seat for her, and to secure the adoption of more women candidates.⁶⁰ In this they were unsuccessful. Mrs. Barton was defeated again in 1929, when she stood for Nottingham Central. Indeed, after the election, the Central Committee recorded that she had received inadequate support from the Co-operative Party.⁶¹ The Guild also failed to persuade the Party to adopt more women candidates. The only other woman to stand for the Co-operative Party in the inter-war period was Mrs. Ganley, who fought the seat at Paddington

North in 1935, also without success.

The national parties exhibited extreme reluctance to take up issues advocated by women. Both the Labour and Co-operative women had conflicts with their national bodies.⁶² Similarly, the TUC sometimes acted against the interests of its women members, notably over family allowances,⁶³ and again, in 1938, over the question of a national maternity service.⁶⁴

The disadvantages of separate women's sections were outlined by an anonymous contributor to Time and Tide. This correspondent pointed out that women had little say in national politics, and that annual conferences were almost immune from the imposition of women's views, while the separate organisations for women in political parties could be used and often were used in order that the influence of the women on the attitude of the party might be retained at a minimum. Reference was made to the fact that women wasted their energies on conferences with limited membership, which were controlled by the party machinery, and were so constituted that they had no political influence of any significance.⁶⁵ The organisation of the women's branches of the two main parties would seem to substantiate these observations.⁶⁶ Melville Currell, in her contemporary study of women in parliament, makes a similar observation. She points out that women's sections are ancillary, and argues

That there are segregated, women-only associations alongside the major party organisation implies the institutionalisation of inequality, and their lack of executive function or autonomy underlines this. Such associations, intended to safeguard women's interests, and perhaps provide a 'sheltered environment' for women's contributions, implies that women accept an inferior position, paternalism, direction.⁶⁷

The leaders of the women's sections, however, remained adamant that a separate forum for women was necessary. They pointed out that women needed to acquire skills and confidence to speak on public platforms, and required a forum which would attract women who had not previously taken part in political activity.

It will be argued in Section Two that women's emphasis on the importance of their work as wives and mothers did not necessarily lead to their incorporation into decision-making bodies: they were expected to regard motherhood as central to their lives, but not expected to voice an opinion on the type of services they required or on their administration. Furthermore, in the wake of technical and scientific advances, and a growing interest in obstetrics, gynaecology and paediatrics within the medical profession women found that many of their transmitted skills were devalued, a development which affected not only women in the home (see Chapters Four and Five) but also women working as midwives (see Chapter Eight). All women health professionals, however, found their relations with male colleagues were influenced by the decision to enter the profession on the basis of their particular aptitude for work with mothers and babies, an issue which is discussed at length in Section Three.

The Equal-Rights Campaigners: the Division between the Old and the New Feminists

There were women who recognised the dangers of the emphasis on the differences between the sexes and who objected to being defined as wives and mothers. These women sought to minimise sexual differences, and wished to demonstrate that, given equal

opportunity, they could compete with men in the field of employment. They were not afraid to declare their intention either to remain childless or to incorporate childbirth with a life outside the home. These women, however, tended to be from middle-class families and were in a position to live independently from the support of a male breadwinner and did not have to face the problem of trying to combine a job outside the home with responsibility for household management and child care.⁶⁸

Following the franchise victory in 1918, the suffrage campaign was effectively split over the question of whether welfare reforms should form part of the platform of the suffrage societies. Eleanor Rathbone led the National Union of Societies for Equal Citizenship (NUSEC), which had replaced the National Union of Women's Suffrage Societies (NUWSS), firmly towards welfare issues.⁶⁹ In this she was supported by the editors of the Women's Leader, the journal of the NUSEC,⁷⁰ although some members of the executive of the NUSEC disagreed with her policies and left the Union in 1927.⁷¹ Eleanor Rathbone argued that women would never achieve meaningful equality without recognition of a woman's maternal role. She called this approach the new feminism and dubbed all those who disagreed with her the old feminists.⁷²

Those who accepted the title old feminist did not form a homogeneous group. Some feminists, including those who formed the Open Door Council in opposition to the NUSEC, argued that no special consideration should be given to women in recognition of their role as mothers, and that equality could be achieved simply by removing legal distinctions between the sexes. At

the same time, others, who classified themselves as old feminists, were not opposed to the ultimate goals of the NUSEC as defined by Eleanor Rathbone; their differences were tactical rather than ideological.

The immediate difference between the NUSEC and the old feminists rested upon their respective assessments of the commitment necessary to ensure the complete removal of legal barriers between the sexes. Old feminists argued that the campaign should not be modified or relaxed until all legal barriers to equality were removed. The WFL was committed to this approach,⁷³ as was Time and Tide.⁷⁴ Winifred Holtby, who was a successful author and journalist as well as an ardent feminist, declared herself to be an old feminist.⁷⁵ She argued that a satisfactory solution to legal inequality was not yet in sight, and she urged women to continue to campaign for a single issue, which had the advantage of being non-controversial and would not arouse divided loyalties.⁷⁶ In 1926, the Six Point Group, formed by Lady Rhondda in 1921 to campaign on six issues considered relevant to the emancipation of women, adopted the same view, making the vote its primary objective.⁷⁷

The old feminists, however, did not simply disagree with Eleanor Rathbone over the speed and certainty of legal reforms. These women did not share her conviction of the need to perpetuate single-sex organisations. Rather than seeking new issues on which to unite and stimulate feminists to renewed activity, the old feminists looked forward to the time when there would no longer be a need for feminism. These women were anxious to break down any barriers between the sexes, and to work with men. An editorial in the Vote, in 1920, gave

a definition of the citizenship towards which feminists were working

The ideal of citizenship of the women who have struggled for their enfranchisement is the co-operation of men and women in all measures in the service of the state and humanity.⁷⁸

Lady Rhondda always intended that the Six Point Group should have a limited existence.⁷⁹ She accepted that other things needed to alter, but she argued that there was a need to change attitudes rather than to implement legislation. Attitudes, she felt, would change only if women actually went out and did things, to prove their worth.⁸⁰ In the 1930s, when she was editor of Time and Tide, she refused to allow the journal to concentrate on the campaign for legal equality, declaring that too much publicity

must tend to perpetuate in the mind of the younger generation a picture of women as a class apart and inferior, always knocking outside the door, never doing, but always claiming the right to do ...⁸¹

Winifred Holtby looked forward to the time when men and women could work together for the good of mankind. It would then be possible to bid 'farewell to feminism', with 'profound relief that the hour for its necessity has passed'.⁸² She hoped that

When liberty and equality of action and status for men and women has been obtained, then all other reforms, including those arrangements of domestic life, such as Family Allowances, concern sons and husbands as well as mothers and daughters. It would be a grave mistake if they appeared to an easily misguided public as purely women's reforms, in which a few kindly and philanthropic men took a measure of gracious interest.⁸³

Many old feminists were not opposed to welfare legislation

per se, and expressed a commitment to seeking an improvement in the conditions under which children were brought up.⁸⁴

Disagreement over timing, however, meant that the maternity and child welfare campaign was organised by those involved in the voluntary organisations and those social reformers who saw no danger either in the maintenance of separate women's groups or in the emphasis on a woman's role as wife and mother.

Feminist Opposition to the Definition of Women as Mothers

The old feminists realised the dangers of the over-emphasis on the importance of maternal duties, which tended to encourage women to devote all their energy to their own family. Lady Rhondda, for example, complained that women were educated to sacrifice everything for their children and to put their homes before the community.⁸⁵ The old feminists considered it essential to persuade women that they should maintain an independent life after marriage, and should not regard marriage as a career.⁸⁶ They argued that, as family size was decreasing, and the infant mortality rate declining, women spent less time with young children; and, furthermore, they pointed out that birth control was enabling women to plan their families, while professional agencies were beginning to take over some of the responsibilities of the mother. They asserted, therefore, that women could combine two roles.⁸⁷ Women were urged not to skimp on training.⁸⁸ Helena Swanwick argued that, if women's work was 'decasualised', they could demand higher pay, and she advocated refresher courses and part-time appointments, to enable women to return to work after childbearing.⁸⁹ Vera Brittain declared that children could readily adapt to the absence of

their mother and benefited from the knowledge that they were not the mother's only concern.⁹⁰ A contributor to Time and Tide, Catherine Welsh, stated that, from a eugenic point of view, the children who fared best were those entrusted to the care of nurses, governesses and schools.⁹¹ These women, however, were all middle class and were in a position to employ domestic servants, thus obviating the need to combine responsibility for young children with commitments outside the home. Moreover, many, being either in a professional job or self employed, had reasonable autonomy at work, and were able to adjust their working life to accommodate family needs. The assumption seemed to be that a woman would receive sufficient remuneration to enable her to employ the requisite staff, and there was no discussion of factory crèches or communal childminding services.

Some old feminists asserted a woman's right to remain childless. Cicely Hamilton and Elizabeth M. Delafield wanted women to have a choice, pointing out that not all women were necessarily suited to childcare.⁹² Such statements, however, were castigated by the maternity and child welfare campaigners, who accused Cicely Hamilton and her associates of denegrating the role of the mother.⁹³ During the debate on the need to combat the anticipated decline in population during the 1930s, Cicely Hamilton was amongst those who refused to be alarmed by the possibility of a shrinking population, arguing that quality was more important than quantity, and claiming that Britain did not necessarily require a large population, opinions shared by Time and Tide.⁹⁴

It was the old feminists who were prominent in the campaign to achieve equality within the education system. There was

vehement criticism of the Board of Education's report on secondary education, published in 1923, which advocated differential education to make allowance for a girl's home duties.⁹⁵

Chrystal Eastman was particularly incensed by the Board's assumption that only girls should do domestic work.⁹⁶ Others pointed out that differential education hampered those seeking a career.⁹⁷ Lady Rhondda argued that education had an important influence on a woman's attitude to life.

Her general education still tends to make the little girl regard herself, not as an embryo citizen whose aim is to become an entirely responsible, self-governing and independent human being, to whom will be entrusted her share of voice and influence in the governing of the community to which she belongs, her share of responsibility for the public weal; but rather as a future help-meet, one whose business with the state and with the world outside the home will be indirect rather than direct, one whose business it will be not to act herself but only to help others to act. She is encouraged not to have overmuch self-confidence, she is induced to regard herself as something slightly inferior.⁹⁸
(italics in original)

Some women wanted to see an end to the belief that household management was solely the responsibility of women. The Vote advocated that domestic science to be treated like any other technical subject on the curriculum and taught to both sexes.

.... why should not boys as well as girls take their share in domestic duties? While it is true that more women than men are always likely to be engaged in managing and working in the home, we want to get rid of the idea that this is exclusively the work of women, and that the chief business in life for all women is to make a comfortable home. There is no reason at all why men should be prohibited from competing with women in making a home comfortable. There is no restrictive legislation applicable to men's work in this direction.⁹⁹

An anonymous contributor to Time and Tide commented

It is true that the mother must have home help, and equally true that the natural source of such help is - her husband. A child has two parents and all will not be well with the family until both parents pull their weight. At the present time too often does the father shirk part of the burden and dislocates our social machinery by overtaxing the mother.¹⁰⁰

Helena Swanwick believed that housework did not suit all women, and she wanted it to be organised on a communal basis, with men doing their share.¹⁰¹

Such sentiments, however, found little support. Winifred Holtby, in a critique of the assumption that women should make themselves responsible for all the domestic duties in a household, even if they were engaged in full-time occupations, remarked

Husbands and brothers and fathers feel themselves aggrieved, if, with 'a woman about the house', any domestic burden still falls on their shoulders, and proposals for communal performance of work now done individually are received with shocked disapproval.¹⁰²

Perhaps paradoxically it was the old feminists who were of more practical assistance to women seeking work in the health services than the welfare campaigners who were anxious for more medical facilities for mothers. The welfare campaigners helped women seeking employment in so far as they encouraged local authorities and voluntary bodies to create more employment, but, as will be discussed in the next section, they were not necessarily anxious to see women working in the health services, except in the low-status jobs with little chance of promotion. Conversely, the old feminists were much more anxious to see women acquire high status jobs and were more vociferous in their demands for equality of education, an end to

the marriage bar and equal pay for equal work, with equal conditions of employment. These matters, as will be discussed in Section Three, were of vital concern to women workers in the health services in the 1920s and 1930s.

The Social-class Differences between Women

Social-class divisions affected both the conduct of the maternity and child welfare campaign and the experience of women working in the health services. Maternity and child welfare workers as well as the old and the new feminists tended to accept that social stratification was inevitable. This assumption runs throughout the inter-war period, despite some blurring of the distinction between the artisan section of the working class and the lower middle class, with the expansion of state education and the growth of employment opportunities in light industry, commerce, the service industries and the health services. The effect of social-class divisions on the maternity and child welfare campaign and on women workers in the health services forms one of the major themes in the following sections.

Prochaska points out that the expansion of charitable work in the nineteenth century was based on an assumption that social stratification was immutable. He finds no evidence to suggest that class guilt motivated these women.¹⁰³ They seemed to accept the hierarchical nature of society, and regarded the distinction between rich and poor as God-given. Although, by the end of the nineteenth century, home visitors were being trained in social work, the majority of them did not develop an interest in social or economic theory. Their work was a

confirmation of the existing system, and their training and experience was entirely in the moral sphere.¹⁰⁴ Summers argues that charities were often opposed to the emancipation of working-class women. She suggests the employment of domestic servants offered the model for the relations between the rich and poor. This model defined the working class as an economically and socially dependent group, which was obedient, disciplined, clean and instilled with the routine of middle-class family life. Summers notes that visitors were urged to be respectful when visiting the poor and needy, but there was no question of a desire to break down social-class barriers.¹⁰⁵ Leonore Davidoff observes that, in contrast to the formal visiting arrangements and strict adherence to etiquette practised by the Victorian middle class, upper- and middle-class people felt they had a right to enter a working-class home at any time, and to ask questions, dispense charity and give orders.¹⁰⁶ In the following sections it will be shown that these ideas were maintained in the inter-war period with significant effect not only on the conduct of the maternity and child welfare campaign but also on attitudes to midwives and health visitors vis a vis the medical profession.

Women's organisations tended to cater either for working-class or middle-class women. Even when there was a common goal, the classes rarely found co-operation easy. In the suffrage movement, for example, working-class and middle-class campaigners tended to retain their separate identity, and demanded the vote for different reasons. Whereas many middle-class women were willing to accept the same limited franchise as men, many working-class women argued that votes for women

would be acceptable only if accompanied by full adult suffrage.¹⁰⁷ Some middle-class women wanted to use their vote to campaign for welfare legislation, based on their findings while doing charitable work, while others wished to remove a social indignity and to achieve full legal equality with men. Working-class women, on the other hand, were more likely to be involved in campaigns to improve working conditions, and wanted to work with men to achieve a more equitable society.¹⁰⁸

Some of the middle-class suffrage campaigners showed little desire to include working-class women in their activities. Esther Roper, a member of the Independent Labour Party and the secretary of the National Society for Women's Suffrage from 1890, was one of the few middle-class women who attempted to involve the working class.¹⁰⁹ Christabel Pankhurst worked briefly with Esther Roper, but the association did not endure.¹¹⁰ When the Women's Social and Political Union (WSPU) was formed, Christabel excluded all but a handful of working-class women. She was determined to keep membership restricted to the middle and upper classes. Ramelson discovered that Christabel's justification for excluding working-class women was that MPs, including those in the Labour Party, were more impressed by demonstrations involving middle-class women than by those involving working-class women.¹¹¹ Sylvia Pankhurst, in her history of the East London suffragettes, reveals that Christabel told her that the East London women were not wanted in the WSPU as they were the 'weakest portion of the sex'.¹¹² The NUWSS did encourage working-class women to participate, and working women were invited to organise the women trade unionists in the

Northern industrial towns, but even in this organisation working-class women were rare at the national level.¹¹³ These working-class women were respected by Mrs. Fawcett and Eleanor Rathbone, but some of their colleagues patronised the working women because they had to claim a salary for their suffrage work.¹¹⁴

Following the franchise victory, women's organisations remained segregated. The WFL and the NUWSS, which changed its name to the NUSEC in 1919, continued in existence, and, although the WSPU did not reappear after the war, the Six Point Group, like the WSPU before it, did not seek to attract mass working-class support.¹¹⁵ Indeed, the NUSEC ceased to seek members from among the working class, turning its attention to drafting private members' bills and lobbying MPs rather than organising mass demonstrations in support of its demands.¹¹⁶

Moreover, the divisions between women were reinforced by the assumption that jobs were suitable either for middle-class or working-class women.¹¹⁷ This was to have a profound effect upon the relations between workers in the health services as well as on attitudes to the degree of autonomy workers should expect, matters which will be discussed in Section Three. This belief that a woman's suitability for a particular occupation depended on her social class enabled feminists to continue to employ other women as domestic servants. Middle-class women, who sought to relinquish their total domestic responsibility, generally saw no conflict in achieving this goal by allowing other women to take over their work. As noted above, there was no discussion amongst these middle-class women of crèches or communal childminding services, while few contemplated a

re-organisation of household management to relieve women of full responsibility. When unemployment began to return after the First World War, working-class women were encouraged to become domestic servants. Mrs. Wintringham, for example, urged the need for more training in domestic work for unemployed women,¹¹⁸ and Aimee Gibbs, a member of the National Executive of the WFL, thought it would be more useful in later life than factory work.¹¹⁹ There was never any suggestion that unemployed men should be trained for this work. Moreover, no one suggested that it was suitable work for middle-class girls. For instance, in a letter to The Times, Katharine Tynan remarked that domestic work would not be suitable for upper- and middle-class girls because they would not be able to socialise with or marry butchers' and bakers' messenger boys. The openings in this work, she asserted, were not for the 'gentle'.¹²⁰ The mother of a children's nurse, also writing in The Times, pointed out that middle-class girls found the work lonely because they could not mix with the servants.¹²¹

There was some discussion about enabling domestic servants to work more socially-acceptable hours, and to have greater independence and improved living conditions.¹²² There were attempts made to raise the status of the occupation by establishing it as skilled work, requiring training.¹²³ It seems possible, however, that demands for registration and training could have been motivated as much by a desire to establish a pool of satisfactory employees as a desire to improve the conditions under which women worked. Ann Pope, in an article in the Women's Leader, recommended that the status of the work be raised, and predicted that there would then be no more tragic

stories of brilliant young women breaking down under the care of home and children, as there would be plenty of domestic help available.¹²⁴ Moreover, these efforts to improve working conditions were counteracted by the fact that, as households became smaller, there was less opportunity for promotion. Loneliness became more of a problem for domestic servants, increasing its unpopularity. Middle-class feminists offered no solution to this problem. Some argued that domestic servants must continue to work unsocial hours, in order that their employers might have an evening meal prepared for them.¹²⁵

Against this background of social-class divisions and of a rift within the women's movement, resulting in the separation of the equal-rights feminists from the welfare reformers, the lay women's maternity and child welfare campaign will be examined. This will provide a basis on which to analyse the history of the women who sought work as doctors, midwives and health visitors in England and Wales after the First World War.

NOTES AND REFERENCES

- 1 Stacey and Price (1981) op. cit., pp. 106-108
- 2 The idea was that the home should shield women and should provide a haven from the political and economic upheavals, see Catherine Hall (1979) The early formation of the Victorian domestic ideology, in Sandra Burman, ed., Fit Work for Women (London: Croom Helm) p. 15
- 3 Evangelicalism inspired middle-class women to attempt to raise moral standards and encouraged them to set an example to the poor, Sally Alexander (1976) Women's work in Nineteenth century London: a study of the years 1820-1850, in Juliet Mitchell and Ann Oakley, eds., The Rights and Wrongs of Women (Harmondsworth: Penguin) pp. 60-62; Leonore Davidoff (1973) The Best Circles: Society, Etiquette and the Season (London: Croom Helm) p. 39; Hall (1979) op. cit., p. 28; Prochaska (1980) op. cit., p. 8; Anne Summers (1979) A home from home - women's philanthropic work in the nineteenth century, in Burman, op. cit., p. 38
- 4 Prochaska (1980) op. cit. and Summers (1979) op. cit. provide detailed accounts of philanthropic work during the nineteenth century.
- 5 Celia Davies recounts the history of the Ladies Branch of the Manchester and Salford Sanitary Association, founded in 1852, which arranged for the circulation of sanitary and temperance literature and for visits by sympathetic Christian women, who would give advice on domestic management, and assesses the changes which occurred when visiting was taken over by the municipalities, Celia Davies (1984) The health visitor as mother's friend: a woman's place in public health 1900-1914, unpublished paper
- 6 Summers (1979) op. cit., p. 33
- 7 Prochaska found that, initially, women had powerful positions because they could devote many hours to the work and were successful fund-raisers, Prochaska (1980) op. cit., pp. 25-45. When the charitable societies became more formalised, it was men who invariably filled the executive positions even when the charities dealt only with infants, see Madeline Roof (1957) Voluntary Societies and Social Policy (London: Routledge and Kegan Paul) p. 42
- 8 The NLH included the National Association for the Prevention of Infant Mortality, the Association of Infant and Maternity Centres, the National League for Physical Education and Improvement, the Mansion House Council on Health and Housing, the National Baby Week Council, the National Society of Day Nurseries, the National Council for the Unmarried Mother and her Child, and the Women's National Health Association of Ireland.
- 9 The constituent bodies of the NCMCW were the Association of

- Maternity and Child Welfare Centres, the Central Council for the Care of Cripples, the Child Guidance Council, the Incorporated Midwives' Institute, the Institute of Infant Welfare Fund, the Invalid Children's Aid Association, the Mothercraft Training Society, the National Association for the Prevention of Infant Mortality, the National Baby Week Council, the National Council for the Unmarried Mother and her Child, the National Society of Day Nurseries, the Save the Children Fund and the State Children's Association.
- 10 The Carnegie United Kingdom Trust was set up in 1913, with a donation of ten million dollars from Andrew Carnegie, who had amassed a fortune following migration from Britain to the United States of America. In 1922, Carnegie House in Piccadilly was opened to provide central administrative offices.
 - 11 Support was withdrawn because the Trust felt the League's interests were too diverse, and its maternity and child welfare work had been superseded by the activities of the NCMCW.
 - 12 In 1890, the Ladies' Branch of the Sanitary Reform Association accepted the direction of the local MOH. Davies argues that this rather than the introduction of training, which middle-class ladies had always advocated, was the decisive step in the development of health visiting, because women became paid public health officials, and thus entered the public domain, Davies (1984) op. cit., p. 5. In 1892, Buckinghamshire County Council became the first county to appoint full-time health visitors who had completed a training scheme run by the Education Committee, McCleary (1935) op. cit., pp. 26-27
 - 13 From the 1850s, women had been allowed to enter workhouses as visitors, and a campaign was launched by Louisa Twining for the appointment of women guardians. The first woman Poor Law guardian was elected in 1875. In 1881, the Society for Promoting the Return of Women as Poor Law Guardians was founded, and ten years' later there were 108 women guardians, 10th Annual Report of the Society for Promoting the Return of Women as Poor Law Guardians (1891) Tuckwell Collection, File 601; Summers (1979) op. cit., p. 47
 - 14 The Local Government Act of 1894 enabled married or single women to be elected as urban, rural or parish councillors.
 - 15 Strachey argues that philanthropic work was responsible for awakening women's consciousness, Strachey (1928) op. cit., p. 13. Some women philanthropists, however, refused to campaign for the vote, arguing that it detracted from the work in hand, Prochaska (1980) op. cit., p. 229
 - 16 Prochaska, ibid., p. 218
 - 17 Opinion expressed by J.P. Sargeant, Chairman of the

Tewkesbury Board of Guardians, quoted in Women as Poor Law Guardians, Opinions of Experienced Authorities, a pamphlet published in 1890, Tuckwell Collection, File 601

- 18 Seventeen Reasons Why Women Are Wanted on the London County Council (1908) pamphlet published by the Women's Local Government Society, Tuckwell Collection, File 601. In the 1920s, Conservative women, who had been elected as councillors, told members of the Women's Unionist Association that they had decided to work on the maternity and child welfare committee, the library committee or on education or public health, e.g. Home and Politics (1923) No. 27, p. 8; No. 29, p. 5; No. 30, pp. 9 and 12
- 19 In 1906, George Newman, an MOH in Finsbury, who went on to become Chief Medical Officer first at the Board of Education and then at the Ministry of Health, published a book on infant mortality in which he placed much of the blame on women with low standards of household management. He advocated education, George Newman (1906) Infant Mortality. A Social Problem (London: Methuen). The French schemes for providing mothers with sterilised milk and advice on feeding were copied. Consultation de Nourrissons were created in Paris by Prof. Pierre Budin, and, in the provinces, an alternative scheme, known as Gouttes de Lait, was started, McCleary (1933) op. cit., pp. 42-48. The first School for Mothers was opened in St. Pancras in June, 1907, McCleary (1935) op. cit., pp. 41-42
- 20 see Jean Gaffin and David Thoms (1983) Caring and Sharing. The Centenary History of the Co-operative Women's Guild (Manchester: Co-operative Union)
- 21 Mothers' meetings were organised, and the Guild soon decided private charity was inadequate to cope with the difficulties experienced by working-class mothers, Catherine Webb (1927) The Woman with the Basket. The History of the Women's Co-operative Guild 1883-1927 (Manchester: Co-operative Wholesale Society's Printing Works) p. 123. The Guild went on to campaign for the registration of midwives and for the payment of a maternity benefit under the National Health Insurance scheme, ibid., pp. 124-127. The Guild, however, also accepted that women needed education, but it wanted this to be provided by trained employees of the local authorities, Margaret Bondfield (1948) A Life's Work (London: Hutchinson) pp. 26-52 and 127. Subsequently, information from members encouraged the Guild to campaign for a national maternity service, based on a service of midwives, backed up by doctors, hospital facilities and ancillary services including milk depots and home helps, see Margaret Llewelyn Davies, ed. (1978) Maternity: Letters from Working Women (London: Virago) first published in 1915. The Guild, therefore, welcomed the Local Government Board's model scheme, issued to local authorities in 1914, but thought many local authorities would not act unless the scheme was mandatory, ibid., pp. 209-212
- 22 see Margaret Cole (1961) The Story of Fabian Socialism

(London: Heinemann)

- 23 Between 1909 and 1913, the Group undertook a survey of working-class wives, designed to discover how women managed on a budget of one pound a week. This survey convinced the Fabian women that education alone would be inadequate to combat poor infant health, Reeves (1979) op. cit.
- 24 ibid., pp. 223-231
- 25 Margaret Bondfield (1914) The National Care of Maternity, a WCG pamphlet, p. 5. The FWG used this argument to justify the appointment of public guardians to offer advice and information on child care, Reeves (1979) op. cit., p. 223
- 26 Emma Paterson founded the Women's Protective and Provident League, later called the Women's Trade Union League, in 1874. The National Federation of Women Workers was started by Mary MacArthur in 1906.
- 27 This led to problems when the Women's Trade Union League was amalgamated with the TUC, as the TUC refused to admit the middle-class women leaders, and, consequently, Margaret Bondfield was the only member of the Executive Committee to be elected to the General Council of the TUC, Sheila Lewenhak (1977) Women and Trade Unions, an Outline History of Women in the Trade Union Movement (London and Tonbridge: Ernest Benn) p. 175
- 28 see press cuttings collected by Gertrude Tuckwell, e.g. correspondence, Manchester Guardian 22 February 1908, Leeds Mercury 21 and 28 July 1908, Mercury Post 24 July 1908, Tuckwell Collection, File 23. Catherine Hall, interviewing women in Birmingham, found that, in the 1920s and 1930s, husbands did not encourage their wives to go out to work, seeing their role as principally domestic, Catherine Hall (1977) Married women at home in Birmingham in the 1920s and 1930s, Oral History, 5, pp. 66-67 and 71-75. Margaret Stacey found the same attitude in Banbury in the 1950s, Margaret Stacey (1960) Tradition and Change, a Study of Banbury (Oxford: University Press) pp. 135-136
- 29 Lewenhak notes that many women trade union leaders thought that the employment of married women outside the home was a threat to married life, Lewenhak (1977) op. cit., p. 91
- 30 The two delegates were Margaret Bondfield and Mary MacArthur. The proceedings of the conference were reported in the Labour Woman (1920) 8, p. 24
- 31 Gertrude Tuckwell, Marion Phillips and A. Susan Lawrence (1919) Labour Women on International Legislation, Labour Party pamphlet, p. 5
- 32 Labour Woman (1929) 17, p. 39

- 33 Banks (1981) op. cit., p. 44
- 34 Regina Morantz (1974) The lady and her physician, in Mary S. Hartman and Lois Banner, eds., Clio's Consciousness Raised, New Perspectives on the History of Women (New York: Harper Colophon Books) p. 50
- 35 The women candidates summarised their platforms in an article in the Daily Mirror 14 December, 1918, Tuckwell Collection, File 324. The one exception was Mrs. Dacre Fox, who stood on an anti-German platform.
- 36 Globe 17 December, 1918, Tuckwell Collection, File 324
- 37 Daily Sketch 11 March, 1919, ibid., File 341A
- 38 Elizabeth Vallance (1979) Women in the House, a Study of Women Members of Parliament (London: Athlone Press) p. 27; Pamela Brookes (1967) Women at Westminster, an Account of Women in the British Parliament 1918-1966 (London: Peter Davies) pp. 17-29
- 39 Vote (1920) 19, p. 497
- 40 Labour Woman (1919) 7, pp. 1-2
- 41 Conservative women were urged to press for reforms 'in regard to health, housing and child welfare, wherein women are natural experts', letter written by Beatrice Chamberlain in 1917 and reproduced in Home and Politics (1920) No. 3, p. 1
- 42 Christabel and Emmeline Pankhurst formed the Women's Party in 1918, and Christabel stood for parliament at the 1918 general election. Although she was the only woman candidate to obtain the coalition coupon, she was not elected, and the Women's Party was subsequently disbanded. In 1928, Emmeline was adopted as a Conservative candidate, but she died before contesting the seat. Banks points out that a Women's Party failed also in the United States of America, Banks (1981) op. cit., pp. 154-157. See also article by Ray Strachey, Fortnightly (September, 1936) pp. 338-339; and Gertrude Tuckwell's collected press cuttings on the speculation about women's voting behaviour in 1918. The newspapers concluded that there was no evidence of women voting for a candidate simply because she was a woman, Daily Express 12 December, 1918, Tuckwell Collection, File 324, The Times 30 December, 1918, ibid., File 324AII. The women MPs, however, were conscious of entering a male institution, see quotation from Mrs. Stanley Baldwin in Stacey and Price (1981) op. cit., p. 90. Several of the women MPs referred to the lack of facilities in the House for women members, e.g. Leah Manning (1970) A Life for Education, an Autobiography (London: Victor Gollancz) p. 91; Edith Pickton-Turbervill (1939) Life Is Good, an Autobiography (London: Frederick Muller) p. 187. Edith Summerskill declared that women were in parliament under sufferance, quoted in Vallance (1979) op. cit., p. 5

- 43 In her maiden speech, Nancy Astor said she spoke for 'hundreds of women and children throughout the country', Parliamentary Debates, Fifth Series (PP) (1920) 125, col. 1631
- 44 e.g. Mrs. Corbett Ashby, who stood for the Liberal Party in Richmond, interview given to the Vote (1920) 20, pp. 33-34
- 45 e.g. Stacey and Price quote Mrs. Philip Snowden, who refused to stand against Lady Astor because of the work she did for women and children, Stacey and Price (1981) op. cit., p. 99
- 46 e.g., in 1936, the Conservative women voted with the opposition on an amendment introduced by Ellen Wilkinson to create a common pay scale for men and women working in the civil service. There was, however, some confusion follow-in the vote, and another vote was taken. On this occasion the Prime Minister made it a matter of confidence in the government, and the Conservative women felt compelled to vote with their Party. The amendment was lost, PP (1936) 310, cols. 2017-2476
- 47 For this reason the WCG repeatedly rejected mixed Guilds, reported in WCG (1920) 37th Annual Report (London: Co-operative Printing Society) p. 3; (1922) 39th Annual Report, pp. 6-7. At their meeting held on 11 and 12 October, 1919, the Central Committee of the WCG unanimously rejected a resolution calling for mixed guilds. It was recorded that any action which destroyed the self-government of the Guild would be detrimental
- to the education and progress of Guildswomen and to their effective work for the Movement, where the collective expression of women's views and experience is of peculiar value, and to the position of the Guild as the principal national organisation representing married working women's needs and views, and as a body through which appointments are made to national administrative posts.
- Minute Book of the Central Committee of the WCG, 11 and 12 October, 1919
- 48 Reported in the Labour Woman (1921) 9, p. 85
- 49 Conservative and Unionist Party (1922) The Campaign Guide, 14th Edition (London: National Unionist Association) p. 981
- 50 e.g. Baldwin has special meetings for women, and wrote an election address specifically for Home and Politics. The Labour Party published a special address to women in the Daily Herald, May, 1929, and the campaign was launched at the National Conference of Labour Women, Labour Woman (1929) 17, p. 55
- 51 The Woman's Vote (1918) Pamphlet No. 1879 (London: National Unionist Association)

- 52 Vote (1919) 18, p. 245
- 53 Lewenhak (1977) op. cit., pp. 172, 188, 192 and 210
- 54 Jill Liddington (1984) The Life and Times of a Respectable Rebel, Selina Cooper 1864-1946 (London: Virago) p. 297
- 55 Time and Tide (1925) 6, pp. 197 and 220
- 56 Leah Manning was elected as president of the National Union of Teachers in 1929 and was taken up by the Union as a prospective Labour candidate. She entered parliament in 1931, Manning (1970) op. cit., pp. 76-83
- 57 Kenner (1979) op. cit., pp. 169-170
- 58 WCG (1919) 36th Annual Report, p. 2
- 59 WCG (1930) 47th Annual Report, p. 5
- 60 Minute Book of the Central Committee of the WCG, 14 December, 1923
- 61 ibid., 20 and 21 September, 1929
- 62 The four principal issues in the Labour Party were over the ratification of the Washington Maternity Convention, adopted by the League of Nations Labour Conference in 1919, which called for the safeguarding of women's jobs during absence for childbirth, financial provision for twelve weeks' absence from work and time off during working hours to feed an infant, the campaign for the introduction of a system of family allowances, the introduction of a national maternity service, and the provision of birth control information at municipal maternity and child welfare centres. The question of birth control aroused the most heated debate, see Ward (1981) op. cit., pp. 98-182. The WCG had a serious rift with the Co-operative Union in 1914 over the question of divorce law reform. The Union withdrew its grant to the WCG until 1918, Gaffin and Thoms (1983) op. cit., p. 48
- 63 The TUC was worried about the effect family allowances would have on wage rates, Lewis (1980) op. cit., p. 172; Macnicol states that many trade unionists favoured maternity benefits in kind rather than a cash allowance, Macnicol (1980) op. cit., pp. 144-149
- 64 The TUC ignored demands for a maternity service because it wanted the BMA's support for working-men's compensation, Frank Honigsbaum (1979) The Division in British Medicine, a History of the Separation of General Practice from Hospital Care 1911-1968 (London: Kogan Page) p. 218
- 65 Letter from R.G. Randall, a Liberal, Time and Tide (1928) 9, pp. 561-562
- 66 The Labour Party reserved seats for women on its national

- executive, but the women's conference could not vote for their own representatives. The women delegates were elected by the national party conference, which was dominated by the trade unions, Dora Russell letter in Labour Woman (1925) 13, p. 206; Mrs. L'Estrange Malone letter in Time and Tide (1928) 9, pp. 513-514. The Conservative women were not expected to put motions before the national conference. Their main task was to rally support and endorse existing party policy, see The Women's Unionist Organisation of the National Unionist Association (1921) Pamphlet No. 2009 (London: National Unionist Association). The complete unanimity in favour of all conference resolutions was declared to be 'confirmation of Conservative principles' Home and Politics (1927) No. 75, p. 15; also Lady Iveagh's defence of the Women's Unionist Association against Time and Tide's accusation that Conservative women did not take up women's issues, Time and Tide (1928) 9, pp. 451 and 512-513
- 67 Melville E. Currell (1974) Political Woman (London: Croom Helm) p. 37
- 68 There were some exceptions. Ada Nield Chew, for example, who was a working-class trade unionist, criticised the campaign for family allowances, arguing that such allowances would force women back into the home and make them regard child care as a full-time occupation, Women's Leader (1922) 14, p. 262; Jill Liddington and Jill Norris (1978) One Hand Tied Behind Us, the Rise of the Women's Suffrage Movement (London: Virago) pp. 259-260
- 69 see Lewis (1975) op. cit.
- 70 The editors of the Women's Leader were Mary Stocks, a fellow member of the Family Endowment Society, who had, like Eleanor Rathbone, been involved in welfare work, and Elizabeth Macadam, who met Eleanor Rathbone in Liverpool before the First World War and who subsequently shared a flat with Eleanor Rathbone in London, Mary D. Stocks (1949) Eleanor Rathbone, a Biography (London: Victor Gollancz) p. 58; see also Mary Stocks' article, Women's Leader (1927) 19, p. 21; leading article following Eleanor Rathbone's 1925 presidential address, in which she outlined her definition of the new feminism, ibid. (1925) 17, p. 195
- 71 Despite winning a resolution in favour of her proposals for the development of the women's movement in 1925, Eleanor Rathbone continued to face criticism from a section of the Executive Committee of the NUSEC, Stocks (1949) op. cit., p. 117. In the following year, her opponents, led by Elizabeth Abbott, formed the Open Door Council, and, in 1927, in the wake of an acrimonious dispute within the Executive Committee, eleven members resigned. Those who resigned were Dorothy Balfour of Burleigh, Winifred Soddy, Elizabeth Abbott, Florence M. Beaumont, K. Bethune Baker, Helen Fraser, Chrystal Macmillan, F. de G. Merrifield, C. Phillips, J. Robie Uniacke and Monica Whateley.

- 72 Women's Leader (1923) 15, p. 44; ibid. (1925) 17, pp. 51-52; Time and Tide (1926) 7, p. 254
- 73 Annual conference resolution, Vote (1920) 20, p. 36; ibid. (1925) 26, p. 308
- 74 From the mid-1920s, Time and Tide was edited by Lady Rhondda, an outspoken opponent of Eleanor Rathbone's definition of feminism, see leading articles, Time and Tide (1925) 6, p. 907; (1926) 7, p. 101; (1927) 8, p. 152
- 75 Winifred Holtby's work appeared regularly in the Manchester Guardian, Time and Tide and the Yorkshire Post. She became a director of Time and Tide in 1926, and Lady Rhondda acknowledged her influence on editorial policy, see obituary to Winifred Holtby, Time and Tide (1935) 16, pp. 1390-1393
- 76 Article, ibid. (1926) 7, pp. 714-715
- 77 Reported, ibid., p. 921
- 78 Vote (1920) 20, p. 84
- 79 Viscountess Rhondda (1933) This Was My World (London: Macmillan) pp. 98-99
- 80 ibid., pp. 299-300; Time and Tide (1928) 9, pp. 328-329
- 81 Editorial comment in response to criticism from Monica Whateley, a Labour member of the London County Council and honorary secretary of the Six Point Group, that Time and Tide had not covered the debate on the status of women organised by the League of Nations, Time and Tide (1937) 18, p. 1402
- 82 article, ibid. (1926) 7, p. 715; quoted in Vera Brittain (1941) Testament of Friendship, the Story of Winifred Holtby (London: The Book Club) pp. 114-115
- 83 Time and Tide (1926) 7, p. 715
- 84 e.g. the Six Point Group advocated ratification of the Washington Maternity Convention, Supplement on the Six Point Group, ibid. (1923) 4, pp. 146-147; Winifred Holtby was interested in child welfare, see article, ibid. (1924) 5, pp. 712-713; Time and Tide gave Eleanor Rathbone's book, The Disinherited Family, an extremely favourable review, ibid., pp. 448-449
- 85 Remarks made in one of a series of articles on the leisured woman, which were written by Lady Rhondda, but which were published anonymously, ibid. (1926) 7, p. 1003
- 86 Cicely Hamilton (1981) Marriage as a Trade (London: Women's Press) first published in 1909; Catherine Welsh, Time and

- Tide (1927) 8, pp. 398-399. Lady Rhondda pointed out that small families did not require the full-time presence of the mother, and urged women not to be kept in idleness by their husbands, ibid. (1926) 7, pp. 1050-1051
- 87 Mrs. Swanwick, in an article on a woman's place, ibid. (1927) 8, pp. 1006-1007; Cicely Hamilton, ibid. (1928) 9, p. 1067
- 88 e.g. Gisela Urban, in an article, ibid. (1926) 7, p. 553. Catherine Welsh declared that, if women changed their attitude, they would be promoted on the same terms as men, ibid. (1927) 8, p. 399
- 89 ibid., p. 1131
- 90 Article, ibid., p. 1054; see also Vera Brittain (1936) Honourable Estate (New York: Macmillan) pp. 516-517
- 91 Time and Tide (1927) 8, pp. 398-399
- 92 Cicely Hamilton declared that she pitied women who had children only because they knew of nothing else to do, article, ibid. (1926) 7, p. 39. Elizabeth M. Delafield argued that some women were not suited mentally, physically or by inclination to bear children, ibid.
- 93 Letter from A.H. Henderson Livesey, ibid., p. 16. Subsequently, an anonymous correspondent reported that Henderson Livesey was setting up a League of Womanhood, designed to promulgate 'real feminine values', based on wifehood and maternity, ibid., p. 112
- 94 Cicely Hamilton asserted that, as Britain was an urban society, inhabitants would not want to populate the empire, and pointed out that a large population would be more vulnerable to air attack and would require more regulation, while a large population did not necessarily make a nation powerful, article in response to a book by G.F. McCleary on the menace of depopulation, ibid. (1937) 18, pp. 516-517; see also leading articles, ibid. (1931) 12, pp. 825-826; (1933) 14, p. 26; (1936) 17, p. 3; (1937) 18, pp. 1601-1602; and article by F.H.A. Marshall, ibid. (1938) 19, pp. 152-153
- 95 The Committee, which was predominantly male, wanted differentiation in mathematics and physics, Board of Education (1923) Report of the Consultative Committee on Differentiation of the Curriculum for Boys and Girls Respectively in Secondary Schools (London: His Majesty's Stationery Office (HMSO)) pp. 123-124. This Committee was chaired by Sir W.H. Hadow, and four of the twenty-one members were women. It began work in 1920. The Committee also suggested that a girl's education should not be divorced from her home duties, ibid., p. 125, and recommended that girls should work shorter hours at school and sit examinations a year later than the boys, ibid., pp. 134-136

- 96 Time and Tide (1924) 5, p. 5
- 97 see Dora Russell (1981) The Tamarisk Tree, Vol. Two, My School Years and the Years of War (London: Virago) pp. 6-8; Vera Brittain, Time and Tide (1923) 4, pp. 216-217; and leading article on the Board of Education's report, ibid., p. 109
- 98 Lady Rhondda's third article on the 'leisured woman', ibid. (1926) 7, p. 979
- 99 Vote (1929) 30, p. 60
- 100 Time and Tide (1922) 3, p. 622
- 101 Article on a woman's place, ibid. (1927) 8, pp. 1030-1031
- 102 Holtby (1934) op. cit., p. 147
- 103 Prochaska (1980) op. cit., p. 125
- 104 ibid., pp. 221-222
- 105 Summers (1979) op. cit., pp. 37-43
- 106 Davidoff (1973) op. cit., p. 46
- 107 Margaret Bondfield, for example, became president of the Adult Suffrage Society when it was formed in 1905. Liddington and Norris found that cotton operatives in the Northern industrial cities split with middle-class suffragists on the question of a limited franchise, Liddington and Norris (1978) op. cit., pp. 25-26. Some working women, however, were willing to campaign with the middle-class suffragists. Selina Cooper was willing to campaign for the vote on the same terms as men, while Ada Nield Chew, who had been a fervent adult suffragist, changed her mind and became a national organiser for the NUWSS in 1911, Liddington (1984) op. cit., pp. 160-163 and 209
- 108 Selina Cooper, for instance, declared that working women wanted the vote to increase their trade-union power, and combined the demand for the vote with socialist objectives. She entered politics as a socialist rather than a feminist, ibid., pp. 129 and 168
- 109 Esther Roper organised meetings at factory gates and had two working women to assist her, reported by Liddington and Norris (1978) op. cit., pp. 75-78; Liddington (1984) op. cit., p. 100
- 110 E. Sylvia Pankhurst (1977) The Suffrage Movement, an Intimate Account of Persons and Ideals (London: Virago) pp. 164-196 (first published in 1931)
- 111 Ramelson (1967) op. cit., p. 141

- 112 Pankhurst (1977) op. cit., pp. 516-519
- 113 Liddington (1984) op. cit., pp. 193-194; see also Ada Nield Chew (1982) Ada Nield Chew, the Life and Writings of a Working Woman, presented by Doris Nield Chiew (London: Virago)
- 114 Selina Cooper became friends with Eleanor Rathbone, Liddington (1984) op. cit., pp. 187-189. Other suffrage leaders, however, looked down on their working-class colleagues, ibid., p. 215. It is apparent that working-class suffragists recognised social-class barriers, Liddington and Norris (1978) op. cit., p. 235
- 115 The Six Point Group was a small middle-class pressure group, which sought only to press for government legislation on issues considered vital to women's emancipation. In 1922, the six points were legislation on child assault, for widowed mothers and for the unmarried mother and her child, equal rights of guardianship for married parents, equal pay for teachers, and equal opportunities for men and women in the civil service, advertisement for the Six Point Group, Time and Tide (1923) 4, pp. 242-243
- 116 Eleanor Rathbone and Eva Hubback claimed that these tactics required work by a few technical experts, unlike the campaign for a single, simple issue like the vote, which benefited from the mass support of women, see Eleanor Rathbone's 1926 presidential address to the NUSEC, reported in the Women's Leader (1926) 18, p. 36. It was this belief that a mass women's movement was no longer necessary which inspired the decision to start the Townswomen's Guilds, see Chapter Five, pp. 141-143
- 117 e.g. some middle-class women, aware of the plight of those who fell on hard times, campaigned for better education for themselves and improved job prospects. In 1841, the Governesses' Benevolent Association was founded. In 1848, Queen's College for Women was opened, followed a year later by Bedford College, and, by the end of the century, there were women's colleges in Oxford and Cambridge.
- 118 PP (1924) 170, col. 2035
- 119 Vote (1920) 18, p. 453
- 120 The Times, 1 May, 1922
- 121 ibid., 22 April, 1922
- 122 Editorial in the Labour Woman (1919) 7, p. 15
- 123 The Central Committee for the Training and Employment of women, for example, set up training centres. Mrs. Ernestine Mills published a book in which she advocated the registration of domestic workers, Ernestine Mills (1925) The Domestic Problem, Past, Present and Future (London: J. Castle). Mrs.

L.H. Reilly, in a letter to The Times, suggested that the training should be given in schools, The Times, 24 April, 1922

124 Women's Leader (1929) 21, p. 134

125 These views were expressed by Violet Markham and Mrs. Pember Reeves, Labour Woman (1919) 7, pp. 59 and 88

S E C T I O N T W O

THE LAY WOMEN'S CAMPAIGNS

INTRODUCTION

This section will investigate the lay women's maternity and child welfare campaign, first, to draw out the effects of the maintenance of rigid social-class divisions, secondly, to analyse the relationship between lay women workers and the Ministry of Health, and, thirdly, to establish lay women's attitude to the role of the medical profession and the place of women as paid workers in the maternity and child welfare services.

The impact of social-class segregation on the conduct of of the lay women's campaign for maternity services will be discussed in Chapter Three, illustrating that working-class and middle-class women often had differing ideas on what constituted an adequate maternity service and how it should be run.

Despite these social-class differences, there was accord between the middle-class reformers and the working-class women's organisations both on the importance of maternity to women's lives and on the place of the medical profession in the midwifery service. These women's definition of a woman's role and their vision of an adequate midwifery service were not radically different from that of the Ministry of Health. The relations between the women campaigners for maternity and child welfare services and the Ministry of Health will be analysed in Chapter Four, revealing a similarity of aims, but a reluctance on the part of the Ministry to allow lay women to play a part in the administration of the maternity and child

welfare services, or to participate in decision making. Particular attention will be paid to women's readiness to defer to the opinions of the generally male obstetricians and women's frequent apathy towards securing these jobs for women doctors.

Both the Ministry and the lay women accepted that a major priority should be a reduction in the maternal mortality rate by improving the midwifery service. The lay maternal mortality campaign reveals that, on a single issue, women from diverse backgrounds were able to unite and were able to exert pressure on the government and keep the issue before the public. At the same time, however, the campaign illustrates the similarity between the approach of the Ministry of Health and the aims of the lay women: both placed their main emphasis on medical solutions, and anticipated major improvements in mortality rates with a more comprehensive adoption of all the provisions of the 1918 Maternity and Child Welfare Act.¹

During the 1930s, this campaign lost some of its appeal and became fragmented. In Chapter Five, the issues which divided the maternity and child welfare campaigners and which affected the goals and structure of the women's movement are assessed, revealing a desire to rely upon the advice of technical experts and a substantial reduction in the activities of the more political lay women's societies.

This section is concluded with an assessment of the achievements of the lay women's health campaign. It is hoped that these data will facilitate an understanding of the pressures placed upon women who entered the health services as paid employees by an articulate section of the lay women's movement and one which was closely involved as recipients of

the medical care given by these women workers. Moreover, it seeks to draw out the part played by women doctors in the campaign, which in effect helped to make these women architects of their own subordinate position in the medical hierarchy.

REFERENCE

- 1 The terms of the Act are given in Appendix One.

C H A P T E R T H R E E

SOCIAL-CLASS DIVISIONS AND THE
MATERNITY AND CHILD WELFARE CAMPAIGN

During the inter-war period, social-class divisions remained a feature of British society. The growth of the lower middle class, and the comparative affluence of some sections of the working class, who were able to benefit from the expansion of clerical work, the service industries and electrical engineering, did not obliterate the barrier between the working class and the middle and upper classes, which was perpetuated by separate education and differing life styles, and reinforced by geographical separation.

Although some middle-class women worked with the working class, and were respected by them, many middle-class women found it difficult to work with working-class women. There was a tendency to work for working-class women rather than with them. Middle-class campaigners often envisaged themselves as 'doing good' to the poor, rather than being of use to all, regardless of social circumstances.¹ Henry Mess, in an analysis of social service provision after the First World

War, remarked that social service was regarded as a process whereby the 'privileged' gave to the 'unprivileged'.² He pointed out that the well-to-do did not expect to make use of the services, which were intended for

the relief of distress, especially material distress, and the combating of evils.³

Working-class women's groups tended to reinforce the divisions between themselves and the middle-class feminists' groups. The WCG, for example, refused to associate with any women's groups other than those representing industrial women, and specifically rejected links with women's citizenship groups and the Women's Institute movement.⁴

The perceived differences between the social classes prevented united action, even when the two groups shared a common goal. This is particularly evident in the campaign for improved maternity care. Although a belief in the importance of the motherhood role meant that both middle-class and working-class women campaigned for welfare provisions, including family allowances and birth control services, significant differences in attitude remained, which inhibited the development of a united movement. Furthermore, these social-class divisions influenced attitudes to the various maternity and child welfare services which in turn had an effect upon the status of workers in these services. The principal causes of cleavage were the maintenance of the belief in the need to provide separate services for the two classes in society, and the continued reliance upon, and support given, to the voluntary societies.

Separate Maternity and Child Welfare Services

Services provided under the Maternity and Child Welfare Act of 1918 were assumed to be for those unable to pay for the services of a doctor. Few considered that all women should have the right, or would wish, to make use of these services. It was accepted that midwives would attend working-class women, while middle-class women would be attended by a doctor, probably in a nursing home. Middle-class demands for raising the standard of competence of midwives were invariably made on behalf of working-class women, so they would have the same standard of care as the rich.⁵ An alternative service for working women was justified on the grounds that working women liked to be attended by someone who lived in their community, thereby implying that the midwife would be a working-class woman.⁶ Others argued that working women would not wish to leave their homes to go into a maternity home.⁷ The place of confinement, however, became a controversial issue towards the end of the 1920s (see pp. 99-116).

The representatives of working women used similar arguments. Margaret Bondfield, for example, argued in favour of an improvement in the status and training of midwives, stating

Under such a scheme as this we thought the working-class mother would have something of the same care which her well-to-do sister already had at command⁸

She, therefore, envisaged a different but comparable service. Furthermore, she presumed that the working-class life style and its attitude to children was different. She continued

I thought then that the working-class mother would make even better use of the science of health than

her richer sister has done, because her life is simple, and her love of home more real. Nothing that has happened since has falsified that belief.⁹

The TUC also assumed that midwives were intended for working-class women. In 1936, following legislation which made provision for a salaried service of midwives, a resolution, calling for midwives' salaries to be raised, was justified on the grounds that the wives of working men should be cared for by people with the highest standards of training and service.¹⁰

Furthermore, it was assumed that middle-class and working-class women would have different requirements regarding child care. For example, in 1919, the NLH opened two 'hotels' in Stoke Newington for babies who had to be separated, temporarily, from their mothers. One was to be for the children of professional families, and would keep the children for one year or more, whilst the mother was abroad or touring. The other was for working-class children, and was to keep the children for no more than one month, whilst the mother was in hospital, or whilst the father arranged alternative care, following the death of his wife.¹¹

All municipal maternity and child welfare legislation, in common with all social services, was regarded as being only for working-class women. Health visitors, for instance, who visited homes after the birth of a child, to check on the baby's development and to proffer advice, were not expected to visit middle-class homes (see pp. 329-330). Municipal clinics were always situated in working-class areas.

Suggestions that municipal services should be available to all women were unusual. In 1920, an article appeared in

Maternity and Child Welfare, a journal intended principally for voluntary welfare workers, on the need for middle-class women to have access to welfare centres. It argued that schools and centres should not be located only in working-class areas, and pointed out that middle-class women had a right to use the services, because they were ratepayers and because they were mothers, and mothercraft was not only a matter of instinct.¹² There is no evidence, however, that this advice was taken up by a significant number of women.

Similarly, the voluntary organisations, which sought to educate mothers and to provide maternity and child welfare services, made it apparent that their services were intended for working-class women. The annual Baby Week, for example, was directed primarily at working-class mothers.¹³ Eleanor Rathbone described it as

that annual festival at which all manner of societies and individuals engaged in teaching the working-class mother draw together for mutual encouragement and for a collective effort to glorify the functions of motherhood and impress on those who discharge it the truth that theirs is indeed 'work of national importance.'¹⁴

Middle-class women, on the other hand, were influenced by the literature being produced by obstetricians and paediatricians for lay readers on all aspects of infant care.¹⁵ Many middle-class women were anxious to follow the expert advice, but they found it difficult to afford the services of the specialists. Some turned to the municipal services.¹⁶ Others, according to Dr. Isabel Elmslie Hutton, attempted to overcome their difficulties by having small families.¹⁷

Those involved in the provision of municipal services dis-

cussed possible ways in which these middle-class women could be catered for separately from the working-class women. MOsH were urged to provide lectures for middle-class women, and means whereby middle-class women could pay for services were discussed by the Society of Medical Officers of Health (Soc.MOsH)¹⁸ and by the National Baby Week Council.¹⁹

A significant number of middle-class women were seeking ways of obtaining services and information. Those with limited means sought private maternity homes, which provided an adequate service at a reasonable price.²⁰ Babies' clubs were started for those who wanted advice on child care. The first of these clubs was opened in Chelsea, and, during the first year, the membership rose from nine to seventy. Clubs were started in other localities, including two more in London. The intention was to deal with problems a busy general practitioner did not have the time to handle. The clubs employed a medical officer, but care was taken to safeguard the interests of the general practitioner, and members were advised to obtain the support of their general practitioner before enrolling.²¹ Interestingly, whereas a junior medical officer, invariably a woman, was deemed suitable to run a municipal maternity and child welfare centre, a consultant was demanded for the equivalent service for middle-class women, while no mention was made of the desirability of the position being held by a woman. Indeed, several of the medical practitioners who predominated in the babies' clubs were men.²²

Vera Brittain was one of those who claimed to have benefited from the existence of these clubs. She stated that, without the discovery of the Chelsea Babies' Club, her first child

might not have survived the after effects of a 'catastrophic' delivery and her own slow post-natal recovery.²³ In an article, published in Time and Tide in 1928, she anticipated that the babies' clubs would fill a need for those women, above the state-aided level, but below the level at which additional expenditure ceased to be a worry.²⁴ She subsequently spoke on behalf of the Federation of Babies' Clubs.²⁵ Eva Hubback was involved in the running of the Hampstead Heath Babies' Club,²⁶ and, in 1931, she published an article giving advice to those planning to start a club.²⁷

The views of Vera Brittain and Eva Hubback were shared by the medical officers involved in the venture. Dr. H.K. Waller, for example, considered those most in need of help and guidance to be those just above the social scale which was officially visited by the municipal health visitor.²⁸ Dr. Eric Pritchard, when giving his support to the Hampstead Heath Babies' Club, which overtly catered for the children of professional and business parents, declared that help was needed for the

independent class that for various reasons did not wish to avail itself of the medical assistance which the State provides, but could not afford the fees of the specialist in children's diseases.²⁹

Subsequently, it was suggested that even trained nannies needed to keep abreast of developments in the theory of infant and child care.³⁰

It is evident that the quality of service offered to middle-class women tended to be significantly different from that provided for working-class women. This is illustrated by the example of the Westminster Health Society, a voluntary

body, which had been providing an infant welfare and mothercraft training service since before the First World War. The Society was in the habit of visiting all expectant mothers who attended its welfare centre, and the Centre was attended by two midwives, with a woman doctor attending once a month. Every baby was seen once a month during the first year, and every three months thereafter. In 1932, the Society decided to open a child welfare club, for which the subscription would be four guineas per annum. A 'suite of attractive rooms' was reserved for the club, and a children's specialist was to attend once a week, whilst a specially-trained nurse would attend daily, to weigh babies and give advice. Mothers were free to attend whenever they wished, and a home visit was made only at the request of the mother.³¹

Separate facilities for middle-class women were criticised by some socialist members of the medical profession. Dr. Stella Churchill, for example, wanted the services to be combined, with visits to affluent as well as poor homes, arguing that this would help to break down social-class barriers.³² Such views, however, found little support.³³ A common justification for the need for separate facilities, offering differing types of service, was based upon the notion that the capacity for learning varied. Few would argue that there was an inherent difference in intelligence, determined by social class, but it was common to argue that different life styles and educational standards made middle-class women more susceptible to new ideas. Dr. Alice M. Hutchison of the Tavistock Clinic, for example, in a paper presented to a meeting of the London Federation of Infant Welfare Centres, on the psychology of working-class mothers,

suggested that a working-class woman's capacity for learning was thwarted by her circumstances.³⁴ Dr. Hazel Gregory, in a discussion on the need for centres to educate middle-class women, argued that the two classes could not be mixed because

the mothers were educated in different schools, they spoke a different language, they had different standards of cleanliness.³⁵

Maternity and Child Welfare ran articles on the problems associated with educating working-class women. A medical officer, Alice Vance Knox, who ran a maternity centre and school for mothers in North Islington, referred to the difficulty of educating the women who attended classes at ante-natal clinics. She claimed difficulties arose because these women had limited means for helping themselves, they found it harder to grasp a new idea, and the circumstances of their daily life were less easily modified.³⁶ Hilda Cashmore, the warden of the University Settlement in Bristol, contributed advice on the teaching of working-class women, advocating a long-term approach, to overcome the fatalism of working-class women, and the notion that the government was the foe.³⁷

Furthermore, the instruction given to working-class women was not confined simply to advice on technical matters, and on the need for ante-natal examinations, but links with the nineteenth-century desire to affect working-class life styles were evident. Working-class women were asked to adopt middle-class child rearing practices. For example, a leaflet, produced by the NLH, listed fifteen points for the raising of an AI family, which ranged from the need to attend an ante-natal clinic, to the time the older children should be in bed, and the type of

furniture the family should purchase.³⁸ Also, as in the late nineteenth century, the need for working-class families to be able to follow the example of middle-class households was discussed,³⁹ and middle-class people were urged to remain in inner cities. Following a social survey of Tyneside for the Bureau of Social Research, Dr. Henry Mess found the community to be 'probably the worst housed community in England and Wales', but he went on to point out that many MOsH in the area attributed the high infant mortality rate to ignorance and carelessness in respect of the maternal function, and he urged the better-off to settle in the area, at least until they had children.⁴⁰

Another link with the nineteenth century was evident in the attitude to those families considered likely to benefit from outside assistance. An article in the Women's Leader explained why visiting formed a part of the work of schools for mothers.

Visiting, in the best sense of the word, has always been a strong feature of the Schools for Mothers. The women are visited as soon as they join in order that home conditions may be tactfully observed There is nothing of an inquisitorial character about these visits, for the heads of the Schools for Mothers rightly consider that certain qualifications are necessary for those who are intending to take up this branch of work, and choose their helpers with care. It is during these visits that one finds out which are the mothers likely to give good results from the care expended upon them, and which are the 'difficult cases'.⁴¹

The voluntary societies' continued involvement in visiting did little to enhance the status of the newly-created municipal health visitors or to ease their acceptance by their mainly working-class clients.

The maintenance of the contribution of the voluntary or-

ganisations in the maternity and child welfare service, once the Ministry of Health had been created and a Maternity and Child Welfare Act had been passed, perhaps caused the most significant rift between the middle-class and working-class women active in the campaign to improve welfare services. The association with charity may have been one reason why middle-class women were reluctant to attend welfare centres and clinics. At the same time, many of them remained committed to the ideals of charity, to alleviate the problems experienced by the working class. Working-class women, for their part, expressed considerable dissatisfaction with the continuance of voluntary workers in the maternity and child welfare services.

The Opposition to Voluntary Work

Those representing working-class women vehemently opposed the continuing reliance on charitable organisations. Jennie Lee, for instance, who was a member of the Independent Labour Party and became an MP in 1929, described charity workers as being

hostile to every honest-to-God effort to root out the causes of poverty, but at hand to plaster over the worst of the wounds that they themselves have helped to inflict⁴²

Another Labour MP, Ellen Wilkinson, also condemned the reliance on voluntary services.⁴³ In the 1930s, the Labour Woman was an enthusiastic advocate of municipal midwives, condemning the Ministry of Health's decision to allow voluntary nursing associations to provide a midwifery service under the 1936 Act.⁴⁴ Furthermore, working women complained about the way the volun-

tary hospitals treated their non-paying patients, which was markedly different from the treatment given to paying patients.⁴⁵

The Co-operative women spoke out against reliance on charity. One correspondent, who contributed to the WCG's book on maternity experiences, revealed that some members were initially opposed to the National Health Insurance maternity benefit, because they believed it to be charity.⁴⁶ They accepted that services were needed for mothers and children, but they argued that these should be provided by the municipality and should be for all women, on a similar basis as council schools, with no association with the Poor Law and its inquisitorial methods. It is apparent, however, that the Guildswomen, who made this recommendation, were considering only working women, and by referring to all women they did not include the middle and upper classes.⁴⁷ The WCG acknowledged that the volunteers had done valuable pioneer work, but argued that their service was too limited, many of the workers were untrained, and they created the impression of charity. Moreover, some homes were being invaded by a succession of visitors.⁴⁸ Margaret Bondfield declared that visitors to working-class homes often did not understand the particular problems of the women.

Only those who have practical experience of working-class life can realise the amount of wasted effort, overlapping, and confusion which exists among the various agencies formed for the purpose of assisting the poor, and the consequent invasion of the home by well-meaning but often inexperienced people, who catechise and admonish and go away, leaving only a feeling of exasperation behind.⁴⁹

A deputation, which visited Lord Rhondda, the President of the

Local Government Board (LGB), in 1917, made the same point.⁵⁰

The WCG demanded the appointment of trained workers, paid by the municipality, who would take over the work of volunteers.⁵¹ Municipal health visitors were regarded by the WCG as experts, who would give the women technical advice, and who would raise the status of the mother's role. The 'woman from the Town Hall' brought gifts of knowledge and sympathy, and the municipal visitor

strengthens the mother to help herself. The mother so helped realises she is important to society and is valued by the city. She respects herself. Not any longer a recipient of bounty, she recognises her status as a partner in the work of bearing and training healthy children, and understands her right to demand from society the fullest opportunity to do her work well.⁵² (*italics in original*)

However, not all working women welcomed the advent of the municipal health visitor, who came into their homes uninvited, and who often had links with the sanitary inspector (see pp. 327-329).

Working women's campaigns undoubtedly inspired some local authorities to employ health visitors, but their ready assumption that these visitors were providing a service specifically for working-class women did not help to raise the status of the occupation.

Official Support for the Voluntary Bodies

Despite the expansion of state involvement in maternity and child welfare (see Chapter Four), the charitable organisations did not become redundant, as they were able to adapt to changing circumstances. Criticisms, made by the Labour and working women's organisations, did little to curtail these

organisations, although the criticisms undoubtedly made the charitable bodies more conscious of their public image, and more willing to defer to expert opinion and to endeavour to obliterate their reputation for being patronising. From the beginning of the twentieth century, co-ordination and co-operation had been improved (see pp. 27-28).

Meanwhile, the Ministry of Health and many local authorities continued to favour the participation of voluntary groups. George Newman, the Chief Medical Officer (CMO) at the Ministry of Health, listed four advantages: they were economical, they could originate and experiment, they were propagandists, and were not bound by parliament, and they brought high ideals of service.⁵³ His successor, Sir Arthur McNalty, upheld his opinion, declaring in his 1938 report that maternity and child welfare still owed much to voluntary work: the volunteers were able to cover different aspects, to do pioneer work, and to give tentative trials to schemes intended to meet new social needs.⁵⁴ It is evident that the voluntary societies valued the consistent support given by the CMOs.⁵⁵

Many of the local authorities were happy to work with the voluntary bodies, believing that a co-ordinated service, which avoided overlapping, was the most appropriate.⁵⁶ The co-operation of the municipal and the voluntary, it was argued, would avoid the disadvantages of a soulless bureaucracy and would provide some elasticity and opportunity for experiment.⁵⁷

Successive Ministers of Health gave their support to this approach. Conservative ministers were particularly enthusiastic,⁵⁸ while financial stringency forced Labour governments to rely on voluntary contributions.⁵⁹ The retention of the

percentage grant for maternity and child welfare was advocated by MPs on both sides of the House when the Local Government Bill was debated, not only because they thought local authorities might not expand their services under the proposed block grant system, but also because under the percentage grant system it was possible to ensure that voluntary societies received help.⁶⁰ The Times fully endorsed parliament's commitment to voluntary work. It had criticised Christopher Addison, the first Minister of Health, for attempting to extend state involvement,⁶¹ and any evidence of moves towards increased centralisation were criticised.⁶² It is perhaps not surprising that a letter, written by Violet Markham in 1928, opposing charity, on the grounds that it lulled people into a false sense of security, and arguing that aid through charity would be similar to running a war through private subscription, was rejected by the editor of The Times.⁶³

The Attitude of Professionals to Voluntary Work

There was some opposition to the participation of volunteers from the male members of the Soc.MOSH, who were anxious to establish the maternity and child welfare service as an important part of the public health service. For example, in 1918, Public Health, the official journal of the Soc.MOSH, published an article from the MOH for Warrington, Dr. G.W.N. Joseph, who opposed the co-opting of individuals on the maternity and child welfare committees, set up under the 1918 Maternity and Child Welfare Act, on the grounds that they would not be responsible to the ratepayers.⁶⁴ Another MOH, Dr. W.H. Snell of Coventry, writing in the same journal, expressed his

opposition to 'amateurs' on these committees. He wanted the local authorities to be strong, and to develop 'meticulous supervision'.⁶⁵ In 1924, an editorial appeared in Public Health criticising the large voluntary organisations. The journal complained that, although voluntary societies were useful on a small scale, the national councils, employing full-time officials, tended to thrust themselves between the public and the expert officers of the large local authorities.⁶⁶ In 1924, Robert A. Lyster, in his presidential address to the Soc.MOSH, objected to public money being given to voluntary organisations, claiming that poor people did not like their inquisitorial methods.⁶⁷ Four years' later, Elwin Nash, in his presidential address to the Maternity and Child Welfare Group of the Society, declared that workers had more freedom under a municipal authority than under a voluntary body.⁶⁸

Many MOSH, however, conscious of the expense involved, were willing to collaborate with voluntary organisations,⁶⁹ while others preferred to devote their limited resources to other spheres of their responsibility.⁷⁰ Dr. F.E. Wynne, the MOH for Sheffield, considered that voluntary workers, if they were reliable, were valuable, as they enabled the trained workers to concentrate on the specialist tasks. He did argue, however, that care must be taken to prevent 'fadists and sentimentalists' from influencing policy.⁷¹ MOSH were often involved in the organisation of the various activities run annually under the auspices of the National Baby Week Council.⁷² The Soc.MOSH also held some joint conferences with voluntary organisations.⁷³

The Continuing Participation of Women in Voluntary Work and
the Adaptation of the Societies to Changing Needs

Successive economic crises during the inter-war period enhanced the value of voluntary work. Although some middle-class women, during this period, took no interest in this work, notably Lady Rhondda,⁷⁴ while Winifred Holtby used her novels to criticise the perpetuation of the tradition of philanthropy,⁷⁵ considerable pressure continued to be exerted on middle-class women to uphold the nineteenth-century tradition.⁷⁶ Middle-class women were told of the value of their charitable work to the quality of working-class women's lives.⁷⁷

Despite the increased opportunity for obtaining work outside the home, charitable work remained an avenue for middle-class women's entry into public life.⁷⁸ Middle-class women were urged to do voluntary work to gain experience prior to work on the municipal maternity and child welfare committees.⁷⁹ Schools for middle-class girls encouraged some form of social work on a charitable basis. For example, Edith Pickton-Turbervill, who became a Labour MP in 1929, stated that her school fostered this tradition.⁸⁰ In 1927, one hundred and fifty schools were affiliated to the Union of Girls' Schools for Social Service.⁸¹

The voluntary societies, for their part, were careful to adapt to changing needs, and to follow official policy. First, the societies readily conceded that some of their work should be taken over by professionals. The National Baby Week Council published a pamphlet arguing that the basis of voluntary work was the maternity and child welfare centre, and volunteers were warned against involvement in the technical side of the work.

But the business of mothercraft which finds its focus in these centres is by no means confined to the high regions of medical lore, and from many aspects the work of the volunteer is invaluable, provided that she (for this part of the business is woman's work) grasps very firmly the limitations of her sphere, and never, under any provocation, allows one word of advice on matters which pertain to the sphere of the expert to escape her naughty tongue. So many of the things which count in a baby's life are little things. The centres are not hospitals for the cure of acute diseases; they are rather preventive centres, where the small deflections from the path of normal health may be corrected, and above all, where the mother may seek knowledge The mother, therefore, will not in many cases be driven to the centres by the urgency of acute illness - she will be drawn thither by sympathetic hands. Foremost among these are the doctor and nurse, but they are not the only agents required. It lies in the hands of the volunteer to make the centres not merely means for alleviating acute trouble, but an integral part of the mother's social life, where she may find comradeship and help in all the diverse problems which confront her, from the feeding of her baby and the knitting of its clothes, to the training of a citizen, and the problems of population.⁸²

Ethel M. Mounsey, a voluntary worker at an infant welfare centre in Sunderland, told readers of National Health, a journal which catered mainly for the interests of those working in maternity and child welfare, that, once voluntary societies had set up welfare centres

It was a very good thing that the authorities should eventually assume responsibility for this work, secure grants for it from the Ministry of Health, and link it up with the modern movement of the State for the benefit of mothers and children. It is work of vital importance to the State, and it is perfectly right that the local authorities should shoulder the burden and seek to develop the whole as efficiently as possible; but many of us are convinced that they also do wisely to recognise the value of voluntary work, given in co-operation with the health visitor.⁸³
(my italics)

Voluntary workers argued that the state would never be able to

cover the whole ground,⁸⁴ and pointed out that volunteers could provide the personal touch and could cater for those with special needs.⁸⁵

Secondly, the voluntary societies sought to extend their sphere of work into areas not covered by local authorities. During the 1920s, for example, societies instigated mothercraft training, and it was hoped that this action would inspire local authorities to provide classes in the state schools.⁸⁶

Thirdly, voluntary organisations responded to demands for the use of trained personnel. The St. Pancras School for Mothers, for instance, initially used voluntary visitors, but it was later acknowledged that

*expert advice was needed in the homes rather than friendliness without thorough knowledge.*⁸⁷ (italics in original)

One of the stated objects of the NCMCW was to promote the standardisation of training for welfare workers, while the NLH set up an employment bureau which supplied health visitors to infant welfare centres. Moreover, the voluntary societies were aware of the danger of giving mothers conflicting advice.⁸⁸ A leading article in Maternity and Child Welfare referred to the importance of trained teachers: social work could no longer be seen as charity, with its attitude of 'superior benevolence, its rules of deterrance, and its merely inquisitorial investigations'.⁸⁹

Attempts were made to give voluntary workers some training. The NLH awarded badges to people who had completed a course of training.⁹⁰ Social work training at universities became popular amongst middle-class women. Much of their

training, however, provided little insight into working-class life styles. Barbara Wootton, who lectured at Westfield College on one of these courses immediately after the First World War, commented in her autobiography

The Social Science students of those days were very different from their modern counterparts. Few of them were training to become professional social workers: mostly they were young women of means and leisure who wished to engage in various charitable activities. Thanks largely to the influence of what was then the Charity Organisation Society they had grasped that if you want to make a success of 'slumming', or to set the poor to rights, it is better to know something about the lives of the people into whose business you propose to interfere. So they came in their cars and their pearls and their elegant clothes to hear what I and others had to say; and I for my part dutifully tried to teach them what I had myself been taught, and not to be put off by the fact that they appeared to be so much more sophisticated worldly-wise than I was myself. But I doubt if any of it had much relevance: I was still lamentably ignorant of any of the practical aspects of economics, and my first hand acquaintance with severe poverty or slum life was virtually non-existent.⁹¹

Bella Aronovitch, a working-class girl who spent four years undergoing treatment in various London hospitals between 1928 and 1932, provides an example of the social-class barriers, which prevented middle-class social workers from helping working-class women. Recounting her experience of a visit to a social worker, following her discharge from hospital, she remarked

The onus was on me to have tried to break down the problem so that she might have understood. In the most favourable circumstances this was no easy task since we were separated by age, by class and by outlook. I had come in the first place to ask for help but had been unable to establish terms of reference. Although we both spoke the same language, we were unable to communicate.⁹²

The continuing involvement of voluntary organisations affected the status of those working in the maternity and child welfare services and helped to foster the ideals of the Ministry of Health and gave support to the recommendations of the medical profession. The societies readily agreed that motherhood was a full-time occupation for which training from an early age was required. The voluntary organisations were always anxious to comply with the dictates of the Ministry, supporting the idea that problems associated with maternity and child welfare would be solved by a combination of education and the extension of medical services. Similarly, these organisations were anxious to follow the advice of the newly-emerging obstetricians and paediatricians, thus aiding their desire to assume overall control of all maternity and child welfare services. Furthermore, the work of the voluntary associations mitigated against the advancement of workers in the maternity and child welfare services both in terms of remuneration and status. Attempts to raise pay and standardise working conditions, terms of employment and training were hampered, while the participation of the voluntary element deterred middle-class women from using the services. Those seeking employment in the services run by voluntary bodies were perhaps more likely to be working-class women who had traditionally been employed by the charities or by those middle-class women who required some income but who wished to follow the nineteenth-century tradition of service to the community. Such women were perhaps more likely to defer to male medical opinion and less anxious to establish autonomy (see Chapter Nine).

NOTES AND REFERENCES

- 1 e.g. this was a criticism levelled at Lady Astor by Bertrand Russell in an exchange over the purpose of nursery education, Russell (1981) op. cit., p. 14
- 2 Henry A. Mess, ed. (1948) Voluntary Social Services since 1918 (London: Kegan Paul, Trench, Trubner) p. 4
- 3 ibid., p. 2
- 4 WCG (1919) 36th Annual Report, p. 6; Minute Books of the Central Committee of the WCG, 10 and 11 March, 1921
- 5 e.g. anonymous articles, Women's Leader (1921) 13, p. 500; Time and Tide (1922) 3, p. 662
- 6 It was argued that working-class women would be more likely to consult a midwife, who lived in the community, early in pregnancy, and would admit to minor ailments, Margaret Leonora Eyles (1922) The Woman in the Little House (London: Grant Richards) pp. 157-158; anonymous article, Women's Leader (1921) 13, p. 500
- 7 e.g. article by a midwife, Katherine Gillett-Gatty, Time and Tide (1922) 3, p. 769
- 8 Bondfield (1948) op. cit., p. 135
- 9 ibid.
- 10 Reported in The Times 10 September, 1936
- 11 Reported in the Medical Officer (1919) 21, p. 116
- 12 Mary C.D. Walters, a member of the Royal Sanitary Institute, Maternity and Child Welfare (1920) 4, pp. 311-313
- 13 The National Baby Week Council was set up in 1917, and was chaired by Lord Astor. Membership included voluntary and professional workers involved with maternity and child welfare. One week in July was designated Baby Week, during which events were organised, to publicise the current recommended child rearing practices, and to foster pride in the task of rearing healthy children. The cinema and exhibitions and lantern slides were used to reach a wide audience. Conferences were arranged for professional workers in maternity and child welfare. The Council continued its activities throughout the inter-war period, and its activities were widely publicised in the national press.
- 14 Eleanor Rathbone (1948) Family Allowances (London: George Allen and Unwin) p. 51 (a new edition of The Disinherited Family, first published in 1924)
- 15 Probably the most influential was Truby King, but he was not alone. For example, in 1925 the Lancet reviewed two handbooks for women, written by doctors, which covered all aspects of the management of pregnancy, including comments

- on clothing, and detailed information on the care of the infant and the home, Dr. Harry Roberts (1924) The Young Wife's Advice Book (London: Ward, Lock) and Dr. Cecil Webb-Johnson (1925) Woman's Health and Happiness (London: Methuen), both reviewed in the Lancet (1925) i, p. 1278. F.J. Browne, Professor of Obstetric Medicine at University College Hospital, published a popular pamphlet, dealing with similar subjects, F.J. Browne (1934, 3rd edition) Advice to the Expectant Mother on the Care of her Health (Edinburgh: E. and S. Livingstone). During the 1930s, Mother and Child reviewed several similar books. The eminent paediatrician, Dr. R.C. Jewesbury, who worked at St. Thomas's, published a book on Truby King's method of infant feeding and management, R.C. Jewesbury (1932) Mothercraft (London: J. and A. Churchill), reviewed in Mother and Child (1932) 3, p. 300. In 1933, three leading members of the profession, Eardley Holland, the obstetric and gynaecological surgeon at the London Hospital, Wilfred Sheldon, a junior physician in the children's department of King's College Hospital, and R.C. Jewesbury, gave a series of wireless talks on the importance of ante-natal care, dealing also with personal hygiene and diet, and giving advice on clothing and all aspects of the care of the infant. These talks were published in a book entitled A Doctor to a Mother (London: Edward Arnold), reviewed in Mother and Child (1933) 3, p. 454. In 1934, the medical officers working at the Chelsea Babies' Club, published a book which, in the section on diet, included specific recipes, Harold Waller, N. Langdon Lloyd, John Gibbens, G. Grovesnor Millis (1934) Recipes for Food and Conduct (London: Chelsea Babies' Club), reviewed in Mother and Child (1934) 4, p. 410
- 16 e.g. the matron of the Infant Hospital, Westminster, Miss M. Hughes, said middle-class girls were seeking advice at hospitals, which were intended for 'quite a different class of mother'. She claimed that the presence of middle-class women deterred the working-class women, reported in National Health (1926) 19, pp. 210-211
- 17 Isabel Elmslie Hutton (1938) The Hygiene of Marriage (London: William Heinemann) p. 120 (first published in 1923) This book was intended to help middle-class parents prepare their children for marriage. She claimed it a disaster that middle-class couples were limiting family size, as this class produced the most intelligent, hard-working and moral members of society.
- 18 see Elwin Nash's presidential address to the Maternity and Child Welfare Group of the Soc.MOSH, quoted in Public Health (1928) 42, p. 17; and scheme to aid women of 'moderate means' to pay the fees of a private nursing home, Medical Officer (1926) 35, p. 118
- 19 see speech by the joint honorary secretary of the National Baby Week Council and MOH for Enfield, Dr. G.H. Geffen, given at the Fifth English-speaking Conference on Maternity and Child Welfare, reported in National Health (1929) 22, pp. 43-45. The matter was discussed also at a meeting of

- the National Baby Week Council, reported in Mother and Child (1930) 1, p. 17; and at the maternity and child welfare conference organised during Baby Week in the following year, reported, ibid. (1931) 3, p. 164
- 20 e.g. letter in National Health recommending a maternity home, where middle-class women could expect expert advice and treatment at a moderate price, National Health (1928) 20, pp. 346-348
- 21 This information was given in a report in Maternity and Child Welfare (1929) 13, pp. 109-110 and 120-122
- 22 e.g. the Chelsea Babies' Club and the Hampstead Health Babies' Club, two of the first and most well-known of these clubs, both had male medical officers, Dr. H.K. Waller and Dr. Eric Pritchard, respectively. H.K. Waller wanted the medical officer to be of consultant rank, and declared that the clubs were doing work that had never been done before, article in Mother and Child (1930) 1, pp. 11-13
- 23 Brittain (1979) op. cit., p. 51
- 24 Article in Time and Tide (1928) 9, p. 305
- 25 In 1932, Vera Brittain spoke at a maternity and child welfare conference organised by the National Baby Week Council. She told the conference that the economic depression was affecting middle-class mothers, and she argued that these mothers lacked the practical experience of the working-class mothers, because they did not usually come from large families, reported in Mother and Child (1932) 3, p. 160
- 26 Diana Hopkinson (1954) Family Inheritance, a Life of Eva Hubback (London: Staples Press) p. 125
- 27 Eva Hubback suggested the club be situated in an area where mothers looked after the baby themselves or employed an inexperienced nanny. She mentioned a desire to extend the service to provide advice on child psychology, Mother and Child (1931) 1, pp. 415-416
- 28 Article, ibid. (1930) 1, p. 13. Harold Waller told the members of the Chelsea Babies' Club, at their first annual general meeting, that middle-class babies had many of the same ailments as working-class babies, reported in Maternity and Child Welfare (1929) 13, p. 121
- 29 quoted in Mother and Child (1930) 1, p. 55. The type of members the Club catered for was referred to, ibid. (1932) 3, p. 53
- 30 Dr. Margaret Emslie, the Medical Officer at the Hyde Park Babies' Club, argued that even a trained nurse could not know everything, ibid. (1933) 4, p. 89. The Club organised lectures for nursery nurses, ibid. (1931) 2, p. 182
Hampstead Heath Babies' Club organised functions intended

- for mothers and nurses, reported, ibid. (1932)3, p. 53
- 31 reported, ibid., pp. 18-19
- 32 Stella Churchill was speaking at a meeting of the London Workers' Section of the Association of Infant Welfare and Maternity Centres to discuss paying centres for middle-class women. Another speaker, Mrs. B. Gilbert, remarked
- Child-birth and maternity place all women on the same level.
- Other speakers, however, claimed poor women would not want to attend at the same time as middle-class women, and that middle-class women, although not minding for themselves, would not want to put their babies' health at risk. Reported in National Health (1926) 19, p. 211
- 33 The Association of Infant Welfare and Maternity Centres subsequently voted in favour of separate paying clinics, reported, ibid. (1927) 20, p. 188
- 34 Quoted, ibid. (1925) 18, pp. 11-13
- 35 Hazel Gregory was speaking at the same meeting as Stella Churchill, see reference 32, ibid. (1926) 19, p. 210
- 36 Maternity and Child Welfare (1919) 3, pp. 369-371
- 37 ibid., pp. 157-158
- 38 How Mrs. John Bull Rears an AI Family, NLH pamphlet, printed in National Health (1924) 17, p. 148
- 39 During the 1860s, Charity Organisation Society members had complained about the exodus of the gentry from inner-city areas. The Society argued that the gentry was needed to ensure adequate running of the local administration, to provide an example for the poor and in order to maintain the balance between charity and the Poor Law, Gareth Stedman Jones (1976) Outcast London, a Study in the Relationship between classes in Victorian Society (Harmondsworth: Penguin) p. 249. Edward Denison, a member of a wealthy family and son of the Bishop of Salisbury, moved to Stepney for a few months in 1867, to try to reverse this separation, ibid., p. 258
- 40 Reported in Maternity and Child Welfare (1928) 12, pp. 349-350
- 41 Editorial in the Women's Leader (1923) 14, p. 395
- 42 Jennie Lee (1939) Tomorrow Is a New Day (London: The Cresset Press) p. 237
- 43 Ellen Wilkinson objected because it would prevent standardisation, and she recommended that leisured women should find other work, PP (1936) 314, cols. 1056-1057
- 44 Editorial in the Labour Woman (1936) 24, p. 50. For a

- discussion of the Midwives' Act, see pp. 274-281
- 45 e.g. Florence G. Fidler (1936) The Patient Looks at the Hospital (London: Robert Hale); Bella Aronovitch (1974) Give It Time: an Experience of Hospital 1928-1932 (London: Andre Deutsch); in 1929, the WCG passed a resolution demanding that public patients in maternity hospitals receive the same treatment as the private patients, reported in WCG (1930) 47th Annual Report, pp. 18-19
- 46 Llewelyn Davies (1978) op. cit., p. 131
- 47 E.A. Wilkin, A.H. Nevitt, J. Booth, M. Butler, C.H. Daymond, E. Hood, M. Found and M. Llewelyn Davies (1917) Memorandum on the National Care of Maternity, WCG pamphlet, p. 1
- 48 Bondfield (1914) op. cit., p. 9
- 49 Bondfield (1948) op. cit., p. 132
- 50 The deputation complained that many middle-class visitors used inquisitorial methods, and fears were expressed that such visitors might not appreciate the problems created by inadequate housing and might report the occupants to be dirty, untidy or improvident, Wilkin et al. (1917) op. cit., p. 7
- 51 Bondfield (1914) op. cit., p. 9
- 52 ibid., p. 5
- 53 quoted in Maternity and Child Welfare (1922) 6, pp. 120-121; the CMO's annual reports often referred to the importance of the voluntary services, e.g. On the State of Public Health (1933) Annual Reports of the CMO of the Ministry of Health (London: HMSO) p. 83; and acknowledged their pioneer work, e.g. ibid. (1934) p. 60
- 54 ibid. (1939) p. 88
- 55 e.g. see Mother and Child's enthusiasm for George Newman's continuing support of Baby Week, editorial, Mother and Child (1933) 4, p. 159. In 1939, the journal was still optimistic about the future of voluntary work, editorial, ibid. (1939) 10, pp. 117-118
- 56 e.g. a meeting in 1919, chaired by Dr. Eric Pritchard, the MOH for Marylebone, discussed the attitude of local authorities to voluntary associations, which unanimously recommended that voluntary work should continue in a co-ordinated system, reported in National Health (1919) 12, pp. 134-135
- 57 ibid., p. 134
- 58 Neville Chamberlain, the Minister of Health under Baldwin and later Chancellor of the Exchequer, was an enthusiastic

- advocate of voluntary work, e.g. see report of his speech to a maternity and child welfare conference, Lancet (1927) ii, p. 79; and presidential address to the National Maternity and Child Welfare Conference organised by the NCMCW, reported in Mother and Child (193) 5, pp. 163-165. The importance of the voluntary contribution was stressed in a Conservative Party pamphlet, Lieut.-Col. Fremantle (1925) Health Building, Pamphlet No. 2542 (London: National Unionist Association) p. 11
- 59 For this reason, during discussions on the re-organisation of local government financing, the Labour Party was anxious not to penalise the voluntary effort in maternity and child welfare, e.g. see PP (1929) 224, cols. 194-195 and 202
- 60 ibid., col. 175. The voluntary societies also opposed the block grant, leading article in Maternity and Child Welfare (1929) 13, pp. 13-14
- 61 e.g. editorials in The Times, 30 October, 1920; 25 February, 1921; 18 April, 1921
- 62 e.g., in 1930, George Newman was criticised for countenancing increased centralisation, editorial, ibid., 4 November, 1930
- 63 Letter dated 21 December, 1928, Markham Papers, File 5/8
- 64 Public Health (1918) 32, pp. 21-22
- 65 ibid. (1919) 32, pp. 52-54
- 66 e.g. voluntary societies were accused of ineptitude in the administration of the 1920 Blind Persons Act and the 1913 Mental Deficiency Act, and of damaging the public health service by employing district nurses rather than health visitors, ibid. (1924) 37, pp. 301-302
- 67 Reported, ibid., 38, pp. 46-55
- 68 Reported, ibid. (1928) 42, p. 15. Elwin Nash, however, was a controversial figure, holding a number of opinions not shared by the majority of those involved in maternity and child welfare work. He was, for example, one of the few to suggest that the work should not be done exclusively by women.
- 69 e.g. twelve MOsH were on the Executive Committee of the National Association for the Prevention of Infant Mortality. Public health officials collaborated with voluntary workers in the schools for mothers, notably at the first of these schools, established in St. Pancras in 1907, National Health (1928) 21, pp. 8-14
- 70 Davies (1981) op. cit., p. 22

- 71 Paper read at a meeting of the Yorkshire Branch of the Soc.MOSH, reported in Public Health (1923) 20, pp. 278-279
- 72 Editorial in the Medical Officer (1931) 46, p. 1
- 73 e.g. the Society helped to organise the annual maternity and child welfare conferences, run for the NCMCW by the National Association for the Prevention of Infant Mortality.
- 74 Lady Rhondda, in her autobiography, remarked that the social work, undertaken by most of her contemporaries, had no appeal for her. She argued that these women were inventing work to make themselves feel busy and were getting pleasure out of patronising people just as good as themselves, Rhondda (1933) op. cit., pp. 101-102
- 75 e.g. this formed a major theme in Anderby Wold, published in 1923, and South Riding, published posthumously in 1936.
- 76 Norah March, in a report on the activities of the 1922 Baby Week, warned that local authorities were likely to run out of money, making the voluntary contribution increasingly important, Women's Leader (1922) 14, p. 188. The VADs, employed during the First World War, were urged to take up voluntary maternity and child welfare work, editorial in Maternity and Child Welfare (1919) 3, p. 21, and, four years' later, the journal devoted a leading article to a plea to leisured women to spare time for voluntary work, ibid. (1923) 7, p. 13. The Women's League of Service to Motherhood appealed through the columns of The Times for volunteers to help educate working-class women in the care of their babies, The Times 7 April, 1923. Leonora Eyles hoped the 'new rich' would follow the tradition of involvement in charity, Eyles (1922) op. cit., p. 51. The economic crisis in the early 1930s gave the voluntary societies a further boost, editorial in Mother and Child (1933) 4, pp. 75-76
- 77 e.g. see article by Ethel M. Mounsey, a voluntary worker in Sunderland, National Health (1920) 12, p. 157
- 78 e.g. Edith Pickton-Turbervill, Mary Stocks and Mrs. Wintringham entered public life through social work.
- 79 e.g. Ethel M. Mounsey used this argument, National Health (1920) 12, p. 156
- 80 Pickton-Turbervill (1939) op. cit., p. 51
- 81 A meeting of the Union, at which Mrs. Stanely Baldwin spoke, was reported in The Times, 28 October, 1927
- 82 This pamphlet was based on a paper read by Barbara Duncan Harris, a voluntary worker in Croydon, to a conference organised by the National Council of Social Service, quoted in Maternity and Child Welfare (1921) 5, pp. 191-192

- 83 National Health (1920) 12, p. 156
- 84 e.g. see remarks made by Mrs. Edwin Gray, the President of the York Infant Welfare Association, to the 1923 Royal Institute of Public Health Congress, reported, ibid. (1923) 16, p. 143
- 85 Unmarried mothers and crippled children were named as two groups the state would not be able to cater for, editorial in Mother and Child (1930) 1, pp. 41-142. Hilda Cashmore argued that voluntary societies could deal with individuals in a way which could not be achieved by official bodies, article in Maternity and Child Welfare (1921) 5, pp. 163-165
- 86 Editorial in National Health (1925) 17, pp. 365-366
- 87 Review of the work of the St. Pancras School for Mothers by the Chairman of the Committee of the School, Alys Russell ibid. (1928) 21, p. 11
- 88 This was the subject of anonymous letters, published in Maternity and Child Welfare (1919) 3, p. 431; (1920) 4, pp. 29-30
- 89 ibid. (1919) 3, p. 386
- 90 Reported in National Health (1925) 17, p. 217
- 91 Barbara Wootton (1967) In a World I Never Made (London: George Allen and Unwin) p. 56
- 92 Aronovitch (1974) op. cit., p. 175

C H A P T E R F O U R

COLLUSION BETWEEN LAY WOMEN, THE MEDICAL PROFESSION
AND THE MINISTRY OF HEALTH DURING THE 1920s

Women have been criticised for their failure to influence the development of the maternity and child welfare services during the inter-war period.¹ What has perhaps been overlooked is the degree of consensus between lay women's groups, the medical profession and the Ministry of Health during the 1920s. Although working-class women were raising questions about the effects of poverty, bad housing and overcrowding on women's health, and were discussing the problems associated with frequent childbearing and the need to do heavy manual work in the home, they were also enthusiastic campaigners alongside middle-class women for further medical facilities to combat illness associated with pregnancy and childbirth, and were exponents of the need for a Ministry of Health with a strong commitment to maternity and child welfare, while they recognised a need for education to prepare for motherhood. The two-fold aim of the Ministry of Health and the lay women's groups was to extend maternity services, especially ante-natal

care, to ensure that all women had access to a trained midwife, backed up by a doctor, and, if necessary, a consultant and full hospital facilities, and to educate women to use the services and follow professional advice.²

The findings presented here do not contradict this work, but the additional data have provided further insight into the attitude to maternity and child welfare of women prominent at the national level, namely their readiness to accept medical intervention in childbirth, their desire to follow the advice of paediatricians, the commitment to the belief that women were first and foremost carers and childbearers and that mothers should be helped to remain in the home and educated for that task, and an urgent desire to contribute towards the campaign to reduce maternal mortality.

The Medicalisation of Childbirth

My previous research on the role of the Ministry of Health emphasised the influence of the medical profession, demonstrating how the Ministry anticipated that medical solutions would solve the problems of high maternal mortality and morbidity as well as the persistently high neo-natal mortality rate (death in the first month of life), but the data did not draw out the change within the medical profession regarding obstetric work and its effect upon women's attitude to childbirth. These additional data provide an insight not only into women's attitude to childbirth but also throw light on women's attitude to women workers in the maternity and child welfare services.

First, members of the medical profession, who wished to

establish obstetrics and paediatrics as medical specialties, were beginning to take an interest in aspects of maternal and child welfare far removed from curative medicine (see p. 73). Secondly, women were being urged to consult a doctor during pregnancy, even if they were not ill: a novel idea for many women.³ F.J. Browne, in his pamphlet on mothercraft, claimed that nine out of ten of the problems of pregnancy and childbirth could be overcome by ante-natal care.⁴ Throughout the pamphlet, the pregnant woman was described as a patient, and she was warned that

Pregnancy, even when it runs a perfectly normal course, is a period of stress and strain.⁵

Indeed, some obstetricians argued that, owing to changes both in the shape of the pelvis, caused by a more sedentary life style, and the size of the average foetus, following mixed marriages, childbirth could no longer be considered a normal physiological process, which could be left to take its course. J.W. Burns, the honorary surgeon at the Liverpool Maternity Hospital, remarked

Probably if mankind were able to live in a natural state, that is, something akin to the wild state in animals, labour and pregnancy would be easy natural processes, and I am afraid there would be very little work for either the doctor or the midwife. Unfortunately, during the aeons of time which have passed since our ancestors enjoyed the happy, carefree atmosphere of the Garden of Eden, conditions have arisen which have so influenced and modified the human frame and its organs and their activities, that labour and pregnancy can no longer be looked upon as normal physiological processes. In fact, pregnancy ought to be looked upon as a definite disease or sickness which lasts ten lunar months and terminates with a crisis called labour. It requires the same respect as any major surgical operation. It is only by adopting this attitude towards pregnancy and labour that the medical and nursing professions can

ever hope to reduce to zero maternal mortality, maternal morbidity and foetal mortality.⁶

Some medical women shared this opinion. Dr. Kathleen Vaughan, in a letter to Time and Tide, warned readers that childbirth was no longer easy, because civilisation had changed the shape of the woman's pelvis.⁷ Dame Louise McIlroy considered that pain was one of the penalties of civilisation, resulting from the mixing of the races and the fact that modern life produced a diminished capacity to bear pain.⁸ A similar argument was used by the honorary anaesthetist at the Royal Free Hospital, Dr. Enid M. Browne, who, in an article on the need for analgesia in childbirth, remarked

This disparity [between primitive and modern women] is accounted for partly by an increased sensibility to pain, partly by the fact that woman has ceased to be natural in her habits and postures. With civilisation has come a disuse of certain important muscles and the over-development of others.⁹

These women doctors maintained that it would be the women doctors who would be best suited to provide the medical care necessary for modern women, thus placing themselves in a different category to male doctors (see Chapter Seven).

At the same time, however, the elite of the medical profession was beginning to take more interest in midwifery, and obstetric techniques were being modified. Obstetricians, anxious to establish a reputation, sought to demonstrate that skilled midwifery was comparable to a surgical operation. As their techniques developed, so a hospital environment became more essential.¹⁰

Eardley Holland, a prominent obstetrician, encouraged women to think that they should be spared the pain of labour, by the

administration of anaesthetics and by access to the services of expert doctors and midwives, working in large maternity hospitals.¹¹ The categories of patients considered to require a hospital bed and an anaesthetic were extended. Whereas, in the early 1920s, an institution was recommended only for emergencies, and when an abnormal birth was expected, by the end of the decade some doctors were suggesting that all first births should take place in hospital.¹² Dr. Isabel Elmslie Hutton recommended a nursing home for all births, as everything would be to hand.¹³ Once the number of cases a medical student was required to attend was increased in the 1920s, it was in the interest of the teaching hospitals to attract more maternity cases. George Newman, in his annual report for 1933, noted the increase in the number of hospital births, which he attributed to the increased attention given to maternity, modern housing conditions, the difficulty of getting domestic help, and the diminution of prejudice against Poor Law hospitals.¹⁴ The following year, Queen Charlotte's Maternity Hospital reported that it had to turn one in three women away owing to the high demand.¹⁵ The dramatic increase in the number of institutional confinements, however, did not occur until the Second World War.¹⁶

The obstetricians' recommendations were endorsed by some MOsH. For example, in 1925, an editorial in the Medical Officer welcomed the rise in the number of middle-class women going to a maternity home.

At all events, it would be more in accordance with the principles of preventive medicine to arrange for confinements to take place in properly equipped maternity homes, where the risk of infection is at a minimum, than to endeavour

to cure by institutional treatment cases arising in the course of domestic practice.¹⁷

The medical profession, however, was not united. The situation was complicated by the rivalry between the hospital-based obstetricians and the general practitioners.¹⁸ The general practitioners, represented by the BMA, did not endorse the arguments in favour of hospital confinements for cases other than the abnormal,¹⁹ with some arguing that anaesthesia could damage the foetus, by slowing down labour.²⁰ Suggestions were made to help women to remain at home.²¹ There is, however, no evidence of divisions between men and women doctors on this issue. Some women doctors argued that obstetrics and gynaecology should be a specialism for women, but there is scant evidence of any women doctors questioning the medicalisation of childbirth per se (see Chapter Seven). Indeed, it would be surprising to find such disagreement as all women doctors were educated according to the existing medical practice, while few women doctors felt their position in the profession was secure.

Women's Deference to the Obstetricians

Women, both middle class and working class, tended to treat doctors with deference.²² The voluntary organisations were in the habit of seeking information from technical experts and from Ministry of Health officials.²³

Both the trade union movement and the Labour Party evolved a tradition of deference to technical experts. In 1925, at the Labour Party Conference, a resolution, calling for measures to ensure that all women received adequate attention before,

during and after childbirth, was passed. Mr. H.M. Schofield moved this resolution to

make it possible for working-class mothers to be spared a great deal of the suffering and the unscientific treatment they had to undergo.²⁴

Those doctors who were sympathetic to socialist principles tended to advocate reliance on specialists. The Socialist Medical Association (SMA), which had close links with the Labour Party, was firmly committed to the medicalisation of childbirth. In 1932, the Labour Party published a memorandum, entitled The People's Health, produced by Dr. Somerville Hastings of the SMA. The section on maternity care acknowledged that some reduction in maternal mortality was to be expected as a result of improved standards of life, but careful and repeated pre-natal examinations, carried out by doctors with special experience, were of equal importance. Attempts should be made to encourage all women to give birth in a maternity hospital.²⁵ This document was not official party policy, but Somerville Hastings was an influential figure in the Labour Party, and especially at the local level on the London County Council (LCC).²⁶ SMA ideals were expounded to the National Conference of Labour women by Dr. Edith Summerskill. In 1936, when a resolution was put demanding a national maternity service, with ante-natal facilities for all women, more maternity beds in hospitals, and more money for training midwives, Edith Summerskill supported the resolution:

She did so because it stressed the need for adequate medical attention She also urged that there should be better facilities in the medical schools for the study of obstetrics and begged the conference to keep on pressing for these She wanted delegates

to remember that 12% of all women who died, did so following an abortion, and 37% died following some infection. It was easy to say that malnutrition was a primary factor in the problem - it was not so. It contributed largely, but the real factor was the lack of good maternity services.²⁷

Subsequently, she told the House of Commons that no birth could be considered normal until after the event.²⁸ The SMA did not demand that obstetric work become the province of women doctors.

Both the WCG and the FWG favoured the extension of medical services, including the provision of more hospital beds. At the WCG's 49th Annual Congress in 1932, a resolution was passed which demanded that a maternity hospital, with an operating theatre and a free ambulance service, be provided in every town with a population over 4,000.²⁹ After the Second World War, the WCG, discussing maternity services, recommended that the country be divided into areas, based on university medical centres. The WCG wanted more hospital facilities, with more specialists in obstetrics, women's diseases and child health, as well as general practitioners, who specialised in maternity work.³⁰ In 1939, the Fabian Society produced a pamphlet on the maternity and child welfare services, which acknowledged that milk and food should be more readily available, but the need for ante-natal care, hospital beds and a service of specialists, coupled with the need to improve administration, was given priority.³¹ The WCG and the FWG were perhaps influenced by the example of some of the London hospitals covering poor working-class areas, notably in the East End, which provided evidence of what could be achieved by a good medical service.³² It is notable that, whereas these women's organisations

were always anxious to point out that mothers preferred to see a woman doctor at a welfare centre, there was no mention of any preference for a woman obstetrician.

Meanwhile, the journals representing the interests of the old feminists tended to assume that any matter which involved high mortality and morbidity must be a medical matter, requiring a medical solution. An editorial in Time and Tide, for example, said the country had been shocked by the publication of the figures on maternal mortality, and by the reports of the CMO of the Board of Education on the physical standards of school children: something must be done, and the cure lay in the hands of the medical profession. There was a need for more hospitals, more medical facilities, and for more doctors for both preventive and curative work. Readers were urged to support the Royal Free Hospital's appeal for funds to build a new maternity unit.³³

Leading middle-class feminists, including some women MPs, were advocating reliance on specialists. Leah Manning informed the House of Commons, in 1931, that the official reports of the Ministry of Health and those of the BMA showed that the preventable deaths occurred because there was a lack of specialist help. Women, she declared, needed more gynaecologists and obstetricians.³⁴ Vera Brittain, who herself went to a nursing home for the birth of her children, in her novel, Honourable Estate, advocated that women should undergo childbirth with 'every alleviation that science could provide'.³⁵ Naomi Mitchison, who had children during the 1920s, stated that, at that time, women thought of childbirth with alarm and excitement. She described the experience as 'going into battle', with every possible ally brought in to help. For her this

meant a Harley Street specialist and a monthly nurse.³⁶

There was some criticism of doctors, but this was not common, and was based, generally, on dissatisfaction with their treatment of certain classes of patient, and did not present a serious challenge to medical expertise. In 1922, Time and Tide published an anonymous article suggesting that doctors did not give enough time to working-class women, because the fees were not large enough, and the doctor had to make a living.

If doctors cannot afford to attend these patients properly for the customary fee, let them say so and help us all to find a remedy. The present state of affairs is discreditable; there are sad happenings in humble homes and one wonders that the profession has not, long ere this, arisen and purged itself.³⁷

There were isolated complaints of the profession failing to acknowledge when mistakes had been made. At the Fifth Maternal Mortality Conference, organised by the Maternal Mortality Committee in 1930, one speaker accused doctors of shielding one another through thick and thin, and demanded a coroner's inquiry into any death in childbirth.³⁸ Similarly, in 1934, following the death of a young Manchester woman, which attracted national publicity, there were complaints that, while medical personnel had admitted privately that the case had been mismanaged, when it came to the public inquiry, no one was willing to speak against a colleague.³⁹

Some general practitioners were thought not to be competent to undertake midwifery, but this was attributed to lack of practice and lack of time. Sylvia Pankhurst, in a book published in 1930, did criticise some general practitioners for using forceps incompetently, and for failing to use aseptic

techniques when removing the placenta. She suggested such doctors should be struck off the medical register.⁴⁰ Furthermore, she criticised the BMA's maternity scheme, published in 1929, as it recommended the abolition of ante-natal clinics, and it did not intend to allow midwives to call a specialist or send a case to hospital.⁴¹

I cannot escape the conclusion that this scheme of the British Medical Association, though not without merit, would benefit the medical profession considerably more than the mothers it purports to safeguard.⁴²

Nevertheless, she did not wish to exclude doctors from childbirth, advocating that a doctor should be present at all confinements, with a midwife acting as the assistant.⁴³ She even defended the doctors, pointing out that the high maternal mortality rate for their cases could be accounted for, first, because the nursing was left to untrained women, and, secondly, because doctors generally had to cope with the more difficult cases.⁴⁴

Obstetricians tended to escape criticism from lay women. Perhaps this is not surprising. Many women, who needed operative assistance owing to pelvic deformity or the presence of an inter-current disease, were unable to receive medical treatment, while there was scope to improve operative techniques in midwifery. The predominantly male obstetricians and gynaecologists thus had the wholehearted support of many women. These doctors were perceived to be advancing scientific knowledge. The fact that they were generally male was not considered relevant. The aim was to save women's lives and the advancement of women in the profession was treated as a sepa-

rate issue.

The journal Maternity and Child Welfare remained an advocate of home confinements. In 1926, a leading article argued that childbirth should be an intimate family affair, and pointed out that childbirth in the poorest homes seemed to be just as safe as in the labour wards.⁴⁵ In 1931, the journal suggested that obstetric interference and the use of anaesthetics might account for the high maternal mortality rate amongst the 'well-to-do' and the 'good working class'.⁴⁶ This opinion was shared by Janet Campbell after her retirement from the Ministry. She argued that there was more risk of infection in an institution, where a woman would be exposed to infection to which she had not built up an immunity.⁴⁷

This enthusiasm for home confinements, however, was not shared by the other journal catering for the interests of the voluntary and professional workers in maternity and child welfare. During the 1930s, Mother and Child, which replaced National Health in 1930, criticised the BMA for its assertion that normal births were safer at home. The journal quoted the example of Willesden and Huddersfield, to illustrate that hospital confinements were both safe and popular with mothers.⁴⁸

Lay women were anxious to extend hospital facilities, and to ensure the availability of anaesthetics. There were also reports in the maternity and child welfare journals of women demanding not only pain relief but also a speedy end to labour by the use of forceps.⁴⁹

Whereas, previously, women had undergone difficult manipulative deliveries and even some surgical procedures at home, during the inter-war period it became acceptable not only to

go to an institution for a complicated delivery, but also for normal births.⁵⁰ Lady Baldwin argued that all first births should be in hospital.⁵¹ Methods for relieving pain during labour were being improved. It is well-known that, in the nineteenth century, Queen Victoria had been given chloroform, making it instantly respectable amongst the upper classes. During the early twentieth century, new techniques were introduced, and pain relief became accessible to more women. In 1919, the first Twilight Sleep Home was opened.⁵² Midwives, however, were prevented from using anaesthesia or analgesia until the late 1930s, thus women who wanted this service were encouraged to seek a hospital confinement, which often would have been cheaper and easier to arrange than booking a doctor and an anaesthetist to attend privately (see pp. 265-271).

Moreover, there were other reasons for seeking a hospital birth. Some of those campaigning for working-class women to be able to have hospital births did so simply because they believed these women should have access to all the services presently available to middle-class women. Mrs. Stanley Baldwin, for example, used this argument when she conducted the campaign, launched in 1929, to raise funds for the provision of anaesthetics for working-class women.⁵³ Others saw the hospital as a place where working-class women could be taught mothercraft.⁵⁴ One MP, Dr. Vernon Davies, argued for an increase in the number of hospital beds available for maternity cases, basing his argument on the need to remove women from the influence of interfering grandmothers.⁵⁵

Meanwhile, the housing shortage prompted others to advocate institutional confinements. James Fenton, the MOH for

Kensington, wanted hospital beds to be available, both for those in inadequate housing and for married domestic servants, who often could not be confined where they lived.⁵⁶ The Medical Officer, a journal designed for doctors working in government and municipal service, claimed that those, forced by the housing shortage to have their first baby in hospital, elected to have subsequent babies in the same 'well-ordered surroundings'.⁵⁷ Sylvia Pankhurst advocated more hospital accommodation as most working-class homes were not large enough for a confinement.⁵⁸ Furthermore, she pointed out that many women exhausted themselves immediately prior to the birth, because they felt compelled to clean the house before strangers entered.⁵⁹

In 1926, during the annual debate in the House of Commons on the civil estimates for the Ministry of Health, Lt.-Col. Fremantle, who was also the County Medical Officer for Hertfordshire, recommended that maternity homes be seen as a temporary feature of the maternity service, as they would be necessary only until housing conditions improved.⁶⁰ Ellen Wilkinson, from the Labour benches, however, disagreed, arguing that these homes should become a part of normal life.⁶¹

In 1938, Edith Summerskill told the House of Commons that women, when not unduly pressed by their husbands, would say they preferred a hospital birth, away from children, housekeeping, husbands and noise. Furthermore, she stated that women in the industrial areas were clamouring for accommodation.⁶² It is not, however, easy to determine the accuracy of this statement. While the leaders of the women's organisations made their opinions apparent, it is not always evident that their enthusiasm

was shared by ordinary working-class women, faced with the problem of running a home, and with little experience of life outside their immediate neighbourhood. Certainly, there was criticism of hospitals. Previously, they had seemed awesome places to many women, associated with acute illness.⁶³

Many of the hospitals imposed strict rules, which must have deterred some women. First, it was common for hospitals to overbook, and not to accept a woman until she was in labour. In 1922, the Standing Joint Committee of Industrial Women's Organisations (SJC)⁶⁴ contacted sixteen London hospitals, which dealt with confinements. It found that practically all the hospitals admitted women only when labour had begun. Six of the hospitals did not reserve beds, although they did have a procedure for emergencies. This inquiry was undertaken in response to the case of a woman, with an admission ticket for St. Thomas's, who was forced to walk home while in labour, because no bed was available, and who gave birth only ten minutes before the nurse arrived.⁶⁵ There is evidence that similar practices continued during the 1930s.⁶⁶ Secondly, as there was no ambulance service, there was a real fear of giving birth on the journey to the hospital, which would often have been undertaken on public transport.⁶⁷ Some districts, during the inter-war period, however, did begin to experiment with the use of ambulance services.⁶⁸ Thirdly, visiting was strictly limited. Queen Charlotte's, for example, allowed no visits to married women until the fifth day, while the unmarried could not receive a visitor until the eighth day after the birth. A survey of maternity hospitals found that half permitted husbands to visit every evening, but others restricted visits to

two or three times a week.⁶⁹ Finally, many hospitals imposed strict entry requirements, accepting unmarried women only if it was their first pregnancy, thus excluding some of those who might have been in need of a hospital bed.⁷⁰ A report, prepared for discussion at the 1924 National Conference of Labour Women, complained that most maternity hospitals discriminated against 'bad characters', while some would take only abnormal cases.⁷¹

Janet Campbell, in her 1927 report on maternal mortality, claimed that the majority of working-class women wanted to have their babies at home, because of the dread of what would happen to the family in their absence, and the difficulty of providing for the household during an absence.⁷² A midwife, Katherine Gillett-Gatty, remarked

The women, themselves, are against extradomestic delivery. Those who know the lives of those eligible, through the size of their incomes, for state insurance know the necessity of the presence of the mother, that amazing Chancellor of the Exchequer, in the 'Little House'. Even in labour she is budgeting for her domain. Away from her husband and children all falls to chaos in her microcosm.⁷³

The MP for Durham, Mr. Ritson, told the House of Commons, in 1936, that the Mrs. Gamp in his area had done good work, and that his mother would not have had anyone else; he had tried, without success, to persuade working-class women in the area to go into an institution, but they did not want to leave their relatives and neighbours.⁷⁴ Winifred Holtby, in her novel, South Riding, based upon her knowledge of life in that area of Yorkshire, stated that women were reluctant to send members of their family to hospital, because it was unpredictable and they liked to know what was happening, while handy women were popular

because they were readily accessible, cheap and known in the community.⁷⁵ Sylvia Pankhurst pointed out that some hospitals, including Queen Charlotte's, would take women only with a letter from a governor or subscriber, a common practice amongst the voluntary hospitals, and many women were reluctant to write begging letters to these people.⁷⁶

Some women, mainly from the working class, were averse to the use of anaesthesia, as it was associated with obstetric disaster, while the avoidance of pain was seen as morally wrong.⁷⁷ It seems probable, however, that these prejudices were being broken down, at least in some areas. In 1931, the Honorary Treasurer of Queen Charlotte's reported that, since 1928, less than 1% of its patients had refused anaesthesia.⁷⁸ The following year, in a letter to the British Medical Journal (BMJ), Dame Louise McIlroy, one of the few women obstetricians, criticised the journal's enthusiasm for the Dutch midwifery system, which did not use anaesthesia, stating that, in her experience, the relief of pain was beneficial, and that all women attending the Royal Free Hospital were demanding its use.⁷⁹ In 1931, the Central Public Health Department of the LCC decided to carry out an experiment in some hospitals of making light anaesthesia available in childbirth. Although there was known to be some prejudice against its use, about 90% of the patients were expected to use the service.⁸⁰ Two years' later, the LCC was able to report that anaesthesia had been administered to 3,729 patients in eight LCC hospitals.⁸¹ No doubt the fact that the National Federation of Women's Institutes (NFWI) and the WCG were campaigning for the provision of free anaesthesia drew more women's attention to the possibi-

lity of pain relief.⁸²

Margaret Bondfield campaigned to break down women's prejudice against maternity homes, which she attributed to ignorance of the care that would be given and fear as to likely costs. She considered that maternity homes were being accepted because of bad housing, and

because the growing complexity of modern civilisation created a category of cases that required far more expert attention than the ordinary general practitioner could give.⁸³

Margaret Bondfield argued that women from poor homes should go into a maternity home even for a normal confinement, and should have the benefit of all 'the modern appliances science can devise'.⁸⁴

In certain areas, women seemed to respond to this campaign, and to the advice given by the women's organisations. It is known that some healthy working-class women sought a hospital confinement because they thought this would provide them with the best available care.⁸⁵

Although it was not until after the Second World War that a majority of women attended a hospital for childbirth, there is ample evidence that the leaders of the lay women during the inter-war years were committed to the need to extend maternity and child welfare, and favoured the medicalisation of childbirth, thus providing evidence of their accord with the Ministry of Health's intention to identify the medical causes of maternal mortality and to extend and improve the maternity and child welfare services. These lay women were thereby supporting the generally male obstetricians at the expense of the general practitioners and the independent midwives. Although

some of these women did not imagine medical services would solve all their problems,⁸⁶ they regarded these services as vital. Indeed, the fact that some working-class women lived in poverty and were poorly housed was used as a further justification for the need for hospital services. Moreover, these lay women wanted to play an active part in the Ministry of Health's plans to develop the maternity and child welfare services.

The Guardians of the Nation's Health: Women's Recognition of the Importance of the Maternal Role

In conjunction with the reliance on the need to extend medical facilities and to raise standards within the midwifery service, the Ministry of Health recognised that the co-operation of women themselves was vital. A key element in the Ministry's strategy was the education of the public in the importance of motherhood and the campaign to encourage women to seek instruction and advice on all aspects of pregnancy and child care.⁸⁷ During the 1920s, various public health officials advocated that school girls should be trained for motherhood.⁸⁸ Concern over the effects of a declining birth rate led to statements urging women to regard motherhood as a national duty.⁸⁹

These sentiments were endorsed by women members of the public health service. Dr. Lillian Ethel Wilson, for example, a medical officer at the Board of Education, wrote in 1929:

The object of educating children is to equip them for the duties and responsibilities of life, and if a girl leaves school ignorant of one of the most important duties which may subsequently devolve upon her, our system of education can hardly be said to have fulfilled its aim

The source and strength of a people depends primarily on motherhood. The health of the in-

fant is largely dependent upon its mother - upon her physical well-being, her knowledge of the care and management of her infant and her control of its food and environment. The fundamental requirement in regard to healthy infancy, which is the gateway of childhood and school life, is healthy motherhood combined with the knowledge and practice of mothercraft and fathercraft.⁹⁰

Many lay women welcomed such statements. We saw in Chapter Two that a number of women, notably a section of the NUSEC, the SJC and the WCG, wanted women's work as mothers and housewives to be recognised and accorded a status comparable to waged work outside the home. These women, therefore, welcomed the opportunity to emphasise women's role as health carers, and were anxious to participate in the work of the municipal maternity and child welfare committees, set up under the 1918 Maternity and Child Welfare Act, although this did not imply that they wished to exclude technical experts. Differences between the middle-class volunteers and the representatives of working women, however, remained apparent. Middle-class voluntary workers were expected to join these committees,⁹¹ while the WCG wished to ensure that the committees were run according to the needs of working women: it felt 'ladies' who sat on charitable committees might be out of touch with the working women's point of view.

Working women must be given a voice in shaping the policy to be pursued and in deciding the ideas to be instilled: otherwise there might be a danger of scientific, eugenic, and official views of the work overriding individual and family rights. Any attempt to impose compulsion of the mother in work of this intimate and personal character would only hinder progress.⁹²

Guildswomen, therefore, were urged to seek election on to the municipal maternity and child welfare committees.⁹³

Both the SJC and the Labour Woman were anxious that women should form a majority on the Consultative Council on General Health Questions.⁹⁴ The SJC, on hearing that the Ministry of Health was to set up consultative councils of 'persons having practical experience', argued for women representatives, stating

Women are in a very special sense the guardians of health. They take more interest in health than men do; they have a larger share of ill-health; on them falls the nursing of those who are ill; above all, the health of future generations is bound up with that of women as mothers.⁹⁵

Both the Labour Woman and Eleanor Rathbone argued that women were the 'custodians of the nation's health'.⁹⁶

Demands for maternity and child welfare services, and in particular for the payment of cash allowances to mothers, were invariably justified on the grounds that mothers were performing a service to the state.⁹⁷ Leonora Eyles, for example, argued that the state should realise that

The mother is its greatest servant, and quite as deserving of payment as the soldier or the civil servant,⁹⁸

A review in the Labour Woman praised Leonora Eyles' book on working-class women in the home, because it recognised that motherhood was a service to the nation.⁹⁹ A similar argument was used by Ellen Wilkinson, when she called for widows' pensions in her maiden speech in the House of Commons:

These women are performing a service to the State, for they are bringing up their children for the State.¹⁰⁰

She used the same argument in her presidential address to the National Conference of Labour Women.¹⁰¹

Eleanor Barton justified the demand of the WCG for the

powers given to the local authorities under the 1918 Maternity and Child Welfare Act to be made compulsory because

The mother is surely entitled to all the medical skill and care that can be provided, for she is rendering to the State the highest service that can be given.¹⁰²

The medical profession encouraged the belief that all normal women would want to have children. Dr. Leonard F. Browne, physician to the Tavistock Square Clinic for Functional Nervous Disorders, in an article on the psychology of mothers, claimed

Most women when they marry look forward to motherhood as their greatest glory, and a great many husbands look forward to being fathers The wife feels that whatever difficulties married life and pregnancy may hold, the baby compensates for everything.

. As soon as she realises she is pregnant she experiences a feeling of satisfaction, which is really the joy of creation. She has a great feeling of importance: she has become more than just herself. This importance should be recognised by everyone concerned, for the mother is of great value to the State, and motherhood should be just as much honoured as any other form of service.¹⁰³

In 1935, Laura Hutton published a book designed to help single women cope with childlessness. She anticipated that all normal women, prevented from marriage, would have to cope with frustrated-maternal instinct. Apart from a small group of women of 'exceptional quality', who derived satisfaction from work, Laura Hutton considered that the absence of eligible men, or a medical complaint, would be the only reasons for remaining single.¹⁰⁴

The shortage of young men after the First World War led people to anticipate that a number of women would be unable to

marry. Violet Markham thought that it would be necessary to bring young girls up with 'very special ideals of service and duty', as they would be forced to sacrifice their hopes for personal happiness.¹⁰⁵ Margaret Bondfield, in an interview given to the Vote, following her adoption as a parliamentary candidate, also referred to the many women who would be unable to marry. She urged women to regard

the vocation of public service as a priceless opportunity to mother the race in connection with our health services, in connection with our schools, in connection with administrative bodies, and above all, in connection with moulding the legislature of our country.¹⁰⁶

Those involved with the voluntary societies were enthusiastic proponents of the need to educate girls for motherhood, but they were careful to make a distinction between mothercraft, for which training was deemed necessary, and mother instinct. Miss J. Halford, the secretary of the NLH, for example, distinguished between 'mothering', which came naturally, and 'mothercraft', which had to be taught.¹⁰⁷ Teachers of mothercraft referred to the innate maternal instinct which these classes revealed.¹⁰⁸ Hester Viney, a health visitor for Dorset County Council, informed readers of National Health that homecraft and mothercraft classes in schools had proved to be of value to the nation and to the individual.

These are subjects which make a definite appeal to girls and which evoke a very warm response; they arouse in the girl the natural instinct of her sex, and develop in her the maternal capacity which produces her at her best as a woman.¹⁰⁹

An editorial in National Health, in 1926, reminded readers:

Mothercraft is not mother-instinct as some

folk even in these enlightened days seem to think. Mothercraft is at once an art and a science to be studied and acquired through sound teaching and example rather than by experience which usually comes too late.¹¹⁰

Some of the contributors to the WCG book on maternity considered they had done their duty to the nation by having children. Two of them pointed out that healthy children would be an asset to the state.¹¹¹ Those who suggested birth control information should be made available never stated they wanted to avoid childbirth.¹¹²

In common with the WCG, the Labour Woman assumed that many of its readers would be mothers, who would wish to see items on child care in the journal.¹¹³ In 1927, the Labour Woman began a series of articles on the nurture of children, written by Beatrice Green, who was described as a teacher and working-class mother. In her first article, she suggested

Motherhood might be regarded as the climax of life's human experience and provided that a woman has decent and proper facilities for rearing her off-spring and carefully looking after their all round development, there is nothing so full of joyous possibilities.¹¹⁴

Meanwhile, the Women's Leader declared that the dangers of a declining population must be overcome, by convincing people that parenthood was a 'duty of citizenship'.¹¹⁵

During the 1930s, however, there was support for eugenic arguments from both middle-class women's groups, voluntary associations and working women's groups, notably the WCG, with advocacy of sterilisation of the unfit.¹¹⁶ The concept of sterilisation was soon discredited by events in Nazi Germany,¹¹⁷ but it does provide further evidence of the widespread commitment to the achievement of an A1 nation, and a recognition of

parental responsibility in its widest sense. It also provides an example of a willingness to defer to medical opinion.

This emphasis on the importance of motherhood tended to obliterate the campaign to enable women to have equal opportunities with men in the work place. Perhaps unwittingly these maternity and child welfare campaigners were lending their weight to arguments that women in employment should be confined to non-technical domestic matters, following the initiative of male technical experts who would devote the whole of their working life to an occupation outside the home.

Despite this consensus of opinion amongst a section of lay women and the Ministry of Health, women were given little opportunity to play an active part in the administration of the health services.¹¹⁸ Their opinion was rarely sought either on the needs of mothers or on the most convenient mode of providing services. The evident dissatisfaction of Labour and working women at the lack of effective representation was largely ignored by the Ministry.¹¹⁹ This failure to permit women to have an effective say in the administration of services encouraged women to use their own organisations to put pressure on the Ministry. Moreover, the Ministry's failure to act on Janet Campbell's recommendations for measures to be taken to reduce the maternal mortality rate¹²⁰ inspired women from disparate organisations to unite to campaign for services deemed likely to reduce the maternal mortality rate. In 1927, a lay committee was formed to campaign for maternity services. This committee's achievements were significant, and give an example of the unity of purpose amongst middle-class and working-class campaigners for maternity and child welfare during the

late 1920s as well as their continuing desire to work with the Ministry of Health.

The Maternal Mortality Committee

The history of this Committee, founded in 1927, particularly in its early years, provides evidence of the cohesion between middle-class and working-class women over the need to take steps to tackle maternal mortality, and these women's support for the tactics advocated by the medical profession and the Ministry of Health. In common with the Ministry, the Maternal Mortality Committee asserted that the first priority must be the reduction of maternal mortality, and links were made with the beneficial effect such a reduction would have on infant health.¹²¹ Likewise, the Committee and the Ministry anticipated that maternal health could be improved by implementation of the 1918 Maternity and Child Welfare Act: both wanted, first, a midwife to attend every case, to act either as a midwife or a maternity nurse; secondly, a doctor to do ante-natal and post-natal examinations and to attend as necessary; thirdly, the availability of a consultant when required by the general practitioner; fourthly, hospital beds for those in need of institutional care; and, lastly, ancillary services to include transport, sterilised equipment, laboratory facilities and home helps.¹²²

The Ministry of Health welcomed the advent of a committee with these aims, as the government had decided that the 1918 Act should not be made mandatory, while the Ministry was anxious to exert pressure on the local authorities to make use of their powers under the Act.¹²³ The Committee's strategy of, first,

directing the public's attention to the persistently high maternal mortality rate, and, secondly, putting pressure on the local authorities to implement the 1918 Act thus corresponded to the needs of the Ministry of Health. Consequently, the Minister, George Newman and Janet Campbell were willing to address the large conferences which the Committee used as the means of conveying its message.

Women from a wide variety of backgrounds were keen to be associated with the Committee. Gertrude Tuckwell, the secretary and prime mover, and May Tennant, the chairman, could draw on the links they had forged with Labour and Liberal women and women trade unionists during thirty years' involvement in public service.¹²⁴ They had been outspoken advocates of protective legislation for women working outside the home in recognition of women's maternal role, and had turned their attention particularly to maternal health after the First World War.¹²⁵ Committee members included women from all the major political parties, the NFWI and the WCG, as well as representatives from religious groups and some of the leading women doctors. Janet Campbell was asked to join, and expressed her sympathy for the Committee's aims, but did not accept because of her civil service job.¹²⁶

The first two conferences, held in October, 1927, and February, 1928, were huge successes, both being widely reported in the press, with the Queen sending a message of support.¹²⁷ Indeed, the success of these two conferences was one of the factors precipitating the Ministry of Health's decision to announce the appointment of two departmental committees, the Bolam Committee and the Newman Committee, to investigate the

training and employment of midwives and the causes of maternal mortality and morbidity.¹²⁸ The Maternal Mortality Committee welcomed the announcement of both these Committees.¹²⁹ Meanwhile, a survey, completed in 1928, revealed that only 61 of the 116 local authorities investigated were using more than half their powers under the 1918 Act.¹³⁰ At the same time, the voluntary organisations were beginning to turn their attention to the welfare of mothers instead of concentrating exclusively on infants.¹³¹ The Maternal Mortality Committee seemed to have a clear-cut objective and to be having an impact.

Both the Bolam Report, published in 1929, and the Interim Report of the Newman Committee, published in 1930, recommended a national maternity service,¹³² which was not dissimilar to the model schemes already published by the BMA and the MWF.¹³³ These reports were well received in the national press, and by lay women's organisations, including the Maternal Mortality Committee,¹³⁴ and the Soc.MOSH.¹³⁵ Some Labour women, however, expressed reservations, pointing out the shortcomings of the Newman Committee's investigations. These women were anxious that the need to improve social conditions be remembered. Mrs. Rackham, the chairman of the SJC, reminded Labour women that the Newman Committee's recommendations were not comprehensive. She urged women to take up the challenge, to ensure that services were brought together and the problems of poverty, overcrowding and ignorance were tackled.¹³⁶ Mrs. Agnes Adams, a councillor in Northampton, pointed out that it was exclusively a medical report.

Whilst recognising the magnificent, and almost monumental character of their work, one feels that at least some portion of the evidence should

have been drawn from the people most concerned
- the mothers.¹³⁷

Furthermore, she commented upon the similarity between the Newman Committee's report and that produced by the SJC for the National Conference of Labour Women.

Indeed, one almost feels that in 1928, at the Portsmouth Conference [of Labour women] the SJC could have told any Government Committee or Department exactly what was required, and what I hope, the women of this country mean to have.¹³⁸

Despite the generally favourable response to the Departmental Committees' call for a national maternity service and the Labour Party's apparent commitment to the need for a major initiative to tackle maternal mortality,¹³⁹ the Labour government failed to take positive action to create a national maternity service.¹⁴⁰ By 1932, when the Newman Report was published, the economic situation had deteriorated with the National government replacing the Labour government. All thought of a national maternity service was shelved, with the emphasis placed instead on what could be achieved without further legislation or additional expense.¹⁴¹

The voluntary societies were ready to follow the Ministry of Health's new tactics. Others, however, chose to widen the debate, to discuss maternal morbidity and to raise the question of the links between poverty, diet and maternal ill health. This effectively marked the end of the unity between the Ministry of Health and the Maternal Mortality Committee, as well as the end of the accord between the welfare societies, women politicians from the major parties and the working women's organisations. During the 1930s, several factors led to a fragmentation of the maternity and child welfare movement. These will be discussed in the next chapter.

NOTES AND REFERENCES

- 1 see Chapter One, pp. 9-12
- 2 see Palmer (1978) op. cit.
- 3 Although there was a dispute within the medical profession over whether ante-natal care should be given at a clinic or by a general practitioner, there was no disagreement over the principle of ante-natal care, which, it was argued, would help to reduce maternal mortality, the still birth rate and the neo-natal mortality rate.
- 4 Browne (1934) op. cit., pp. 7-9
- 5 ibid., p. 12
- 6 This is an extract from an address given to post-graduate midwives in Liverpool, which was published also in Maternity and Child Welfare, which was, at that time, the official journal of the NCMCW, Maternity and Child Welfare (1928) 12, pp. 369-370
- 7 Time and Tide (1930) 11, p. 1633
- 8 Report of the conference of the International Association of Medical Women, held in Paris, Maternity and Child Welfare (1929) 13, pp. 274-276
- 9 Article, ibid. (1933) 17, p. 135
- 10 Jane Lewis has pointed out that doctors, as well as introducing new mechanical methods, began to insist upon rigorous antiseptic procedures for all labours, similar to those used in preparation for a surgical operation, and recommended that the delivery position be changed, Lewis (1980) op. cit., pp. 126-127
- 11 A Baby Week address, quoted in Maternity and Child Welfare (1928) 12, pp. 236-237
- 12 e.g. letter signed by J.C. Ryder Richardson, BMJ (1929) ii, p. 368
- 13 Hutton (1938) op. cit., p. 88 (this book was first published in 1923)
- 14 He quoted the figures for Manchester, which he considered representative of urban areas. Hospital births had gone up from 10.9% in 1924 to 40.36% in 1933, On the State of Public Health (1934) pp. 78-79
- 15 Letter signed by the superintendent of Queen Charlotte's Maternity Hospital, published in The Times 17 November, 1934
- 16 Ann Oakley attributes the increase in the Second World War to the dislocation caused by the evacuation, Oakley (1984)

- op. cit., pp. 116-118. Jane Lewis notes that in 1944 the Royal College of Obstetricians and Gynaecologists estimated that 70% of births would be in a hospital, Lewis (1980) op. cit., p. 132
- 17 Medical Officer (1925) 33, p. 129
 - 18 Honigsbaum, in a comprehensive study of the divisions within the medical profession, has traced a rift between hospital-based consultants and general practitioners, which was fostered by the introduction of the national health insurance scheme in 1911, Honigsbaum (1979) op. cit., pp. 7-21
 - 19 The BMA published a maternity scheme in 1929, which was based on a domiciliary midwifery service, BMJ (1929) i, Supplement, pp. 258-262. The BMA advocated this type of service throughout the 1930s, e.g. a report in The Times 26 March, 1936
 - 20 Medical women at the conference of the International Association of Medical Women were divided on this issue, reported in Maternity and Child Welfare (1929) 13, pp. 274-276
 - 21 e.g. Dr. Helen Jardine suggested that a home helps service would be a way of reversing the trend in favour of hospital births, letter to the BMJ (1936) i, pp. 773-774
 - 22 Bella Aronovitch, writing of her experience as a patient in the late 1920s, remarked that patients had faith in the doctors because they wrote in Latin, spoke about strange matters and entered the wards like royalty, Aronovitch (1974) op. cit., p. 39
 - 23 e.g. the national conferences on maternity and child welfare, organised annually by the National Association for the Prevention of Infant Mortality on behalf of the NCMCW, always had leaders of the medical profession to address the sessions, while the conference was opened by a senior politician, often the Minister of Health or his parliamentary secretary.
 - 24 Report of the Annual Conference of the Labour Party (1925) (London: Labour Party) p. 295
 - 25 Somerville Hastings (1932) The People's Health, memorandum published by the Labour Party, pp. 12-13
 - 26 For an outline of Somerville Hasting's role within the Labour Party see Honigsbaum (1979) op. cit., pp. 327-328
 - 27 Quoted in the Report of the Seventeenth National Conference of Labour Women (1936) (London: Labour Party) pp. 43-44
 - 28 PP (1938) 338, cols. 3405-3406
 - 29 WCG (1932) 49th Annual Report, p. 23
 - 30 WCG (1946) Maternity services in my area, Notes for Speakers, Hull DCW 5/26

- 31 Fabian Society Research Bureau, Health Services Subcommittee of the Social Services Committee (1939) The Maternity and Child Welfare Services (London: Fabian Society Research Bureau)
- 32 e.g. McCleary quoted the figures for the East End Maternity Hospital, which had a maternal mortality rate of 0.68 between 1921 and 1928, McCleary (1935) op. cit., p. 181. Other hospitals in poor areas with particularly good records included Plaistow Maternity Hospital, which covered the poor area of West Ham. It claimed a maternal mortality rate of 1.04 over twenty-four years, reported in The Times 27 March, 1935. Similarly, King's College Hospital, Denmark Hill, which covered Peckham, Camberwell and New Cross, had an excellent record, with only one death, an emergency case, in eighteen months, reported in Time and Tide (1922) 3, p. 709
- 33 Time and Tide (1928) 9, pp. 675-676
- 34 PP (1931) 255, col. 2399
- 35 Brittain (1936) op. cit., p. 506
- 36 Naomi Mitchison (1979) You May Well Ask, a Memoir 1920-1940 (Victor Gollancz) pp. 31-32
- 37 Time and Tide (1922) 3, p. 662
- 38 Reported in the BMJ (1930) ii, p. 753
- 39 This complaint was made by Mrs. M. Anderson, North West Organiser of the Women's Section of the Labour Party, in a report on the death of Molly Taylor in a Manchester hospital, Labour Woman (1935) 23, p. 11. A similar criticism was made by the Manchester Guardian, in its report of the case, which was reprinted in Time and Tide (1934) 15, pp. 1534-1535. Indeed, Time and Tide claimed that this was not an isolated case.
- 40 Sylvia Pankhurst (1930) Save the Mothers (London: A.A. Knopf) p. 140
- 41 see BMJ (1929) i, Supplement, p. 260
- 42 Pankhurst (1930) op. cit., p. 140
- 43 ibid., p. 97
- 44 ibid., p. 102
- 45 Maternity and Child Welfare (1926) 10, pp. 299-301
- 46 ibid. (1931) 15, pp. 253-254
- 47 Campbell was worried also about the shock of transfer from hospital to home on convalescence and lactation, editorial, based on Campbell's views, Mother and Child (1936) 6,

- pp..432-434; and paper read by Campbell at the 1936 National Conference on Maternity and Child Welfare, quoted in Mother and Child (1936) 7, pp. 173-174
- 48 Editorials, ibid., pp. 1-2 and 42-42
- 49 e.g. Maternity and Child Welfare (1928) 12, pp. 113-114
- 50 A contributor to Time and Tide referred to the benefit a woman derived from
- the complete rest and freedom from worry that she can enjoy within the carefully guarded walls of a hospital ward.
- Helen M. Turner, Time and Tide (1922) 3, p. 709
- 51 Remarks made when opening a new maternity unit at West Kent Hospital, reported in The Times 27 October, 1937
- 52 Twilight sleep was a form of analgesia, popular in the 1920s in this country and in America, but which was later abandoned as being unreliable, report on the opening of the first home in The Times 4 April, 1919
- 53 This campaign formed part of the activities of the National Birthday Trust Fund, which was set up in 1928 by Lady George Cholmondeley to provide funds for maternity services and to educate public opinion as to the high maternal mortality rate. Initially, people were asked to donate one shilling on their birthday. In the following year, in an attempt to raise more money, people were requested to give one shilling or one pound for every year their mother was alive, reported in The Times 25 October, 1929
- 54 e.g. two correspondents in Maternity and Child Welfare recommended that working-class women should have their babies in hospital, so they could be taught the correct way to feed the infant, as well as to enable the mothers to have some good food and exercise, Maternity and Child Welfare (1926) 10, pp. 27-28
- 55 PP (1930) 237, cols, 1018-1021
- 56 Article in the Medical Officer (1928) 39, pp. 197-199
- 57 Editorial, ibid. (1930) 44, p. 65
- 58 Pankhurst (1930) op. cit., p. 38
- 59 ibid., p. 32
- 60 PP (1926) 198, col. 282
- 61 ibid., col. 286
- 62 ibid. (1938) 338, col. 3406
- 63 e.g. Bella Aronovitch's description of her fear of visiting

- an out-patients' department, Aronovitch (1974) op. cit., p. 9. Hannah Mitchell, who sat on the public health committee of her city council from 1924 to 1935, complained that hospitals were run on military lines, with no concession to homeliness, and failed to provide good food, Geoffrey Mitchell, ed. (1977) The Hard Way Up, the Autobiography of Hannah Mitchell, Suffragette and Rebel (London Virago) p. 211
- 64 The SJC was founded in 1916 to advise the Labour Party on the views of working women. It organised deputations to Ministers, gave evidence to departmental committees, undertook surveys, arranged conferences and prepared the reports on the annual National Conference of Labour Women. It was made up of representatives from the WCG, the Labour Party, and trade unions and socialist societies, including the FWG
- 65 These findings were published in the Labour Woman (1922) 10, pp. 186-187
- 66 Possibly the most publicised case was that of the young Manchester woman, Molly Taylor, who had booked at a hospital, but on arrival no bed was available. Soon after the birth of her child, she was transported to another hospital where an examination was delayed, culminating in the woman's death. The cause of death was given as obstetric shock. An analysis of the case was published in the Labour Woman, which condemned the practice of overbooking, Labour Woman (1935) 23, p. 11. I am indebted to Judith Emanuel for allowing me to listen to tape recordings of interviews she had with people in Manchester about maternal health in the 1930s.
- 67 Sylvia Pankhurst commented that fear of being confined on the journey to hospital was one factor deterring women from selecting a hospital confinement, Pankhurst (1930) op. cit., p. 39
- 68 In 1922, the lying-in hospitals in eight London boroughs conducted a successful scheme of night-time ambulances, which the women telephoned for when labour began, reported in Labour Woman (1922) 10, pp. 186-187
- 69 A report was produced for discussion at the National Conference of Labour Women, ibid. (1924) 12, p. 69
- 70 These hospitals accepted the unmarried for a first birth on the grounds that pregnancy could be the result of a lack of moral training.
- 71 Labour Woman (1924) 12, p. 67
- 72 Campbell (1927) op. cit., p. 48
- 73 Letter in Time and Tide (1922) 3, p. 769
- 74 PP (1936) 311, cols. 1153-1154
- 75 Winifed Holtby (1947) South Riding, an English Landscape

- (London: Collins) pp. 130-131
- 76 Pankhurst (1930) op. cit., pp. 38-39
- 77 Information from the LCC, reported in the BMJ (1933) ii, p. 884
- 78 Letter, ibid. (1931) i, p. 474
- 79 ibid. (1932) ii, p. 421
- 80 reported, ibid. (1931) i, pp. 364-365
- 81 ibid. (1933) ii, p. 884
- 82 In 1935, the NFWI voted in favour of the provision of free anaesthesia, reported in The Times, 16 May, 1935. The WCG incorporated a demand for the availability of anaesthesia for all women in its resolutions on maternity and child welfare, WCG (1931) 48th Annual Report, p. 22; and (1936) 53rd Annual Report, p. 24
- 83 Remarks made to justify her amendment to exclude maternity homes from Clause Thirteen of the Local Government Bill, which dealt with the payment for hospital services according to means, PP (1928) 223, cols. 2874-2875
- 84 ibid., col. 2876
- 85 Wilkin et al. (1917) op. cit., p. 3
- 86 Kenner illustrates how working-class women in London were raising issues of housing, and the effects of poverty caused by unemployment and low wages, Kenner (1979) op. cit., pp. 135-143. The WCG consistently demanded services over and above those envisaged by the Ministry of Health, see Lewis (1980) op. cit., pp. 89-90; and Eleanor Barton (1928) The National Care of Motherhood, a WCG pamphlet. The same theme was adopted by the SJC, see SJC report published after the First World War, SJC (no date) The Position of Women after the War, Tuckwell Collection, File 374; and article by Mary Macarthur, Yorkshire Post 21 October, 1919, and the West Sussex Gazette 11 December, 1919, Tuckwell Collection, File 324 AII; and article by Beatrice Green on the nurture of children, Labour Woman (1927) 15, p. 37. During the 1920s, Labour women and the WCG campaigned for the provision of clean, cheap milk, and the abolition of the means' test to determine eligibility for food and milk, see Wilkin et al. (1917) op. cit., p. 4; WCG (1920) 37th Annual Report, pp. 10-11; Labour Woman (1920) 8, p. 79. At the same time, while the welfare groups remained silent, the Labour women took up the case of the plight of mining communities during the coal strike, see leading article, Labour Woman (1922) 10, p. 40; and report, ibid. (1926) 14, p. 154. It was not until the 1930s that others began to question the links between poverty and diet, see Chapter Five, pp. 145-155

- 87 George Newman had always been convinced of the value of education, see Newman (1906) op. cit., pp. 222 and 257-258. The education of women became of paramount concern to the Ministry of Health, see Palmer (1978) op. cit., pp. 27-29
- 88 e.g. Dr. J.E. Spence, the MOH for Eccles, wanted girls at public elementary schools to be taught mothercraft and housewifery rather than commercial subjects, reported in the Medical Officer (1923) 29, p. 167
- 89 e.g. see article, ibid. (1919) 21, p. 185; and editorial, ibid., 22, p. 160
- 90 Articles on teaching mothercraft, National Health (1929) 22, pp. 71 and 75
- 91 e.g. ibid. (1920) 12, p. 156; Maternity and Child Welfare (1923) 7, p. 13
- 92 Wilkin et al. (1917) op. cit., p. 3
- 93 WCG (1919) 36th Annual Report, p. 2. The Guild published annual statistics on the number of women serving on these committees. Although in the first two years (1919-1921) the numbers were 290 and 275, for the next seven years the numbers ranged between 60 (1923-4) and 89 (1925-6). Unfortunately, from 1928, the figures for membership of the municipal committees were combined with those for the voluntary committees.
- 94 This was one of four consultative councils set up by the Ministry of Health to represent the interests of those affected by the creation of the Ministry. The other councils represented the interests of the local authorities, the medical profession and the approved societies, which administered the National Health Insurance scheme.
- 95 Evening News 13 March, 1919, Tuckwell Collection, File 324 AII
- 96 The Labour Woman used this argument to justify the need for women on the Consultative Council, Labour Woman (1919) 7, pp. 23-24. Eleanor Rathbone used the same phrase in her first presidential address to the NUSEC, reported in the Women's Leader (1920) 12, p. 128
- 97 The Women's Leader advocated the use of family allowances to stimulate the birth rate of the 'desirable' sections of the population, namely the thrifty middle class, professionals and artisans, Women's Leader (1920) 12, p. 597. Eleanor Rathbone was prepared for family allowances to be regulated to affect population changes, Macnicol (1980) op. cit., pp. 35, 82-83 and 87-89; while Eva Hubback suggested that allowances be graded, and the unemployed excluded, remarks made at a meeting of the Eugenics Society, reported in Maternity and Child Welfare (1934) 18, pp. 46-47
- 98 Eyles (1922) op. cit., p. 146

- 99 Labour Woman (1922) 10, p. 129
- 100 PP (1924) 179, col. 245; and quoted in the Labour Woman (1925) 13, p. 14
- 101 ibid., pp. 84-85
- 102 Barton (1928) op. cit., p. 8
- 103 National Health (1930) 22, p. 239
- 104 Laura Hutton (1960) The Single Woman, Her Adjustment to Life and Love (London: Barrie and Rockliff) pp. 108-111 (first published in 1935)
- 105 Violet Markham (n.d., possibly 1916) draft of a speech on women's war work, Markham Papers, File 13/1
- 106 Vote (1920) 19, p. 498
- 107 Remarks made during a lecture on the growth of the maternity and child welfare movement, National Health (1921) 13, pp. 208-209
- 108 e.g. teachers' remarks at a conference of the Education Association of the Central Council for Infant and Child Welfare, reported in Maternity and Child Welfare (1924) 8, pp. 51-52
- 109 National Health (1924) 17, p. 111
- 110 ibid. (1926) 18, pp. 407-408
- 111 e.g. Llewelyn Davies (1978) op. cit., pp. 129 and 154
- 112 e.g. ibid., pp. 59-60, 60-61 and 94
- 113 e.g. the journal organised a competition to find the most 'healthful' baby, and readers were asked to send photographs, Labour Woman (1925) 13, p. 15
- 114 ibid. (1927) 15, p. 57
- 115 Women's Leader (1920) 12, p. 597
- 116 The maternity and child welfare journals published articles on the folly of attempting to create an AI nation whilst allowing the unfit to bear children, e.g. see Dr. Elizabeth Wilks, a medical officer at an infant welfare centre in Hackney, Maternity and Child Welfare (1919) 3, p. 372; Dr. C.J. Bond, National Health (1921) 13, pp. 248-251; Dr. J.J. Heagerty from the Department of Health in Ottawa, ibid. (1925) 18, pp. 116-117; Prof. F.J. Browne, paper read at a meeting of the Royal Institute of Public Health, quoted in Mother and Child (1932) 2, p. 409. Some argued that the reduction in the infant mortality rate resulted in the unfit being kept alive, e.g. G. Bollen, Dr. Inge and

Mr. Wickstead Armstrong, in a letter to The Times, argued that there was a danger of 'breeding a nation of C3 parasites, The Times 2 June, 1931. From the late 1920s, some Labour women and leading feminists were expressing eugenic ideas, see Joan Austoker (1982) Positive Eugenics and Social Reform - the Role of C.P. Blacker, unpublished paper; Michael Freeden (1979) Eugenics and progressive thought: a study in ideological affinity, Historical Journal, 22, pp. 645-671; Geoffrey R. Searle (1979) Eugenics and politics in Britain in the 1930s, Annals of Science, 36, pp. 159-169. In 1929, Time and Tide published two articles on the sterilisation of the unfit, Time and Tide (1929) 10, pp. 676-677 and 806-807. Mother and Child considered how the biologically-suited could be brought together, Mother and Child (1933) 4, pp. 117-118. In 1932, an NUSEC deputation to the Minister of Health raised the question of voluntary sterilisation to curb the spread of mental deficiency, reported in the Medical Officer (1932) 47, p. 54 (the deputation was led by Mrs. Corbett Ashby and the speakers included Gertrude Tuckwell, Lady Askwith and Miss Amy Sayle). In the same year, the WCG passed a resolution in favour of compulsory sterilisation of the unfit, reported in WCG (1932) 49th Annual Report, p. 23; and, in 1936, another resolution in favour of voluntary sterilisation was passed, reported, ibid. (1936) 53rd Annual Report, p. 26

- 117 Freeden (1979) op. cit., p. 668; Searle (1979) op. cit., pp. 167-168. In 1934, St. John Irvine, writing in Time and Tide, questioned how one defined a person unfit to be a parent, Time and Tide (1934) 15, pp. 97-99, 133-135 and 166-167
- 118 The Ministry of Health stipulated that two members of the maternity and child welfare committees set up under the 1918 Maternity and Child Welfare Act must be women. The Maternity and Child Welfare Department in the Ministry was headed by a woman, Janet Campbell, with a predominantly female staff. In 1928, when parliament debated the provision of public assistance committees under the Local Government Bill, Neville Chamberlain argued that some members should be women, because they had the ability and leisure to do Poor-Law work, PP (1928) 223, col. 76
- 119 Women did form the majority of the members on the Consultative Council on General Health Questions, set up belatedly after the creation of the other three councils (see ref. 94 above), following pressure from women's groups, Honigsbaum (1979) op. cit., pp. 49-50. Lady Rhondda chaired the Council, and the other women members were Mrs. Aspinall (United Textile Factory Workers' Association), Mrs. F. Harrison Bell and Miss Margaret McMillan (Labour Party), Mrs. Burke and Mrs. Hood (WCG), Mrs. Ogilvie Gorden (President of the National Council of Women), Mrs. Mayo (member of Dorset County Council), Miss E.M. Phelps (National Association of Domestic Workers), Mrs. Pember Reeves (FWG), Lady Edmund Talbot and Miss Gertrude Tuckwell. The Councils, however, never wielded any power, and were criticised by the SJC and the WCG, Minute Books of the

Central Committee of the WCG, 24, 25 and 26 September, 1920, and 10 and 11 March, 1921, Hull DCW 1/7 and 1/8. When the Central Council for Health Education was set up in 1927, MOsH predominated and there were no women members, reported in Public Health (1927) 41, pp. 1-2. Women were poorly represented on the Bolam and Newman Committees. Two women and thirteen men, all members of the medical profession, sat on the Newman Committee, and requests from the WCG and the National Conference of Labour Women for the inclusion of lay women were rejected, Minute Books of the Central Committee, 9 and 10 May, 1928, Hull DCW 1/9; Labour Woman (1928) 16, p. 89. The Final Report of the Newman Committee gives no indication that lay women's groups were consulted, Ministry of Health (1932) Report of the Departmental Committee on Maternal Mortality, the Newman Report (London: HMSO). Eleanor Barton, of the WCG, was appointed to the Bolam Committee, but her name was included only after pressure from the SJC, see George Newman's minute to the Secretary, Sir Arthur Robinson, 16 March, 1928, Public Records Office (PRO) MH55/238; report in the Daily Herald 8 June, 1928. This Committee, like the Newman Committee, was dominated by male members of the medical profession.

- 120 Janet Campbell, in her 1924 report, argued that the skill of the medical attendants needed to be improved, and she suggested that all maternal deaths should be investigated, Campbell (1924) op. cit., pp. 84-85. Her recommendations were welcomed by the lay public but not by the medical profession, Palmer (1978) op. cit., pp. 31-37. In her second report on maternal mortality, Janet Campbell outlined a complete maternity service, with the emphasis on medical services, ante-natal care and the education of mothers, Campbell (1927) op. cit., pp. 33-50
- 121 One of the Committee's first acts was to publish a leaflet, prepared by Alice Gregory and May Tennant, linking maternal mortality with death during the first four weeks of life, reported in The Times 20 October, 1927
- 122 Reported in the BMJ (1930) ii, p. 752
- 123 Minute from George Newman to the Secretary, Sir Arthur Robinson, 27 June, 1929, and the draft of a speech to be read at a Maternal Mortality Conference, 30 September, 1930, PRO MH55/262. In 1929, when the payment of grants to local authorities was altered from a percentage grant to a block grant, Ministry officials feared their control over the local authorities would be weakened, thus making a pressure group seem more valuable, see minute from George Newman to Sir Arthur Robinson, 26 October, 1932, PRO MH55/262
- 124 For their biographical details, see Violet Markham (1949) May Tennant, a Portrait (London: Falcon Press) and Gertrude Tuckwell (1949) Reminiscences, unpublished autobiography
- 125 Gertrude Tuckwell claimed her interest was aroused during her service on the Royal Commission on National Health In-

urance, Tuckwell (1949) op. cit., Chapter 28, p. 2. May Tennant turned her attention to health after the death of her son and the failure of her husband to be re-elected to parliament, Markham (1949) op. cit., p. 53

- 126 Membership was not constant, although Tuckwell and Tennant remained secretary and chairman until 1937. The membership was predominantly, but not exclusively, female. The members in the early years were Lady Barrett (Dean of the London School of Medicine for Women), Mrs. Barton (WCG), Mrs. Bramwell Booth (Salvation Army), Lady Margaret Boscawen (NFWI), Lady Cynthia Colville, Miss Cox (Young Women's Christian Association), Mrs. Crozier (Mothers' Union), Lady FitzAlan, Miss Alice Gregory (British Hospital for Mothers and Babies), Miss Haldane, Mr. Kershaw (Trade Union Approved Societies), Dr. Marion Phillips (Chief Woman Officer of the Labour Party and member of the SJC), Miss Constance Smith and Mrs. Usher. Subsequently, the Countess of Iveagh (Conservative MP for Southend), the Viscountess Erleigh, Mrs. George Morgan, Mrs. Eva Hubback (Eugenics Society and NUSEC), Mrs. Piercey, Mrs. Henry Haldane, Lady Noel-Buxton and the Viscountess Harcourt joined the Committee.
- 127 e.g. The Times published two reports before the first conference, plus a leading article and another report afterwards. The conference resolution was quoted in full as well as a detailed report of George Newman's speech, The Times 28 and 29 October, 1927. The message the Queen sent to the second conference was quoted, ibid., 29 February, 1928
- 128 Minute from Janet Campbell to George Newman, 16 January, 1928, PRO MH55/266. The factors leading up to the Ministry's decision to appoint these Committees are discussed in Palmer (1978) op. cit., pp. 39-61
- 129 A resolution, passed at the 1927 conference with only one dissentient, declared that it was essential for mothers to have skilled medical and midwifery services available both for ante-natal advice and treatment and for the time of birth. It called for improved midwifery training to be the first priority, quoted in The Times 20 October, 1927. The following February, the conference passed a resolution calling for an inquiry into all maternal deaths, quoted in The Times 29 February, 1928. The Newman Committee's terms of reference were to advise on the application to maternal mortality and morbidity of existing medical and surgical knowledge, and to inquire into the needs and direction of future research. One of the first acts of the Committee was to prepare a questionnaire to be completed by the local MOH following a maternal death. See the Ministry of Health (1929) Report of the Departmental Committee on the Training and Employment of Midwives, Bolam Report (London: HMSO); (1930a) The Interim Report of the Departmental Committee on Maternal Mortality (London: HMSO)

- 130 Reported in the Lancet (1928) ii, p. 956
- 131 In 1928, the National Baby Week Council announced that Baby Week was to be called Mother and Baby Week. In 1929, a joint committee was set up, under the auspices of the National Association for the Prevention of Infant Mortality, to enlighten public opinion on maternal mortality and morbidity. Committee members included doctors, midwives, nurses, and representatives from voluntary societies and the WCG. The first meeting was held on 13 May, 1929, reported in National Health (1929) 21, p. 411. The Committee, however, was able to agree only on the need to educate women, ibid., p. 412
- 132 Ministry of Health (1929) op. cit., p. 7; (1930a) op. cit., Chapter 8
- 133 Both schemes were based on a domiciliary midwifery service using midwives for all normal confinements, BMA scheme quoted in the BMJ (1929) i, Supplement, pp. 258-262; MWF scheme quoted, ibid. (1930) i, Supplement, pp. 5-7
- 134 see Palmer (1978) op. cit., pp. 80-82; the Maternal Mortality Committee's unanimous resolution welcoming the Bolam Report, reported in The Times 22 October, 1929; and of the Interim Report, reported in the BMJ (1930) ii, p. 752; Vera Brittain's review in Time and Tide (1929) 10, pp. 1140-1141; WCG campaign for legislation based on the recommendations of the Bolam Report, WCG (1930) 47th Annual Report, p. 8; Labour women's hopes that the Labour government, elected in 1929, would honour its election pledge to create a national maternity service, Labour Woman (1929) 17, p. 169; National Conference of Labour Women resolution demanding a national maternity service, quoted in the Labour Woman (1930) 18, p. 88
- 135 see Public Health (1929) 43, pp. 66-67; Medical Officer (1929) 42, p. 139
- 136 Labour Woman (1930) 18, p. 154
- 137 ibid.
- 138 ibid.
- 139 When in opposition, the Labour Party had attacked the Conservative Party's record, and, in 1923, the Party stated its intention to make the 1918 Maternity and Child Welfare Act compulsory, (1923) The Labour Speakers' Handbook, Facts and Figures for the Worker (London: Labour Party). The policy documents produced in 1927 and 1928 declared that medical services before and after childbirth should be an essential part of the national insurance scheme, (1927) Labour and the Nation (London: Labour Party). In July, 1928, in a private memorandum, the existing maternity services were scrutinised and a complete maternity service was described, based on the 1918 model scheme, Research and Information Department Public Health Advisory Committee (1928)

Memorandum on Maternal Mortality, Labour Party Archives 329(LAB)A1 28/31. A pamphlet, published during the 1929 election campaign, claimed the Labour Party would have taken action on Janet Campbell's 1924 report on maternal mortality Labour Party (1929) Women and the General Election, an election pamphlet. In the election manifesto, the Party pledged to take action on maternal mortality, Report of the Annual Conference of the Labour Party (1929) p. 307; Labour Woman (1929) 17, p. 71

- 140 The government delayed action on the Bolam Report because it wanted to await the findings of the Newman Committee, see Palmer (1978) op. cit., pp. 72-75; but when the Newman Committee also recommended a national maternity service, the government found it needed to consult with the vested interests, see ibid., pp. 82-87. A circular was sent to the local authorities urging them to use their powers under the 1918 Act, Ministry of Health (1930b) Maternal Mortality, Circular 1167, issued to all maternity and child welfare authorities, in conjunction with Memo. 156/MCW (London: HMSO). Response to the circular, however, was poor, and before further action was agreed, the Labour government had resigned, see minute signed by George Newman, 6 May, 1932, PRO MH55/273; Report of the Committee on National Expenditure, the May Report (1931) (London: HMSO). The May Report recommended abandoning plans for a national maternity service, although two members, Charles Latham and Arthur Pugh, disagreed, arguing that such a service would be a true economy, ibid., p. 255. For details of the Cabinet crisis, which resulted in the resignation of the Minister of Health, Arthur Greenwood, see A.J.P. Taylor (1965) English History 1914-1945 (Oxford: Clarendon Press) pp. 291-292 and Note A, p. 297
- 141 In September, 1931, an economy circular was issued to local authorities, Circular 1222, issued on 11 September, 1931. The Ministry of Health's policy in the light of this circular was determined the following week. It decided to sanction schemes only if the maternal mortality rate was consistently high, minute from Sir Arthur Robinson to George Newman, 18 September, 1931, PRO MH55/272. In April, 1932, the new Minister of Health, Sir Edward Hilton Young, told the House of Commons that negotiations on a national maternity service were terminated, PP (1932) 264, col. 725

C H A P T E R F I V E

THE FRAGMENTATION OF CONSENSUS IN THE 1930s

The uniformity of opinion on the need for an extension of medical services in order to improve maternal health, coupled with a desire to encourage women to bear children and to regard motherhood as a central part of their lives, which had united disparate groups in the 1920s and had blurred professional, sexual, social and political differences began to crumble in the 1930s.

The principal lay women's organisations were changing, with the old-established suffrage societies in decline while the Women's Institutes and the Townswomen's Guilds were burgeoning. The Maternal Mortality Committee was beginning to consider questions of morbidity and to discuss non-medical matters, including poverty and the importance of diet, thus losing the support of the Ministry of Health and the voluntary societies. Indeed, the debate over the relationship between diet, poverty and maternal well-being became one of the key issues in the 1930s, with a division between those who believed a correct diet was a matter of education alone and those who argued that poverty pre-

vented women from eating healthy foods. The separation of lay and professional women was further enhanced both by the attitude of some leading members of the women's movement and by the further encroachment of the technical expert into child care. Increased specialisation, with the extension of scientific knowledge, intensified divisions between general practitioners and specialists and between the medical profession, midwives and health visitors (see Section Three). Finally, social divisions were reinforced by the development of the natural childbirth movement and the emergence of theories on the need to consider the psychological development of children.

Changes within the Women's Organisations

During the 1930s, several changes occurred in the membership of women's organisations. The old-established suffrage societies were declining, while new groups were developing with more diverse interests.

The WFL, by the late 1920s, was in severe financial difficulties. No doubt, once the 1928 Franchise Act was passed, the League found it increasingly difficult to attract members. Following the death of the League's treasurer, who had injected considerable funds into the WFL, publication of the Vote was suspended.¹ Although the League was not disbanded, its influence inevitably waned.

The NUSEC was also undergoing changes. Eleanor Rathbone and Eva Hubback were convinced that, because of the technical nature of the legislation required to further equality between the sexes, the time for mass demonstrations had passed. They argued that a mass campaign had been ideal for a simple issue

like the vote, but that complex issues, such as family allowances, required lobbying by technical experts, thus giving support to the segregation between the lay person and the professional (see pp. 103-108). Consequently, although they wanted the NUSEC to continue, they did not see the need to seek to maintain a high membership or to recruit the presently non-political women.

As an alternative for those women who did not possess technical knowledge and were not accustomed to public activity, a new organisation for town dwellers, akin to the Women's Institute movement for country folk, was proposed. In 1929, the Council of the NUSEC started the Townswomen's Guilds.² Initially, the aims of the NUSEC were to be incorporated, but a separation between the two organisations was soon effected. Plans to combine the weekly Women's Leader with a monthly journal for the Townswomen proved unworkable.³ The editorship changed, and with it the political nature of the paper, while the name was changed to the Townswoman. Articles on home matters predominated, and, by the end of 1935, the political element of the journal had disappeared.⁴

The Townswomen's Guilds, in common with the Women's Institutes, expanded rapidly during the 1930s.⁵ Both the National Union of Townswomen's Guilds (NUTG) and the NFWI provided a valuable service, giving women in the home an opportunity to meet and to discuss matters of mutual interest. They were, however, determined to be both non-political and non-sectarian in order to attract the widest possible membership.⁶ Both organisations believed that their members needed education before they could express an opinion, and they sought this education

by seeking the opinions of technical experts and government officials rather than through internal discussions and research.⁷ Both were conscious that they represented women in the home, and showed no signs of wishing to alter the status quo.⁸ This attitude fitted well with the pressures being placed on women during the mid-1930s. The high unemployment rate reduced job opportunities,⁹ while those opposed to women working outside the home argued that the available jobs should be reserved for men, claiming that the high male unemployment rate was affecting the birth rate, as the unemployed were less likely to marry and to have children.¹⁰ At the same time, fascist doctrines were being proclaimed in Europe, which also advocated a purely domestic role for women.¹¹

Working women's groups remained politically active, and membership of the WCG continued to grow. Financial difficulties, however, were evident. The Labour Woman was reduced in size, and, in 1933, the price was cut in order to maintain sales. The WCG found the interest of some of its members in political action was declining. There were demands that more time be devoted to social activities, perhaps as a reaction against the difficulties created by the economic depression, which forced many working-class women either to exist on public assistance or to work full-time outside the home to support their families. In the annual report for 1936-1937, the WCG admitted that it was suffering because of the encroachment of other women's organisations, and the development of community centres, which were offering an alternative to co-operation.¹² Furthermore, those who remained politically active became more involved in the worsening international economic crisis and the threat

of war, which inevitably diverted attention away from domestic issues.¹³

The Demise of the Maternal Mortality Committee

The conservative nature of the NFWI and the NUTG, and their readiness to follow advice given by government officials and professionals did not lead them to support any moves by the Maternal Mortality Committee which deviated from government policy. In this respect they were more in accord with the voluntary maternity and child welfare organisations, which remained loyal supporters of the Ministry of Health's policies.¹⁴ Consequently, when the Maternal Mortality Committee continued to press for an extension of services after 1932, it lost the support not only of the Ministry of Health but also the voluntary societies, and failed to attract the public support which had been evident from 1927 to 1930.

The Committee further antagonised the Ministry by its decision to ask for an inquiry into maternal morbidity.¹⁵ Although the Ministry admitted privately that an inquiry would reveal high levels of morbidity, it decided that the issue should not be discussed as the Ministry was not in a position to take any action.¹⁶ The Ministry ceased to give its support to the Committee. The Minister was no longer advised to address conferences,¹⁷ while George Newman told the 1934 conference that, although the Committee had done useful work raising public awareness, 'the impartial scrutiny of the scientific mind' was presently required to determine the cause of maternal mortality.¹⁸

The voluntary organisations objected to the Maternal

Mortality Committee's decision to raise the question of a link between low pay and unemployment, malnutrition and maternal mortality, on the grounds that such a link had not been scientifically proven. In 1934, the NCMCW refused to join a deputation to the Minister of Health, which was organised by the Maternal Mortality Committee.¹⁹ Mother and Child accused the Committee of inaccuracies in its assessment of the maternity and child welfare provision made by individual local authorities. The journal suggested that a mere perusal of the statistics without an intimate knowledge of the area could be misleading.²⁰

At the same time, the Maternal Mortality Committee began to acquire a reputation for militancy. Mother and Child was critical of the hostile reception given to George Newman's 1934 speech at the Committee's conference. The Committee was accused of ignoring the complexities of the problem of maternal mortality.²¹ This sentiment was shared by The Times.²²

The Maternal Mortality Committee continued its activities until 1937, but it never again achieved the national recognition of its early years. It is evident, however, that the Ministry continued to regard it with sufficient respect to justify careful monitoring,²³ while the fact that May Tennant met the Minister of Health socially ensured that the Committee was kept informed of Ministry policy.²⁴

The Nutrition Debate

Much of the concern which had been focused on maternal mortality switched during the 1930s to the debate on the effects of diet on health, and the evidence for a rise in the incidence of malnutrition. Opinion was divided on the extent to which

diet could influence mortality, and in particular maternal mortality, and on whether the population was suffering because of the economic depression. Indeed, the debate continues. Some authors have suggested that, although areas of depression persisted, the overall trend was towards higher living standards.²⁵ Charles Webster has recently reviewed the literature and re-assessed the evidence, reminding us that an assessment of health cannot be made simply on the basis of the infant mortality rate, but must include consideration of all the mortality statistics as well as the available evidence on morbidity.²⁶ Furthermore, those who accepted that diet influenced maternal health, failed to agree on whether a poor diet was the result of ignorance or fecklessness, or whether it was a direct outcome of poverty. The difficulties were compounded by the failure to agree upon a definition of malnutrition and on how it could be measured.²⁷ Definitions remained subjective, making it likely that an investigator's judgement would be influenced by the standards of the area.²⁸

Clinicians had been directing attention towards the relationship between food and health for a number of years, stimulated by work on the classification of the constituents of food, and by the need to introduce food rationing during the First World War. During the 1920s and 1930s, major studies were undertaken on the influence of diet on growth and development,²⁹ and recommendations were made concerning the ideal diet for pregnant and lactating women.³⁰ Moreover, suggestions were made that diet could have a direct effect upon two of the principal causes of maternal death: puerperal sepsis and toxæmia.³¹

The Ministry of Health responded to this work, and local

authorities were sanctioned to extend their provision of milk and meals to infants and expectant and lactating mothers.³² The Ministry, however, attributed many cases of poor diet to a lack of knowledge of food values and cookery rather than poverty. Demands for an increase in the allowances paid to those on public assistance were resisted on the grounds that people must be encouraged to help themselves. The nineteenth-century fear of pauperisation persisted.³³

Campaigns to educate women in food values were organised.³⁴ The Times predicted that maternal mortality would be reduced if young women were taught how to buy and prepare food,³⁵ and maintained that even the poorest mothers could obtain good results if they knew the correct diet.³⁶ The voluntary organisations and the Women's Institutes were encouraged to participate in the task of educating girls and women. The Women's Institutes were called upon to organise classes, giving instruction on the Ministry's definition of an adequate diet.³⁷ Schools were asked to make cookery classes practical, and to teach methods that could be employed in a working-class home. Health visitors were told of the need to educate women to spend their money wisely.³⁸

The maternity and child welfare conference, organised by the NCMCW, held in Birmingham in 1934, had a session on nutrition. Of the three papers, two dealt with the education of mothers and the importance of establishing good dietetic habits, and only Dr. G.M.C. M'Gonigle, the MOH for Stockton-on-Tees, suggested that it was small purchasing power which stopped people consuming nutritious food.³⁹ In the same year, the special propaganda subject of the National Baby Week Council

was the nutrition of children. The National Baby Week Council also commissioned Professor Cowell to write a pamphlet on diet for expectant mothers.⁴⁰ A series of competitions was organised for school children: the girls were to devise six rules for preparing family meals, and the boys six rules for the garden, to help their mother to give the family a better diet.⁴¹

The Ministry of Health continued to insist that no deterioration in health had been observed as a result of the depression.⁴² In 1933, Hilton Young stated that tuberculosis rates were a good barometer of health and nutrition, and that they were declining, as was the overall death rate.⁴³ The following year, he referred to the education of the mothers.⁴⁴ Indeed, he was accused by one Labour MP of 'skipping over' maternal deaths.⁴⁵ By the use of national statistics, regional variations were obscured. At the same time, MOSh were encouraged by George Newman to express an optimistic view of progress.⁴⁶ The few unfavourable local reports were dismissed or regarded as aberrations.⁴⁷ Eleanor Rathbone, however, told the House of Commons that she considered George Newman's reports to be too optimistic, and she accused him of selecting the most favourable reports from the MOSh for inclusion in the analyses.⁴⁸

Similarly, links between maternal mortality and malnutrition were treated with scepticism. Commentators were able to draw on the fact that official reports had consistently denied a link between maternal mortality and social conditions. The Conservative Party produced literature discounting any links.⁴⁹ MPs were told that medical evidence showed that diet was not an important factor in maternal mortality, because it was found that, in at least half the cases, there was no poverty.⁵⁰

These arguments were substantiated by the work of Professor E.P. Cathcart, who claimed the bulk of malnutrition and faulty diet to be the result of gross ignorance rather than financial difficulties, and Dr. Robert Hutchinson, who thought tuberculosis was probably the only disease affected by nutrition.⁵¹

Some public health officials were outspoken in their support of this argument. Dr. Letitia Fairfield, of the Public Assistance Department of the LCC, declared that she was dubious about the links between maternal mortality and nutrition, because of the high rate in the United States of America, where standards of nutrition were probably the highest and the most scientific ever known.

Some mothers undoubtedly do die because their standard of nutrition is inadequate; but there is no evidence whatever that this is frequent. It would be a mistake to assume that the percentage of mothers who die in childbirth can be reduced appreciably by concentrating on that one factor.⁵²

The Medical Officer was impressed by the findings of E.P. Cathcart and Dr. A.M.T. Murray, based on a study of working-class populations in Reading and Cardiff. A leading article concluded

Poverty does not appear to be the chief difficulty these days, more common is lack of housewifery, It seems that the normal woman has an instinctive knowledge of catering for her household and though her instincts are not proof against sophistication and are much influenced by superstition, prejudice and custom, it seems clear that education in dietary properly given should produce an immediate response.⁵³

A leader in the journal, in 1934, saw a need to get the new information on nutrition to the lay public.⁵⁴ The journal favoured the term ill-nutrition in preference to malnutrition.⁵⁵

Medical opinion, however, was not unanimous, and Labour and Co-operative women, who had consistently drawn attention to

the effect of poverty on women's health,⁵⁶ were able to draw on the research showing links between diet and deficiency diseases. Labour women also carried out their own investigations. In 1933, for example, the Labour Woman published a report on malnutrition based on information received on weekly budgets from the Labour Women's Advisory Councils. It found that only one budget allowed enough money for food.⁵⁷ The following year, readers submitted their comments on the BMA's recommended diet. Food generally cost more than was estimated by the BMA, while the saving made on the cheap cuts of meat was partially offset by the costs of the necessary lengthy cooking. One respondent pointed to the stupidity of allowing twenty-eight pounds of bread and only half a pound of butter, while many complained of the monotony of the diet.⁵⁸ In 1936, the journal published further information on diet and income, which it received from readers. The journal pointed out that the information refuted any claim that the unemployed and the low paid could manage quite well if the mother knew how to cook and spend her money wisely. Women had to think how to appease hunger and not how to build healthy bodies.⁵⁹

In 1933, the Maternal Mortality Committee sent a letter to local authorities reminding them of their powers to provide milk and food to women during the last three months of pregnancy and while they were lactating. Dr. Helen Mackay was quoted as saying that she was in no doubt that the health of mothers in the East End of London was affected by the depression.⁶⁰

At the 1934 conference of the Maternal Mortality Committee, several speakers referred to the links between poverty, mal-

nutrition and maternal ill-health. Mary Sutherland, representing the SJC, stated that it was essential to tackle the question of income before that of dietetic ignorance. She quoted M'Gonigle, who argued that education on food values was useless, unless the purchasing power was adequate to carry out the instructions. She pointed out that those who criticised working-class women, for preferring a tin of salmon to more nutritious food, forgot that the tin opener was often her only labour saving device, and that if she bought the recommended foods there would be no money left to do the cooking.⁶¹ Eleanor Barton, of the WCG, declared that many poor women were under-nourished, and claimed that she knew of many cases where women had been helped by the provision of food.⁶² Opinion, however, was not unanimous, with one speaker presenting the government's point of view.⁶³ This was one of the issues responsible for the rift between the Committee and the NCMCW (see pp. 144-145).

Divisions between Conservative and Labour women over the question of malnutrition and maternal mortality were clearly marked. The Conservative women in the House of Commons consistently denied evidence of a link.⁶⁴ In 1935, the Central Women's Advisory Committee of the Conservative Party discussed maternal mortality. The resolution lauded the interest of the Ministry of Health, and deprecated the attempts to focus attention on malnutrition, advocating that effort should be directed towards those measures that had already proved beneficial.⁶⁵

It is evident, however, that public concern over malnutrition, and in particular its effect upon children was mounting. The research on diet coupled with the dramatic rise in unemploy-

ment in the wake of the economic crisis,⁶⁶ and the discussion on a cut in unemployment benefits as part of a reduction in national expenditure,⁶⁷ focused attention on the minimum income required for a healthy diet. The BMA set up a committee to investigate nutrition, and its report was published in 1933.⁶⁸ The Committee did not consider the extent of malnutrition in the population, but it did state that, with adequate money, the average housewife provided a satisfactory diet for her family.⁶⁹

The government also set up the Nutritional Advisory Committee. Embarrassingly for the government, these two committees reached differing conclusions, despite the fact that Professor V.H. Mottram served on both committees. The discrepancy, however, was accounted for by the fact that the committees had different terms of reference.⁷⁰

In 1934, two pressure groups were set up, the Children's Minimum Committee (later to be called the Children's Minimum Council) and the Committee against Malnutrition.⁷¹ These committees avoided the controversy over the causes of maternal mortality. Moreover, the Children's Minimum Committee was likely to arouse little antagonism, as it was concerned only with children. Provision for children was always less controversial than for adults, who, it was argued, could provide for themselves.⁷² Both committees were able to draw on the increasing body of evidence indicating the prevalence of undernourishment, as a result of poverty, in certain areas of the country.⁷³

Furthermore, other factors were influencing the attitude to the national diet. First, the threat of war focused attention on the state of army recruits. There was alarming evidence that over 50% of the recruits were rejected as being phy-

sically unfit.⁷⁴ Neville Chamberlain drew attention to the need to improve physical fitness, in preparation for war.⁷⁵ Secondly, increased productivity in agriculture, and in particular in the provision of milk, inspired a discussion on the ways in which markets could be expanded. At the same time, it seemed wise to ensure that the country was as self-sufficient as possible, as a civil defence measure. The Times used these arguments, making direct links between improving physical fitness and expanding agricultural markets.⁷⁶ In March, 1936, The Times advocated a national food policy, commencing with the distribution of milk to all school children.⁷⁷

Gradually the government began to extend its involvement in the provision of food. In 1936, Sir Arthur McNalty, who had replaced George Newman, announced an increase in the supply of school meals and milk,⁷⁸ and, the following year, the local authorities received increased resources, following a revision of the block grant formula.⁷⁹ During the debate on the King's Speech in 1938, the Prime Minister announced the government's intention to introduce a milk bill during the current session of parliament. He did warn MPs, however, that the enormous armaments programme prohibited a large expenditure on social services.⁸⁰

Moreover, the government became involved in an experiment to provide food to expectant mothers in selected depressed areas. In 1933, the National Birthday Trust Fund had begun a scheme to provide food, at the MOH's discretion, to women in the Rhondda Valley. The scheme proved so successful that the Fund was given a grant by the Commissioner for the Special Areas to extend the scheme to other special areas.⁸¹ The Ministry of Health, how-

ever, remained cautious, insisting that the scheme was an experiment, and that no firm conclusions could be drawn from existing statistics.⁸²

It was not until after the outbreak of war that major national schemes were introduced. In 1940, a national milk scheme and a scheme for the provision of cod-liver oil and fruit juice were introduced. Subsequently, expectant and nursing mothers were allocated four eggs per week, while others were limited to one egg; and, from 1942, expectant and nursing mothers could also obtain vitamin preparations.⁸³ Moreover, after the war, the links between diet and the resistance to infection were proclaimed by the Conservative Party. In its notes for speakers, prepared for the 1945 general election campaign, it stated

Researches within the last ten years or so have shown that the health of the mother during confinements and after is determined to a great extent by the adequacy of her diet during pregnancy. The decline in the mortality rate, which has taken place during the war, can therefore be attributed in some measure to the improved diets of expectant mothers.⁸⁴

The opinion of the Labour women, which had been articulated from the early 1920s, was finally accepted. The campaign provides a good example of the divisions between many of the middle-class voluntary workers and the leaders of the working women, with the latter raising questions of poverty, while the voluntary workers sought a solution through education. Once again, many involved in the debate attributed problems to the lack of training in housewifery, placing more pressure on girls to prepare for the role of wife and mother and to regard it as a full-time commitment. Acceptance of the link between diet and ill-

health depended ultimately on the findings of scientists: the technical expert had thus taken control of another aspect of women's expertise.

Natural Childbirth and the Elimination of Fear

Divisions between middle-class and working-class women and the increasing reliance on the technical expert are evident also in the natural childbirth movement. By the 1930s, the failure to reduce the maternal mortality rate inspired quests for an, as yet, unconsidered cause of death. It was postulated that fear could have an adverse effect upon women. Grantly Dick Read, an obstetrician who published widely during the 1930s on the advantages of natural childbirth, was one of the principal exponents of the need to combat the fear of childbirth. He argued that fear created tension, resulting in a long labour, and claimed that much of the pain of childbirth was subjective and had not been experienced by primitive women. He asserted that it was the obstetrician's duty to keep the mother calm and happy, a message which was given not only to professional workers but also to the voluntary maternity and child welfare organisations.⁸⁵ His theme was taken up by others.⁸⁶ George Newman, in his report for 1929, referred to the need to guard against the danger of making women apprehensive by the continual reference to the dangers of pregnancy.⁸⁷ In 1932, he observed that 'undue attention' had been placed on the pathology of obstetrics, although he did acknowledge that this had been inevitable in the creation of general public interest, and had stimulated the voluntary organisations.⁸⁸

Fear was said to be having a depressing effect on the birth

rate at a time when there were worries about a declining population.⁸⁹ Moreover, the desire to encourage a more positive attitude to childbirth and to minimise the risks involved fitted well with the need to limit government expenditure, which precluded the creation of a national maternity service (see p. 126).

In 1933, the Committee on Local Expenditure declared that there were too many health conferences. Local authorities were urged to consider whether they were really necessary, and were advised to send only one delegate to conferences organised by voluntary societies.⁹⁰ In the following year, when Janet Campbell resigned from her job at the Ministry of Health, her replacement, Dr. Jane Turnbull, who had been working as her deputy in the Maternity and Child Welfare Department, was not made a senior medical officer. This inevitably led to suggestions that the Ministry wished to scale down its activities in maternity and child welfare work.⁹¹ Hilton Young, however, argued that the administrative changes, brought about by the 1929 Local Government Act, meant that local authorities were given more autonomy, and, therefore, did not require detailed supervision by the Maternity and Child Welfare Department.⁹²

George Newman was adamant that attention should be diverted from maternal mortality.

There is no need to fear. The number of women who die in childbirth is relatively small. Comparative statistics are difficult to evaluate, but it can be said that motherhood in this country has reached a high level of safety. The young married woman can be told with confidence that if she is a normal healthy woman and will take the ordinary and sensible precautions advised by her doctor or the Ante-natal Centre the risk she will run in childbirth need be no matter of anxiety.⁹³

The medical profession, anxious to demonstrate that maternal

mortality was a purely medical matter, requiring a medical solution, readily supported the argument that death during childbirth should no longer be a matter for public debate. The BMA passed a resolution, stating

That the British Medical Association regrets that the question of maternal mortality has become the subject of widespread political discussion, receiving great publicity in the lay press. Maternal mortality is a scientific and administrative problem which deserves careful and scientific study, but, in the experience of practising doctors, the publicity which it is receiving today is tending to terrify childbearing women and is, in itself, a cause of increased mortality.⁹⁴

The Medical Officer also took the view that the question of maternal mortality was a matter only for discussion by experts. For example, in 1932, the journal recommended the report on high maternal mortality in certain areas,⁹⁵ but only to 'advanced students of maternal mortality' (italics in original), as the document might be misinterpreted by others.⁹⁶ Following the announcement that the People's League of Health was setting up a committee to investigate nutrition and maternal mortality, the Medical Officer declared that the committee would not be useful, arguing that it was known what action should be taken, while in some areas the maternal mortality rate had already reached its lowest level.⁹⁷ An editorial in the following year reiterated the belief that there was no need for further public agitation was regard to this issue: it was simply a matter of proceeding with the work.⁹⁸

The voluntary societies followed the medical profession's lead. Maternity and Child Welfare contrasted the fearful English with the placid Swedes.

the expectant mother faces her ordeal with a calm

hopefulness which has a profound influence in producing easy labour.⁹⁹

In 1932, Mother and Child criticised a book on ante-natal advice, as it doubted the wisdom of the constant emphasis on the strain of pregnancy, which was likely to frighten an already timorous mother.¹⁰⁰ In the same year, Dunstan Brewer, the MOH for Swindon, told readers that fear was the root cause of many of the fatalities associated with childbirth. He wanted people to get away from the idea of regarding pregnancy as a disease.¹⁰¹ Voluntary workers in Warwickshire, at a meeting which discussed the Newman Report, were told by the Assistant County Medical Officer, Dr. Agnes Young, that the lay press should be blamed for giving prominence to maternal mortality; while Miss E.M. Pye, the President of the Midwives' Institute, spoke of the lowering effect of the fear of pain on mothers.¹⁰²

In 1935, Mother and Child declared that there were too many conferences on maternal mortality, suggesting that maternal vitality should be stressed. Dame Louise McIlroy was quoted on the need to help women to look forward to childbirth.¹⁰³ In the following volume, Mother and Child reviewed the recent comments on maternal mortality and morbidity, and was pleased to record that the 'sensational element' was slowly disappearing. It pointed out that several authoritative speakers, including Eardley Holland and Louise McIlroy, had argued that the rise in maternal mortality was more apparent than real, being the result of the more accurate recording of the cause of death.¹⁰⁴ Indeed, May Tennant acknowledged that maternal mortality had received sensational treatment in the press. The Maternal Mortality Committee conducted a survey of the literature produced

by the local authorities, and found not a few deplorable examples of pamphlets likely to engender fear in the pregnant woman.¹⁰⁵

In 1935, the National Baby Week Council decided that the maternity and child welfare propaganda for the coming year should concentrate on maternal welfare, with the emphasis on vitality rather than mortality.¹⁰⁶ The Council declared its intention to do its utmost to eliminate fear, and to fight the use of scare propaganda. Grantly Dick Read was quoted, following his recommendation that ante-natal investigations to eliminate abnormalities should be kept in the background. He argued that the mother should be protected from the knowledge of complications, and her mind should not be infiltrated with questions of abnormal urine, minor contractions of the pelvis, the unsatisfactory position of the child, and other such complications.¹⁰⁷

Indeed, withholding information perhaps enhanced the mystic of childbirth, making women more ready to consider a hospital confinement. This process, coupled with the advent of medical intervention into all aspects of infant care (see pp. 163-164) could have made young women more willing to acquiesce to the dictates of the technical experts.

These theories on natural childbirth and the elimination of fear, propounded by technical experts and Ministry of Health officials and endorsed by the voluntary societies, however, did not correspond to the experience of working women, faced with the reality of debilitating complaints which perpetuated after childbirth and the evidence of a continuing high incidence of death during childbirth.¹⁰⁸ The natural childbirth movement thus provides further evidence of the differences between middle-class and working-class women and also of the gulf between lay

women and the professionals. Moreover, it is interesting to note that it was a male obstetrician who remained at the forefront of the debate and that the favoured means of allaying women's fears was to advocate a hospital environment, where the mother was not given information on possible complications, rather than a return to home-centred maternity care supervised by a midwife. This illustrates the declining confidence in the independent midwife, which is discussed at length in Chapter Eight.

Changing Attitudes to Childcare

During the 1930s, the notion that women were experts in matters of childcare was further undermined, while middle-class women were encouraged to devote more time to their own family, rather than concern themselves with the welfare of working-class households. Women were told they needed instruction in the management of their babies, while attention had to be paid to the psychological development of young children, requiring the woman to receive technical advice and to obtain help from their husbands.

Moreover, the manner in which fathers became involved in childcare had the effect of minimising women's competence to assume complete responsibility for children. During the 1930s, fathers were increasingly encouraged to take a more active role in childcare. They were not, however, expected to share the woman's work. Fathers had an entirely separate role, performing tasks a woman was unable to do.

Initially, the co-operation of fathers was sought in order to add weight to the campaigns to secure better housing and a

complete maternity and child welfare service for their wives and children,¹⁰⁹ to encourage their wives to submit to ante-natal examinations, and to allow their babies to be inspected by health officials.¹¹⁰ For this purpose, some welfare centres started fathers' clubs or councils, a development that was welcomed by the National Baby Week Council.¹¹¹ It is interesting to note, however, that Mother and Child hoped these fathers' councils would remain independent, so they could criticise voluntary or official maternity and child welfare work, if it failed to reach the standard required.¹¹² Women, on the other hand, were expected only to accept advice and instruction.

Fathers were expected to take an interest only in their own child.¹¹³ National Health reported that the literature for fathers was always popular. The journal, nevertheless, anticipated that men would find it difficult to assume any responsibility for children.

Biologically man is built for enterprise, spasmodic interest, impatience, living in the moment, just as woman, on the hand, is, biologically, built for reserve, patience, foresight - essentials of maternity.¹¹⁴

Similarly, Maternity and Child Welfare commented

In some ways it is harder to be a good father than a good mother; maternal instinct, however hard to define, is a fact, and the extraordinary gift of self-sacrifice demanded by the task of caring for a young baby seems to come naturally to mothers in every rank of life.¹¹⁵

Increasingly, however, men were expected to play a more active role, as it was asserted that children, and especially the boys, required the presence of a father. In 1927, the NLH pamphlet To Wives and Mothers was re-issued as To Mothers and Fathers.¹¹⁶ This was followed, in 1931, by a pamphlet specifi-

cally for fathers.¹¹⁷ The National Baby Week Council discussed the role of the father.¹¹⁸ In 1931, the Council decided to involve boys as well as girls. A competition was organised: boys were to make a cot and the girls the bed clothes.¹¹⁹

In 1935, the Joint Honorary Secretary of the National Baby Week Council, Dennis H. Geffen, in a lecture to health visitors at their winter school asserted that parentcraft came naturally to girls, and they should be encouraged to dress a doll in a hygienic way, and should be taught how to bath it and clean its teeth, and learn the constituents of a good diet. He went on to advocate that working-class girls should do practical sewing in school, and he recommended that they brought socks to darn. He went on to argue, however, that teaching parentcraft to boys was more difficult. He saw no harm in boys playing with dolls, providing they took the manly side of the procedure. He suggested a boy should learn to be the father of a family of dolls, and should be encouraged to see they went to school regularly, ate their meals and were tidy. A boy, he declared, should learn to scold the dolls when they misbehaved, and should learn to become a good leader.¹²⁰

Dr. Alice Hutchinson, of the Tavistock Clinic, warned of the dangers of the maternal instinct in exaggerated forms. She argued that all boys, from the age of three and a half years, should be taken for walks and talked to by their fathers, so they could have him as an ideal.¹²¹

An editorial on fathercraft in Mother and Child pointed out that it was never the intention to make fathers mother-substitutes. The mother's first duty remained the manage-

ment of the child.¹²² Mothers had their natural competence questioned, but they were still expected to regard childcare as a full-time occupation.

From the mid-1920s, the growth of interest in the psychological development of the child meant that, despite the reduction in family size, the amount of time the mother was expected to devote to the home did not diminish. During the 1930s, there was a noticeable change in middle-class attitudes to childrearing. Middle-class women wanted to learn the latest theories on infant management (see pp. 73-75). Naomi Mitchison was one of those who followed the Truby King method, with four-hourly feeds and no cuddling except during prescribed periods.

I don't know why this was accepted, but worried mothers have a habit of accepting authoritative books, by doctors.¹²³

The journals, which had previously been concerned primarily with the education of the working-class, and the provision of services for those who could not afford to pay, began to offer advice to middle-class women on the upbringing of their own children. Davies has observed that the regular cartoons in Maternity and Child Welfare altered during the latter years of the journal's publication, and began to depict middle-class women in their homes.¹²⁴

From the mid-1920s, the National Baby Week Council began to concern itself with the development of the child's mind. In 1925, one of the themes of baby week was the psychological aspects of character formation;¹²⁵ and the following year Baby Week was devoted in part to propaganda on the care of the toddler,¹²⁶ a theme that was repeated in 1931 and in 1935.¹²⁷

When Mother and Child began publication in 1930, it said that it would, unlike its predecessor, National Health, be concerned also with children of school age.¹²⁸ In 1933, the journal referred to a growing interest in child psychology.¹²⁹ In the same year, George Newman told a maternity and child welfare conference that, as infant mortality had been halved, it was necessary to concentrate on improving the quality of the infants. This, he considered, depended not only on the state, but also on the 'physical and moral qualities of the homemaker herself'.¹³⁰

Despite the reduction in overall family size, married women continued to be encouraged to remain home centred. Winifred Holtby was convinced this had a detrimental effect on women's lives, and on their involvement with wider social issues. She welcomed the fact that parents were interested in their children, and that modern women were better able to share their children's interests, and to help them outside the home.¹³¹ She considered, however, that a high price was paid for the maintenance of the tradition of the woman as the homemaker. Moreover, she suggested that some women used domestic work to escape all other responsibilities, finding it easier to be 'a good housewife than a good citizen'.

So long as their own children are healthy and happy, why worry because others are ill and frightened? Yet women are praised for the maternal instinct which makes the care expended on their own children natural and pleasant; they are criticised for the political activities which result in the safeguarding of other people's children as well as their own. So slums remain uncleared, milk is wasted, nursery schools are exceptional luxuries, educational reforms are delayed, while 'good wives and mothers' shut themselves up in the comfort of their private lives and earn the approval of unthinking society.¹³²

She went on to argue that some of these women, in order to fill their time, created domestic work for themselves, by making their homes more elaborate and failing to seek labour-saving devices.

Women's unacknowledged fear lest, robbed of domestic work, they should find no real function in life, does unceasing damage to standards of domestic architecture and furnishing. It has retarded the whole progress of scientific labour-saving

Yet every year standards grow higher Conscientious and well-to-do housewives like conscientious and well-to-do mothers, burden themselves with entire libraries on colour schemes, cocktail recipes, and etiquette for the weekend party; while working-class women, with more elaborate furniture bought on the hire-purchase system, advice from health visitors and infant welfare instructors, and articles in the popular press, give themselves three times the work done by their more primitive predecessors.¹³³

During the 1930s, further pressure had been placed upon women to remain home-centred and to regard motherhood as a full-time occupation. At the same time, however, women's natural competence in domestic matters had again been brought into question. Professional advice on diet and on the psychological development of children proliferated. The women who sought to introduce alternative arguments to those presented by the professionals received little support from women outside the Labour and Co-operative movements. Meanwhile, some women's leaders fostered the split between the professional and the lay women, while scant progress was made towards reducing the distinctions between the social classes.

NOTES AND REFERENCES

- 1 I am indebted to David Doughan, of the Fawcett Library, for giving me this information.
- 2 Reported in the Women's Leader (1929) 21, pp. 44-45
- 3 A weekly political journal did not combine satisfactorily with a monthly publication devoted largely to handicrafts and housewifery, see ibid. (1930) 22, p. 169; (1931) 23, p. 227
- 4 In 1931, Eva Hubback, Elizabeth Macadam and Mary Stocks resigned as editors and were replaced by Mrs. Priestley. Political items began to disappear, and, in April, 1933, the name was changed to the Townswoman, with Mrs. Blanco White as the new editor. In December, 1935, Mrs. Corbett Ashby, who had replaced Eleanor Rathbone as president, resigned, and, after her departure, the journal ceased to include any items on politics or women's rights.
- 5 Mary Stott (1978) Organisation Women, the Story of the National Union of Townswomen's Guilds (London: Heinemann)
- 6 e.g. birth control was not discussed by the NFWI, Gervas Huxley (1961) Lady Denman GBE 1884-1954 (London: Chatto and Windus) p. 82; for the NUTG's stance see Stott (1978) op. cit., pp. 43-45 and 151-157
- 7 e.g., when the NUTG wanted to become informed about maternal mortality, George Newman's opinion was sought, address given by Newman to the annual Council Meeting of the NUTG, quoted in the Townswoman (1933) 1, pp. 21-23
- 8 see Mrs. Corbett Ashby's first presidential address to the NUTG, reported in the Townswoman (1933) 1, p. 1; and Huxley (1961) op. cit., pp. 57; Stott (1978) op. cit., p. 10
- 9 Winifred Holtby discusses the effect of high unemployment on women's job prospects, Holtby (1934) op. cit., p. 153
- 10 e.g. see the literature of the National Men's Defence League which had the slogan 'Men's Jobs for Men', Markham Papers, Section 9/1; and newspaper cuttings collected by Violet Markham during the 1930s, ibid. Section 7/3
- 11 e.g. see letter from a German woman, Manchester Guardian, quoted in Holtby (1934) op. cit., p. 157; Sir Oswald Mosley's policy statement, quoted, ibid., p. 161. Vera Brittain argues that fascist doctrines encouraged a number of British and American women to adopt a disdainful attitude towards the women's movement, Vera Brittain (1953) Lady into Woman, a History of Women from Victoria to Elizabeth II (London: Andrew Dakers) p. 113
- 12 WCG (1937) 54th Annual Report, p. 3

- 13 Peace had figured in the women's movement from 1915, when the Women's International League for Peace and Freedom was formed at the International Congress of Women held at The Hague, see discussion in Gertrude Bussey and Margaret Tims (1965) The Women's International League for Peace and Freedom 1915-1965, a Record of Fifty Years Work (London: George Allen and Unwin); and see also report of the Annual Conference of the National Council of Women in Time and Tide (1923) 4, p. 1072; Lady Astor speech reported in The Times 13 December, 1927; Margaret Llewelyn Davies (n.d., 1921-1924) Death or Life? a Call to Co-operative Women, a WCG pamphlet, University of Hull Archive, Box DCX 5. Both the League and the WCG criticised the terms of the Treaty of Versailles in 1919, Bussey and Tims (1965) op. cit., pp. 30-31; Minute Books of the Central Committee of the WCG, Hull DCW/1 1/7. Women were active in the League of Nations. A meeting on women and the League of Nations was held at the Albert Hall, and was well attended, reported in the Manchester Guardian 7 February, 1920, Tuckwell Collection, File 324B. Lady Gladstone urged members of the NUSEC to join the League of Nations Union, Women's Leader (1920) 12, p. 318; see also Bussey and Tims (1965) op. cit., pp. 50-51; article by Helen Fraser, Daily Chronicle 20 June, 1919, Tuckwell Collection, File 601. Vera Brittain and Winifred Holtby became lecturers for the League of Nations, Brittain (1941) op. cit., pp. 112-113; Brittain (1978) Testament of Youth, an Autobiographical Study of the Years 1900-1925 (London: Virago) pp. 538-576 (first published in 1933). The women's peace movement became more active in the 1930s, with the worsening international situation, Bussey and Tims (1965) op. cit., pp. 91-144; see also the Labour Woman during 1932 and 1933; the commitment of the WCG intensified in 1930, when the Guild began a campaign for peace training in schools, reported in WCG (1931) 48th Annual Report, p. 4; and WCG concern became more acute following the collapse of the Labour government, WCG (1932) 49th Annual Report, pp. 7-9; in 1933, the Guild began the distribution of peace pledge cards, WCG (1934) 51st Annual Report, pp. 10-13; the Annual Report for 1937-1938 was dominated by peace, to the exclusion of all mention of the maternity campaign, WCG (1938) 55th Annual Report. From 1929, when Mrs. Corbett Ashby became president of the NUSEC, the Women's Leader devoted more space to peace and disarmament, see her presidential address, quoted in the Women's Leader (1929) 21, pp. 147-148; leading article, ibid. (1931) 23, p. 67, published during the NUSEC's disarmament year.
- 14 During the 1930s, the voluntary associations were keen to demonstrate what could be achieved without a national maternity service, e.g. editorial in Mother and Child, in response to the Newman Report, which acknowledged the need to improve the training of midwives and other medical personnel but, in line with the Newman Committee, asserted that the most important element was the education of mothers, Mother and Child (1932) 3, pp. 191-192; see also Harold Waller's article, ibid. (1935) 5, pp. 473-476, and the journal's response, ibid., pp. 490-491

- 15 In July, 1932, May Tennant and Gertrude Tuckwell had a meeting with Sir Arthur Robinson, the Secretary to the Ministry of Health, at which they suggested an investigation into illnesses found in women as a result of pregnancy similar to that on maternal mortality, meeting held on 28 July, 1932, recorded in PRO MH55/262
- 16 Janet Campbell acknowledged the high incidence of ill health amongst childbearing women, and suggested the form an investigation could take, Minute from Janet Campbell to George Newman, 15 August, 1932, PRO MH55/262. Newman thought an inquiry unnecessary from the Ministry's point of view, and noted that publication of statistics might have a depressing effect on the birth rate and would arouse public opinion, creating a demand which would have to be met. He suggested, instead, that the existing policy should be maintained, with local authorities encouraged to set up 'Mother Centres', which would be inexpensive, to deal with post-midwifery sickness, Minute from George Newman to Sir Arthur Robinson, 26 October, 1932, PRO MH55/262. These minutes were passed to the Minister, Hilton Young, but he decided that the matter should be dropped, Minute from Sir Arthur Robinson to Sir Edward Hilton Young, 2 November, 1932, and reply from Hilton Young to Robinson, 7 November, 1932, PRO MH55/262
- 17 e.g. in January, 1934, the Minister was advised not to accept an invitation to address a conference planned for April as he might be heckled and the Ministry had no new initiative it wished to publicise, telephone call from Gertrude Tuckwell, 12 January, 1934, recorded PRO MH55/262; minute from Sir Arthur Robinson to Hilton Young, 22 January, 1934, PRO MH55/262
- 18 quoted in Mother and Child (1934) 5, p. 339
- 19 The NCMCW pointed out that Hilton Young had stated that there was no evidence to prove that malnutrition was a cause of maternal mortality, and observed that at least half the maternal deaths were amongst the well-to-do, reported, ibid. (1935) 5, pp. 397-398
- 20 The journal quoted the example of Huddersfield, where there were no ante-natal clinics, as the medical supervision of pregnant women was done by home visits, ibid., p. 451
- 21 ibid., p. 339
- 22 The Times pointed out that the Ministry had recently issued a circular on maternity and child welfare services (Circular 1433, issued 10 October, 1934), reported in The Times 6 November, 1934; see also leading article following the Maternal Mortality Committee's 1934 conference, ibid. 7 November, 1934
- 23 e.g. an assessment of the aims of the Maternal Mortality Committee prepared in December, 1935, PRO MH55/262; May Tennant's meeting with the Minister of Health, 12 December,

- 1935, ibid.
- 24 e.g. it was noted in the Ministry of Health files that the Minister had spent a weekend as a guest of May Tennant at her home in Kent, 29 June, 1938, PRO MH55/679
- 25 e.g. John Stevenson and Chris Cook (1979) The Slump, Society and Politics during the Depression (London: Quartet); J.M. Winter (1979) Infant mortality, maternal mortality, and public health in Britain in the 1930s, Journal of European Economic History, 8, pp. 439-462
- 26 Charles Webster (1982) Healthy or hungry Thirties?, History Workshop Journal, Issue 13, pp. 110-129
- 27 the BMA's Committee on Nutrition, in a report published in 1933, noted with regret that there was
no satisfactory and accepted routine method by which the nutritional condition or state of individuals can be assessed and by which the findings of different observers can be compared.
BMJ (1933) ii, Report of the Committee on Nutrition, Supplement, p. 5. The lack of a suitable definition was noted also in Maternity and Child Welfare (1934) 18, p. 11
- 28 e.g. Webster has commented on this point, and has noted a change in the statistics following a change in the terms used, Webster (1982) op. cit., p. 119. A Labour Party pamphlet, based on information collected by the SJC, drew attention to the possibility that reports would be influenced by the standards in that area, Labour Party (1936) Protect the Nation's Mothers (London: Labour Party)
- 29 e.g. May Mellanby's research, based on experiments using dogs, which was published in the Medical Research Council Special Report Series, No. 140 (1929) Diet and Teeth: an Experimental Study Part One; No. 153 (1931) Diet and Teeth, A. Diet and Dental Disease, B. Diet and Dental Structure in Mammals other than Dogs (London: HMSO). These reports were the subject of editorials in Public Health (1930) 43, pp. 163-164; (1931) 44, p. 242. Dr. William Cramer addressed the Soc.MOSH on the effects of vitamins on health, reported in Public Health (1924) 37, pp. 178-179. Edward Mellanby published on the importance of calcium, Public Health (1923) 36, pp. 192-194. Helen M.M. Mackay, assisted by Lord Goodfellow, completed a five-year study on anaemia in infancy, Medical Research Council Special Report Series (1931) No. 157, Nutritional Anaemia in Infancy, with Special Reference to Iron Deficiency (London: HMSO)
- 30 In 1932, nutrition was the subject of an editorial in the BMJ. It argued that calcium, phosphorus and vitamin D were vital, and that milk was an almost perfect food, BMJ (1932) ii, pp. 848-849. S.J. Cowell, the Professor of Dietetics at the University of London, published an ideal diet for pregnant women, Public Health (1936) 50, p. 20

- 31 Edward Mellanby published a paper suggesting that Vitamin A might affect puerperal sepsis. This paper formed the basis of an editorial in the Medical Officer (1930) 44, p. 233
- 32 On the State of Public Health (1930) p. 23. In 1930, the regulations laid down in the 1918 Maternity and Child Welfare Act were extended, Circular 1072, 12 February, 1930. Two years later, local authorities were asked to ensure that mothers and young children received adequate quantities of vitamin D, obtainable in cod-liver oil and milk, and were informed that they could give necessitous women meals throughout pregnancy, and not just in the last three months, Circular 1290, 27 October, 1932
- 33 Mr. Harris, the MP for Bethnal Green, attributed a decline in the death rate to the distribution of free milk. He declared one pint of free milk a day could not possibly push a woman towards pauperism and demoralisation, PP (1928) 220, Col. 2245. Successive governments, however, wanted public assistance to remain below the level of the minimum wage, as an incentive to seek work. Lt.-Col. Fremantle stated in the Commons that he opposed the indiscriminate provision of milk and meals, as bad and careless parents would provide less, when the aim should be to make them more self-supporting, PP (1936) 317, cols. 156-158
- 34 Literature appeared on the constituents of an adequate diet. E.g. in a review of What's Best to Eat? by S. Henning Belfrage, Public Health stated that modern civilisation required some rational knowledge, rather than a reliance on instinct, Public Health (1927) 40, p. 127
- 35 The Times 23 June, 1934, and 14 September, 1934
- 36 ibid., 2 February, 1932
- 37 In 1934, the NFWI, in conjunction with the National Baby Week Council, organised a competition on how to feed a family of four, with two children under five years, on thirty shillings a week, reported in Mother and Child (1934) 4, p. 484
- 38 Papers read to health visitors at their winter school, reported in The Times 1 January, 1932 and 3 January, 1936
- 39 The two other papers were read by V.H. Mottram, Professor of Physiology at the University of London, and Eric Pritchard, Chairman of the Executive Committee of the National Baby Week Council and the paediatrician at Queen Charlotte's Hospital, reported in Mother and Child (1934) 5, pp. 193-198
- 40 Reported in Public Health (1934) 47, p. 311
- 41 ibid., pp. 311-312
- 42 e.g. see leading articles in The Times 10 July and 15 September, 1933. The following year, The Times noted that a

a decline in standards of health in certain areas had been offset by an improvement in other areas, ibid. 19 September, 1934

- 43 Comments made during the supply debate on the civil estimates, PP (1933) 280, cols. 653-654
- 44 ibid. (1934) 291, col. 392
- 45 George Griffiths put the blame for maternal mortality on poverty. He declared
The reason why so many mothers die is because, when it comes to the vital point, they have not the necessary strength. They have, I might say, been starved to death. In many cases they have not had sufficient to eat and not having had sufficient to eat, they cannot survive under the stress of childbirth.
PP (1934) 291, col. 432
- 46 Webster (1982) op. cit., pp. 111-112
- 47 Webster makes this point, and produces evidence to show that doctors who persisted in associating poverty and ill-health were threatened with censure, ibid., pp. 112-113. Malcolm Collidge's research in Sunderland corroborates this argument, Malcolm Collidge (1983) Growth and depression in the 1930s, paper read at the History Workshop Conference, 12 November, 1983
- 48 PP (1935) 299, col. 1648
- 49 e.g. Saving the Mothers (1934) Pamphlet No. 3450 (London: National Unionist Association)
- 50 Statement made by Geoffrey Shakespeare, parliamentary secretary to the Minister of Health, PP (1935) 299, col. 1693
- 51 Reported in Public Health (1935) 48, pp. 286-291
- 52 Comments made at a Council meeting of the Association of Maternity and Child Welfare Centres, reported in Mother and Child (1935) 5, p. 344
- 53 Medical Officer (1932) 47, p. 221
- 54 ibid. (1934) 51, pp. 252-253
- 55 e.g. editorial, ibid. (1934) 52, p. 11
- 56 Labour and Co-operative women had consistently argued that women's health would not improve simply by expanding medical services and improving medical training, and that measures to tackle poor home conditions and financial hardship must also be adopted. Particular reference was made to the need to ensure mothers had access to a plentiful

- supply of clean milk and to the evidence of malnutrition in mining communities following the strike, see pp. 115-116 and ref. 86, p. 132
- 57 Labour Woman (1933) 21, p. 53
- 58 ibid. (1934) 22, p. 67
- 59 ibid. (1936) 24, pp. 72-73
- 60 Reported in Maternity and Child Welfare (1933) 17, p. 223
- 61 Maternal Mortality Committee (1934) Maternal Mortality, Report of a meeting held at the Friends' House, Euston Road, 6 November, 1934 (London: Maternal Mortality Committee) p. 18
- 62 ibid., p. 11
- 63 e.g. Mrs. Frankenburg, representing the Women's Conservative Association, used the argument of high maternal mortality rates among the well-to-do, ibid., p. 13
- 64 e.g. Mrs. Tate, Conservative MP for Willesden, PP (1935) 299, cols. 1605-1608. The Countess of Iveagh, MP for Southend-on-Sea, thought causes must be various, ibid., cols. 1637-1638. Lady Astor argued that too much attention was paid to malnutrition, ibid., 297, col. 2059; and, subsequently, she argued that the experts believed that the depressed areas and maternal mortality were not linked, ibid., 307, col. 195. Florence Horsburgh, in 1936, accepted that there was some malnutrition, but it was not widespread, with individual cases needing help. What was widespread was ignorance of food values and the constituents of a balanced diet, ibid. (1936) 314, cols. 1280-1281. In 1939, Mrs. Tate declared that she wanted more attention paid to the teaching of cookery in schools, ibid. (1939) 345, col. 1516
- 65 Reported in The Times 29 May, 1935
- 66 Unemployment, which had been fairly constant over the preceding few years (approximately 1,200,000, 10% of the insured working population) rose to 2,000,000 in July, 1930, and reached 2,500,000 by December, 1930, and was expected, incorrectly, to reach 3,000,000 in 1931, A.J.P. Taylor (1965) op. cit., p. 284
- 67 Bentley B. Gilbert discusses the debate on the cut in the unemployment benefit in 1931 and the subsequent legislation brought in by the national government, Bentley B. Gilbert (1970) British Social Policy 1914-1939 (London: Batsford) pp. 162-175
- 68 BMJ (1933) ii, Report of the Committee on Nutrition 25 November, 1933. The Report was published also as a pamphlet. The members of the Committee were E.K. Le Fleming (chairman), G.C.M. M'Gonigle (honorary secretary), Sir Henry Brackenbury (chairman of the Council of the BMA), N. Bishop

Harman, G.F. Buchan (MOH and School Medical Officer in Willesden), S.J. Cowell, G.E. Friend (Medical Officer of Christ's Hospital, Horsham), Robert Hutchinson (physician at the London Hospital) and V.H. Mottram (Professor of Physiology, University of London)

- 69 ibid., p. 15. The Committee produced an estimate of the number of calories required per day, and worked out a balance between the various types of food, ibid., pp. 8-14. It also produced sixteen specimen diets for households of various sizes, which included estimates of costs, e.g., for a family of five, with the eldest child a teenager, it estimated that the cost would vary between 22 shillings 6½ pence and 18 shillings 5¼ pence, according to geographical location, ibid., pp. 21-39
- 70 The Ministry of Health appointed the Nutrition Advisory Committee in January, 1931. The members were Prof. Maj. Greenwood (chairman), Prof. E.P. Cathcart, Sir Frederick Gowland Hopkins (President of the Royal Society), Miss Jessie Lindsay, Prof. Edward Mellanby and Prof. V.H. Mottram. The Committee was to advise on the practical application of the modern advances in knowledge of nutrition, reported in the BMJ (1931) i, p. 108. The government, however, attached little importance to the work of this Committee, see Webster (1982) op. cit., p. 120. In 1934, the Ministry announced that Gowlands Hopkins, Cathcart and Mellanby, physiologists on the Ministry's Committee, were conferring with Mottram, Cowell and Crowden, the physiologists representing the BMA, on the differences between the Committees on the amount of calories and first-class protein appropriate as a basis for a suitable diet, reported in the BMJ (1934) i, p. 161. An agreed report was published which pointed out that the terms of reference were different. The Ministry recommendation (3000 calories per day) was a guide for MOsH and was an average for the entire population. The BMA recommendation (3,400 calories per day) was based on an unemployed man working on an allotment and keeping fit. The report stated that nutrition was not an exact science, and a sliding scale of calorie requirements was produced, reported, ibid., pp. 900-901
- 71 The Committee against Malnutrition was a group of doctors and scientists. The members of the Children's Minimum Committee were mainly lay women. Eleanor Rathbone was in the chair, with Eva Hubback her vice-chairman, and Mrs. Ayrton-Gould, Mrs. Eleanor Barton, Mrs. Barbara Drake, W.T. Elliott, Edward Fuller, Sir Edward Grigg MP, Lady Hall, Dr. Somerville Hastings, Miss F. Hawtrey, the Rev. C.P. Kirk, Miss Elizabeth Macadam, Mrs. Masterman, Mrs. Oliver Strachey, Miss Mary E. Sutherland, Miss Symons and Miss Gertrude Tuckwell were members.
- 72 The Children's Minimum Committee obtained support from twenty-four organisations including welfare groups, educational associations, women's groups and religious societies. As the CMO stated in his report for 1938, health and efficiency for all was the aim, but adults could only

be advised whereas the case for children was different, not only because they were dependent but also because neglect of a child's health could lead to permanent defects and chronic invalidism, On the State of Public Health (1939) p. 70

- 73 Webster reviews the data, Webster (1982) op. cit., pp. 120-122. This information was being disseminated to a wider public. E.g., in 1936, the Gas, Light and Coke Company produced a film, based on M'Gonigle and Kirby's Poverty and Public Health. The film showed that people spending less than ten shillings per week on food were suffering from deficiencies of calcium and iron, and that malnutrition was caused predominantly by poverty and not ignorance, while expectant and nursing mothers and children under five years were the worst sufferers, reported in Time and Tide (1936) 17, p. 1439. Moreover, women's groups were amassing more information. The SJC produced a report on nutrition for the 1936 National Conference of Labour Women, in which it was estimated that many families of the unemployed and the low paid had only between two shillings and three shillings and six pence per head to spend on food each week, reported in The Times 2 May, 1936. Following an address by Sir John Boyd Orr, the NFWI passed a resolution calling for a reduction in the price of milk, reported in The Times 21 May, 1936. In 1935, two women investigated the effects of unemployment on mothers for the Council of Action for Peace and Reconstruction. They chose areas that had been depressed for some time and concluded that women suffered because there was insufficient food for the whole family and husbands and children took priority. They found women suffered particularly during pregnancy and lactation, and called for more research into the effects of diet on pregnancy, Margaret I. Balfour and Joan C. Drury (1935) Motherhood in the Special Areas of Durham and Tyneside (London: Council of Action). The Women's Health Enquiry Committee, which published the results of its survey in 1939, also provided evidence of undernourishment, Spring Rice (1981) op. cit., pp. 155-187
- 74 In 1933, 52% of recruits were rejected as unfit, of which most were between the ages of eighteen and nineteen years, while in the North the number of rejects rose to 70%, with 80% for the Lancashire Territorials. The following year, Maj.-Gen. P.H. Henderson, of the War Office, told a health congress in Bristol that army recruits, during a short stay at an army depot, gained eight pounds, while the weaker men gained a full stone, evidence quoted by Marjorie Green (1934) Some Observations on the Report of the CMO to the Ministry of Health for 1934, with some further Evidence on the Ill-effects of Unemployment on Health (London: Children's Minimum Committee) Appendix and Supplementary Memorandum, evidence on malnutrition.
- 75 Chamberlain's comments on the need for physically-fit army recruits were made in a policy statement at the Conservative Party Conference in 1936, quoted in The Times 3 October, 1936

- 76 A leading article in 1935 expressed regret that increased agricultural productivity had not been accompanied by an increase in consumption, ibid. 18 September, 1935. In a leading article, following publication of the League of Nations inquiry into diet and health, which concluded that half the population of Western Europe, although not hungry, did not have an adequate diet, the paper advocated free milk for all school children, ibid. 13 February, 1936. A leading article three months' later argued that home-produced food was vital for civil defence, ibid., 21 May, 1936. When Kingsley Wood became the Minister of Health in 1935, The Times referred to the school meals' service and the distribution of potatoes to the unemployed in West Auckland, and urged him to consider further experiments, ibid., 18 July, 1935.
- 77 Leading article, ibid., 31 March, 1936; and the need to expand the special milk service to mothers and infants was advocated in a leading article in November, ibid., 12 November, 1936.
- 78 On the State of Public Health (1937) p. 59
- 79 This announcement was made when a deputation from the Children's Minimum Council was received by the Minister of Labour, reported in The Times 1 March, 1937
- 80 PP (1938) 342, cols. 29-30
- 81 The other areas were Merthyr Tydfil, the whole of the special areas of Monmouthshire, Gateshead, South Shields and Sunderland, see report on preliminary findings by Lady Rhys Williams in Public Health (1936) 50, pp. 11-19
- 82 e.g. see the Minister of Health's statements in the House of Commons, PP (1936) 309, cols. 1557-1558; (1938) 333, cols. 590-592 and 1371-1372; 336, cols. 575-576; 342, cols. 2188-2189
- 83 On the State of Public Health during the Six Years of War (1946) pp. 92-93
- 84 Conservative Party (1945) General Election 1945, Notes for Speakers and Workers (London: Conservative Central Office) pp. 158-159
- 85 Grantly Dick Read published in both medical and maternity and child welfare journals. His notion of natural childbirth, however, did not imply that he anticipated an end to the involvement of the obstetrician in normal confinements. He was sure that the obstetrician was essential, but he thought the obstetrician, who was likely to be male, should avoid the use of drugs and mechanical interference during labour, Grantly Dick Read (1933) Natural Childbirth (London: Heinemann) pp. 16-34, 36, 59-66, 86-115
- 86 e.g. see lecture given to nurses by the Matron of the

- General Lying-in Hospital, London, reported in The Times 22 July, 1937; and article by Dr. H.P. Newsholme, the MOH for Birmingham, Public Health (1936) 49, pp. 174-177
- 87 On the State of Public Health (1930) p. 24
- 88 He named the NFWI, the WCG and the NUTG, ibid. (1933) p. 83
- 89 One Liberal MP, Mr. Janner, in a discussion on maternal mortality, argued that propaganda should not lead people to think that childbirth per se was dangerous, as the birth rate would go down, PP (1935) 302, col. 1082. Similarly, Comyns Berkeley, an Obstetrician, claimed the attention given to puerperal sepsis was having a depressing effect on the birth rate, Medical Officer (1935) 53, p. 16. A correspondent in the BMJ stated that fear of death was encouraging women to seek an abortion, BMJ (1935) i, p. 84 Birth rate statistics are given in Table Two.
- 90 Reported in Mother and Child (1933) 4, p. 2
- 91 erg. see editorial, ibid. (1934) 4, p. 478; questions in the House of Commons, PP (1934) 293, cols. 1254 and 1255
- 92 ibid., cols. 1254-1255
- 93 On the State of Public Health (1936) pp. 52-53
- 94 Quoted in the BMJ (1935) ii, p. 600
- 95 Janet M. Campbell, Isabella Cameron and Dilys Jones (1932) High Maternal Mortality in Certain Areas, Reports on Public Health and Medical Subjects, No. 68 (London: HMSO). This report was intended as a supplement to the findings of the Newman Committee. The areas investigated were rural Wales and the industrial North of England.
- 96 Medical Officer (1932) 48, p. 158
- 97 ibid. (1935) 54, p. 42
- 98 ibid. (1936) 55, p. 94
- 99 Leading article in Maternity and Child Welfare (1928) 12, p. 241
- 100 G.R. Birtwood (1932) Ante-natal Advice for the Expectant Mother - Fifty Ante-natal Talks (London: John Bales Sons and Danielsson) reviewed in Mother and Child (1932) 3, p. 35
- 101 ibid., pp. 121-124
- 102 reported, ibid. (1933) 4, p. 13
- 103 Leading article, ibid. (1935) 5, pp. 147-148. McIlroy had made these remarks in an article in the Daily Telegraph.
- 104 Mother and Child (1935) 6, pp. 58-61

- 105 Mrs. Tennant collected examples of the literature produced by the local authorities, which she sent to the Minister of Health. She suggested the Ministry should produce its own leaflet, letter dated 15 December, 1937. Isabella Cameron, however, argued against this suggestion. The Ministry should not issue clinical instructions or directives, because medical opinion was divided, and a number of different approaches had achieved good results, while the BMA would object, minute from Dr. Cameron to Sir Arthur McNalty, 18 December, 1937, PRO MH55/679
- 106 Those attending this Council meeting included the Minister of Health, Kingsley Wood, Sir Arthur McNalty, Jane Turnbull and A.B. Maclachlan, the principal assistant secretary at the Ministry, reported in Mother and Child (1935) 6, p. 348
- 107 ibid.
- 108 see maternal mortality statistics, Table Three; and discussion of the high incidence of maternal morbidity, p. 144
- 109 e.g. leading article in Maternity and Child Welfare (1923) 7, p. 83
- 110 Dr. James Fenton, the MOH for Kensington, formed a fathers' council for this reason, reported in Mother and Child (1934) 5, pp. 129-130. The NLH organised classes for fathers as it realised the father could persuade his wife to attend for treatment, reported in National Health (1925) 18, p. 164
- 111 One of the three points for Baby Week for 1926 was the father's share in the child welfare movement, reported in the Women's Leader (1926) 39, p. 204
- 112 Editorial on the fourth annual conference of Fathers' Councils, in Mother and Child (1934) 4, pp. 1-2
- 113 e.g. leading article in Maternity and Child Welfare (1925) 9, pp. 153-154
- 114 Editorial in National Health (1924) 17, p. 38
- 115 Maternity and Child Welfare (1929) 13, p. 47
- 116 Reported in Public Health (1927) 40, p. 338
- 117 To Husbands and Fathers, published by the London Association for Maternity and Child Welfare Centres. Information was provided on sex education for boys, on the services available to the mother, marriage relations and the psychology of the mother, and the father's duty before and after the confinement. The second edition was reviewed in Mother and Child (1933) 4, pp. 151-153
- 118 This was one of the themes introduced in 1926, reported in Public Health (1926) 39, p. 238
- 119 Reported, ibid. (1931) 44, pp. 305-306

- 120 Quoted in Mother and Child (1935) 6, pp. 48-50. Dennis Geffen was also the MOH for Enfield.
- 121 Address given to health visitors and school nurses at their winter school, reported in The Times 3 January, 1929
- 122 Mother and Child (1938) 9, pp. 205-206
- 123 Mitchison (1979) op. cit., p. 33
- 124 Davies, personal communication, 1981
- 125 Reported in The Times 4 July, 1925
- 126 Reported in the Women's Leader (1926) 18, p. 204; Public Health (1926) 39, pp. 238 and 245
- 127 Reported in Public Health (1931) 44, pp. 305-306; (1935) 48, p. 305
- 128 Mother and Child (1930) 1, pp. 1-2
- 129 ibid. (1933) 4, pp. 293-294
- 130 Address given to the Sixth English Speaking Conference on Maternity and Child Welfare, organised by the National Association for the Prevention of Infant Mortality, reported in Public Health (1933) 46, p. 350
- 131 Holtby (1934) op. cit., p. 145
- 132 ibid., pp. 148-149
- 133 ibid., pp. 149-150

C H A P T E R S I X

AN ASSESSMENT OF THE LAY WOMEN'S CAMPAIGN
TO EXTEND HEALTH AND WELFARE SERVICES

It is evident that the social-class divisions and the assumption that women's primary role was that of wife and mother, which had a major impact on the way in which women entered the public domain (see Chapter Two), remained in evidence in the inter-war period, influencing the way in which the women's health campaign was organised.

Social-class divisions, as discussed in Chapter Three, provided a justification not only for separate services for middle-class and working-class women but also for the perpetuation of voluntary work in the maternity and child welfare services. These divisions weakened the health campaign, as middle-class and working-class women often disagreed about the type of service required and on the priorities, thus creating an impression of ambivalence about what was needed. Meanwhile, the emphasis on services designed to help women remain in the home did little to break down the barriers between the equal-rights campaigners and the welfare reformers. As wel-

fare services were seen as separate from the campaign for equal rights, it was not inconsistent to campaign as women while at the same time accepting definitions and solutions laid down by technical experts who were invariably male.

The lay women welfare campaigners' ready acknowledgement of the importance of motherhood and their willingness to defer to the opinion of the expert made it easy for them to support the government initiative to improve maternity and child welfare services during the 1920s. Their major concern was to extend welfare services, and they gave their support to the medicalisation of childbirth. This collusion with the Ministry of Health and the medical profession meant lay women gave little support to the independent midwife and took little interest in the employment opportunities for women outside the home. They wanted to see women working only in those jobs which could be regarded as an extension of their domestic role, and accepted that, ideally, married women with children should not have to work outside the home. It is not surprising, therefore, that governments welcomed women's actions to publicise the need to extend maternity and child welfare services. It is evident, however, that the Ministry of Health's enthusiasm for the support given to its endeavours by lay women fell short of seeking to include these women in any decision-making process or advisory body.

Although the consensus of opinion disintegrated in the 1930s, there is little evidence either of a change in lay women's attitude to their role in society, enabling welfare workers and equal-rights campaigners to draw together, or of a disintegration of social-class divisions. Working-class

women became more overtly concerned with tackling the problems created by poor housing and poverty, with special attention being given to the effects on women of a poor diet. Middle-class women, on the other hand, continued to rely on the opinion of technical experts. Many, therefore, accepted the argument that poor diet was due to a lack of knowledge of dietary requirements. Middle-class women also began to spend more time considering the welfare of their own families, paying particular heed to the work of child psychologists and analysing their own attitude to the trauma of childbirth, in the wake of the natural childbirth movement. The nutrition debate, the development of child psychology and the debate on the effect of fear on maternal mortality, however, tended not only to reinforce social-class differences but also to increase women's reliance on technical experts, while further undermining their confidence in their own transmitted skills. At the same time, changes within the women's organisations meant that lay women were given less encouragement to become politically active. The emphasis shifted from campaigning for equal rights and for services catering for the needs of women to a desire to provide recreation and education for isolated women. Those women who had acquired technical skills set themselves apart from other women, a process which was particularly evident in the NUSEC.

Nevertheless, the lay women's health campaign, given the constraints which continued to be placed upon women's activity in the public domain, did achieve some success. It is apparent that the lay Maternal Mortality Committee attracted considerable publicity, and was regarded by the Ministry of Health as a useful means of keeping pressure on the local authorities

to extend and improve their maternity and child welfare services.

Certainly, those involved with the Maternal Mortality Committee were pleased with the influence the Committee had on the development of the maternity and child welfare service. The Committee made a special effort to contact local authorities. A leaflet was produced, outlining the services the municipalities could provide under the 1918 Maternity and Child Welfare Act. Each year the Committee wrote to local authorities to ask what provisions were being put into operation. The Committee kept the issues before the general public by the organisation of well-publicised conferences in London, while questions were asked in parliament and deputations were received by the Minister of Health (see Chapter Four). Violet Markham remarked

Thanks to these measures, public attention was arrested and the Local Authorities stimulated.¹

Moreover, she considered

The work achieved by this Committee is a striking example of the value of a voluntary body working alongside and stimulating the State machinery.²

Janet Campbell, in 1949, told Gertrude Tuckwell she believed the Committee had been successful in persuading backward local authorities to take action on maternal health.

The Maternal Mortality Crusade had certainly yielded paying results. Pioneer work is apt to get forgotten but it was after all the foundation of what is being done now and of the very good results which are being obtained.³

Labour women also were convinced that one of their roles was to keep the debates alive. When announcing the visit of

a deputation of Labour women to the Minister of Health, the Labour Woman declared that publicity was an effective way of achieving better services.

There is a tendency in many quarters to deplore the publicity which has been given in recent years to the question of maternal welfare, and to insist that it is not a 'political' question. Such people suggest that it is in rather bad taste of Labour women to mention it on a political platform.

Some of the services came under public authority work, while some of the causes were within public control.

If a Government or Local Authority refuses to adopt measures which experts consider to be necessary, the question must come into the field of political controversy, however much we might prefer that a matter which involves the lives and health of mothers should be settled quietly and without controversy.⁴

The quote, however, indicates that differences remained between those who wanted the women who entered politics to demonstrate their equality by devoting their attention to matters which had traditionally dominated political debate, and those who wanted women to use their presence in the public arena to raise questions which were primarily of concern to women and which had previously been trivialised or ignored. The means whereby women could maintain their differences from men and yet achieve equality remained unresolved.

It seems probable that women's groups were influential in keeping alive the debate on maternity and child welfare during the 1930s, when the economic difficulties and the rise of fascism in Europe, coupled with the rearmament programme and the growing threat of war, could have diverted the government's attention from the problems of maternity and child welfare.

It is, however, evident that, as discussed in Chapter Four, much of the activity of the women's organisations was to campaign for policies advocated by the Ministry of Health, and to follow the recommendations of the medical profession. Few women openly criticised the medical profession, while most welcomed technical advances and considered that the advice of professional workers in all aspects of maternity and child welfare was helpful.

The campaign for maternity and child welfare services tended to reinforce the social-class divisions, through its assumption that services would be class specific. The continuing involvement of the voluntary organisations hindered co-ordinated action. The opportunity to create a mass movement was, therefore, limited. This acceptance of social-class divisions, however, was not confined to those working for maternity and child welfare services. The equal rights feminists, by their attitude to domestic work, demonstrated a similar regard for the existing social stratification (see pp. 49-51).

Furthermore, the maternity and child welfare campaign was affected by the deference shown to the professional experts. Women tended to lose confidence in their transmitted skills and knowledge. The ready acceptance of the need to medicalise childbirth and the desire to follow child rearing methods advocated by doctors being prime examples (see pp. 73-75 and 163-164). At the same time, women who had acquired technical expertise tended to set themselves apart from those with no recognised qualifications. Rather than attempting to bring in as many women as possible to campaign for legislative changes, they argued that such changes depended upon the work of a few

with technical knowledge (see pp. 141-142).

The structure of the campaign affected women who sought employment in the health services. First, the assumption that class-specific services would remain did little to raise the status of the midwife or the health visitor. Secondly, the middle-class enthusiasm for voluntary involvement in much of the maternity and child welfare work helped to maintain a distinction between this service and other branches of the health services. Thirdly, women's ready acceptance of the need to defer to the opinion of technical experts led them to follow the dictates of the largely male medical elite, encouraging women to place themselves in the hands of a male obstetrician rather than a female midwife. Finally, the separation from the old feminists, the emphasis on the need to raise the status of motherhood, and the wish to foster the idea that motherhood was a full-time occupation did not fit well with any campaigns to gain equality with men in the job market. Moreover, the changes within the women's organisations, discussed in Chapter Five, meant that there were fewer organisations campaigning for women's rights and equality, while those offering education and recreation were attracting a wider membership.

Maternity and child welfare workers wanted women to work in the service, but, as will be revealed in the next section, the lay women were rarely prominent in the struggles of the women health workers. When they did become involved, lay women were more likely to concern themselves with improving training standards and not with questions of autonomy from the medical elite or parity with male colleagues. For the lay women the provision of services was the key issue, while many

visualised women providing the ancillary services rather than the technical expertise. Meanwhile, women entering the health services as paid workers were encouraged to emphasise their ability to fulfil a caring role, their knowledge of the home and children, and their desire to work specifically to improve the health and welfare of mothers and babies. They were thus contributors to the categorisation of women's work in the health services.

Whilst it is argued that, given the constraints which continued to be placed upon women stepping out of the private domain of the home into the public domain, the lay women's campaign for improved health and welfare services was not without success, it is nevertheless apparent that the campaigns waged by these women did little to break down existing barriers. The separation between men and women in the home remained intact, with men continuing to take the dominant role. Distinctions between the lay and the professional were more clearly defined, with the professionals' technical knowledge undermining women's transmitted skills and knowledge. Indeed, the desire to secure a place in the changing services enhanced rivalry not only between the various health professions but also within the medical profession, with conflicts between general practitioners and consultants. Finally, the nature of the maternity and child welfare campaign failed to break down the division between the middle-class welfare workers and the Labour and Co-operative women. These divisions had an effect upon the manner in which women were incorporated as paid workers into the health services. It is against this background that the history of women in medicine, midwifery and health visiting

during the inter-war period will be discussed.

NOTES AND REFERENCES

- 1 Markham (1949) op. cit., p. 55
- 2 ibid., p. 53
- 3 Letter from Janet Campbell to Gertrude Tuckwell, quoted in Tuckwell (1949) op. cit., Chapter 28, p. 6
- 4 Editorial in the Labour Woman (1935) 23, p. 114. The deputation referred to comprised Dr. Esther Rickards, Mrs. Eleanor Barton, Alderman Rose Davies, Miss Loughlin, Mrs. Ayrton Gould and Miss Mary Sutherland, the Chief Woman Officer of the Labour Party and editor of the Labour Woman. The deputation was demanding better co-ordination of services, to ensure all women had adequate care during pregnancy, childbirth and the six weeks after the birth. The deputation also reiterated demands for the Maternity and Child Welfare Act to be made mandatory, financial assistance for depressed areas, the better training of doctors and midwives, a municipal midwifery service, more ante-natal and post-natal clinics, hospital beds and home helps, further inquiries into maternal mortality, and an inquiry into the effect of diet on the health of the mother.

S E C T I O N T H R E E

WOMEN HEALTH PROFESSIONALS :
WOMEN DOCTORS, MIDWIVES AND
HEALTH VISITORS.

INTRODUCTION

In certain respects women employed in the health services were in a more favourable position than women who tried to enter politics. By the beginning of this century, women had won the right to train as doctors, although a number of the country's leading medical schools refused to admit women, while opportunities upon qualification were restricted. During the First World War, however, several of the London teaching hospitals were persuaded to open their doors to women,¹ and women doctors were able to demonstrate their abilities in a number of new spheres, including the treatment of war casualties in France.² By 1920, The Times could say that women doctors had become valuable and indispensable servants of the community, who had achieved a splendid record during the war.³ Meanwhile, the development of the infant welfare movement from the early years of this century ensured that attention would be directed towards establishing and improving two occupations, midwifery and health visiting. Occupational associations had been formed by nurses, midwives and the women public health workers, and attempts were being made to improve the status, working conditions and remuneration of these occupations. At the same time a start was being made on the regulation and standardisation of social work.

Nevertheless, women in these occupations were not able to establish themselves as influential groups, able to determine policy, and in a position to achieve high status

and reward in the wake of the heightened public interest taken in national health, and maternity and child welfare in particular. One of the principal difficulties arose from the tendency to consider women as separate and distinct from male health workers. Women health professionals, like women in parliament, faced the problem of entering a well-established service as a minority group. They too initially were encouraged to emphasise the differences between the sexes, in order to justify their entry and, consequently, they became isolated from their male colleagues, and were treated as a special category, and, as such, found it problematic to avoid the stigma of inferiority. Throughout the inter-war period, much of their effort, therefore, was directed towards establishing their right to participate and to be recognised as professionals receiving a salary comparable to male practitioners doing similar work. This lack of security and low remuneration meant that they were in a weak position to influence policy. Furthermore, insecurity and the lack of clearly defined spheres of work, meant that throughout the period there was considerable rivalry, hampering the creation of a united lobby to press for women's rights. This rivalry was accentuated by the common assumption that doctors would be recruited from the more affluent families, while midwives and health visitors would come from the lower middle class and artisan section of the working class.

In order to illustrate this assertion, the careers of women in medicine, midwifery and health visiting are analysed. They were the key workers in maternity and child welfare and each, owing to the nature of the work, faced distinct diffi-

culties. This does not imply, however, that the experience of these workers was necessarily different from that of women engaged in nursing, social work and other public health work. The problems encountered by health visitors and midwives differed from those of women doctors, as the first two were in recognised women's occupations, whereas the doctors were entering an existing male profession; but all three faced separate problems in their endeavours to secure recognition as professionals accorded equal status with male workers in the health services. The midwives, working in an old-established women's profession were faced with the challenge from doctors seeking to take control of the work. The health visitors required to establish, that, although their work was new, and performed by women, it was entitled to be regarded as a profession. Meanwhile, the women doctors were faced with the problem of coping with the categorisation of being workers concerned only with women and children.

NOTES AND REFERENCES

- 1 In 1916, St. Mary's, St. George's and the Charing Cross took women, and they were followed in 1917 by the Westminster, and, in 1918, by the London, King's College and University College. Only St. Bartholomew's, Guy's, the Middlesex and St. Thomas's remained men-only colleges.
- 2 In 1914, the government was not prepared to use medical women, and independent steps were taken by the NUWSS and the WSPU. Elsie Inglis, secretary of the Scottish branch of the NUWSS, organised the Scottish Women's Hospital, which was established under the French Red Cross in October, 1914. The WSPU formed the Women's Hospital Corp, under Flora Murray and Louisa Garrett Anderson, which also went to France in 1914 under the French Red Cross. In January, 1915, a hospital was established at Wimereux, which acted as a clearing house for war casualties en route to Britain, and, subsequently, the hospital was transferred to London. By the time it closed in 1919 it had, despite initially hostility from the Royal Army Medical Corp, dealt with 26,000 patients, Louisa Martindale (1922) The Woman Doctor and her Future (London: Mills and Boon) Chapter Two; MWF lecture notes, no date, MWF Archive, Section 4(4). Emmeline Pethick-Lawrence refers to the patients' satisfaction with their treatment, Emmeline Pethick-Lawrence (1938) My Part in a Changing World (London Victor Gollancz) pp. 306-307. Dr. Flora Murray was given the rank of Lieutenant-Colonel for the purposes of pay and allowances, but she was not allowed to be addressed by that title. It was not until 1950 that women were commissioned in the same way as men.
- 3 The Times 19 October, 1920

C H A P T E R S E V E N

THE HALF-OPEN DOOR:
WOMEN DOCTORS IN THE INTER-WAR PERIOD

When women entered the medical profession, it was assumed they would specialise in the low-status occupations, namely the new field of preventive work and the care of women and children, leaving the male doctors to dominate the profession as physicians and surgeons, reserving for themselves the prestigious honorary hospital appointments. During this century, obstetrics, gynaecology and paediatrics have become recognised specialties within the profession. In 1923, the General Medical Council took steps to improve the obstetric and paediatric training given to medical students. The British College of Obstetricians and Gynaecologists, later to be given a royal charter, was established in 1929. Nevertheless, during the inter-war period, with a few notable exceptions, it was men who became the gynaecologists, obstetricians and paediatricians, while women continued to perform the routine maternity and child welfare work, in many cases denied the opportunity to obtain resident hospital appointments,

essential for advancement. Consequently, women failed to achieve positions of power and influence in the profession, and were forced to struggle for their right to a place. Despite their excellent war service, and their high standards in examinations, the women doctors continued to be considered as distinct from and often inferior to their male colleagues.

Thus, in the early 1920s, Sir Humphrey Rolleston, the President of the Royal College of Physicians, in an address given at the Royal Free Hospital, which provided the clinical facilities for the London School of Medicine for Women, argued that a greater variability of mind existed in men than in women, thus making it more likely that the people of exceptional ability would be men. Marriage hindered those women who continued to work, while it stimulated men to greater activity. He acknowledged that women were often better students, but remarked that they did not necessarily make the best doctors; women were more prone to nervous breakdowns, and, as they had fewer outside interests, there was a danger of them becoming stale and mentally dyspeptic. Women had the attributes of tact and self-oblivion, important for physicians, but most women were conscientious followers rather than leaders. He did admit some exceptions to this rule, and that work at the Royal Free might result in more in the future.¹

Although it was generally accepted that women doctors acquitted themselves well during the First World War, once the hostilities ceased, women doctors, in common with other women workers, were expected to give way to the demobilised soldiers.² Virtually no one anticipated that women would cease to practise medicine,³ but influential members of the profession expected

women once again to confine their activities to certain spheres, which were generally the less prestigious branches of the work and new fields in which the established physicians and surgeons could not envisage future eminence.

The Classification of Women's Work

A prominent member of the profession addressed the opening session of the London School of Medicine for Women. This occasion was often used to suggest the branches of medicine considered most suitable for women students. In 1922, Lord Burnham recommended the public health service and 'the hitherto but little trodden paths of pathology, bacteriology, and electro-therapeutics'.⁴ Four years later, Sir Walter Fletcher, the Secretary of the Medical Research Council, told the students that he believed men and women should confine their activities to the branches of the work most suited to their abilities. He argued that surgery and general practice would not be suitable for women, and recommended, instead, that women should seek to become competent in the new field of nutrition, so that they could make themselves 'mistresses of their own house.' Alternatively, he recommended preventive medicine, and he urged all women students to concentrate on those aspects of medical education which were likely to be useful to them in married life.⁵ No one, however, suggested that women should predominate in the fields of gynaecology, obstetrics or paediatrics, which were becoming favoured specialties amongst male medical practitioners.

Articles in the medical press advocated separate work for women. Prospective students were warned of the intense

competition in medicine, and were urged either to work in the maternity and child welfare services or to work overseas, notably India, where religious beliefs prevented women from consulting a male doctor.⁶ The BMJ argued women were lucky to specialise in maternity and child welfare, as this branch of medicine was expanding.⁷ Women, however, were never allowed to become dominant in maternity work, as medical men controlled obstetrics and gynaecology. When the British College of Obstetricians and Gynaecologists was founded women members were exceptional (see pp. 228 and 230).

Public health journals also expected women's work to be curtailed. Dr. James Fenton, the MOH for Kensington and a leading member of the Soc.MOSH, stated that medicine was undoubtedly a profession in which there was a definite sphere for women. Women should work in maternity and child welfare, the school medical service, dentistry and pharmacy.⁸ Maternity and child welfare had not been popular with the majority of MOSH, and they were pleased to designate this work to women assistants.⁹ This practice continued in the 1920s. For example, Dr. J.W. Naylor Barlow, the MOH for Wallasey and the president of the Soc.MOSH in 1923-4, in an article on public health work as a career, anticipated ante-natal work would be done by a female assistant, who would also undertake the school work. He went on to suggest that if no woman was available, the work should be done by a part-time general practitioner.¹⁰

When Janet Campbell criticised midwifery standards in her report on maternal mortality,¹¹ some MOSH suggested women doctors should undertake midwifery work for general practitioners.¹² This was a controversial suggestion, however, as the BMA was

fighting for the right of all general practitioners to do midwifery work. A leading article in the Medical Officer proposed that a woman doctor could do the obstetric work for a number of neighbouring practitioners, thus establishing a specialist panel without the danger that a general practitioner might lose patients to a rival if he did not do midwifery work. The journal, however, was careful to point out that men need not be excluded from this work.

Of course there need be no restriction about such a panel; we only suggest this as one hopeful outlet for the surplus, if such there be, of women doctors.¹³

The role of the woman doctor was discussed frequently in the columns of The Times during the 1920s. The paper was sympathetic to the need for women doctors, but, following the example of the elite of the profession, anticipated that the women's role would be demarcated.

A great part of the burden of welfare work among the poorest is borne by medical women, who are acting as missionaries of health, and, by their unselfish toil, laying the foundations of a happier future. This work cannot be performed by men; and it is more urgent today than at any other period.¹⁴

Dame Louisa Aldrich-Blake, the Dean of the London School of Medicine for Women, was anxious that women should not be expected to confine themselves to a limited sphere, arguing that openings for women in the medical profession were widening.¹⁵ Indeed, she set an example, becoming one of the few women to practise general surgery.¹⁶

Many of the women in the profession as well as leaders of the women's movement, however, presumed that women would specialise in work which would utilise their womanly attrib-

utes. Women in the medical profession, in common with the majority of women who entered parliament, accepted that women had different experiences and temperaments, and that, as a consequence, they had a unique contribution to make, which would complement that of men already established in the work. This was a powerful weapon to secure entry, but was one which subsequently was used by the male elite to curtail the participation of women. The desire to make the women's voice heard was one reason for the creation of the MWF in 1917. The Federation, moreover, performed a useful function, as women, owing to their inferior numbers and the segregation of the sexes within the profession, were not able to secure a place on the Council of the BMA until 1943, when a seat was reserved for them. Its existence, however, had disadvantages, The Medical Society of London, for example, argued women need not be considered for membership, as they had their own society.¹⁷ The medical women were thus in a similar situation to the women members of the major political parties who were encouraged to form separate women's sections (see pp. 33-34).

There was a widespread belief amongst women in the profession that they had a distinct contribution to make in the field of diseases of women. In 1919, Dr.Emily Fleming, the president of the London Association of the MWF, in her presidential address, referred to the advantages of women doctors confining their interests:

women were favourably placed for research in that their practice was, as a rule, narrowed to the care of diseases of women and children only, and the very fact of their observation being directed to one part of the community alone should enable women to achieve more

eminence in their special lines.¹⁸

Louisa Martindale, a senior surgeon at the New Sussex Hospital in Brighton who became president of the MWF from 1930 to 1932, anticipated that gynaecology would fall more into the hands of women, while men's diseases would remain in the hands of male doctors.¹⁹ She made the same prediction in a book, published in 1922, on the future of women in the profession.²⁰ Ante-natal work, work in maternity hospitals, and investigations into pure milk coupled with food reform were all essentially women's questions, in which the help of a woman doctor was invaluable.²¹ A woman was particularly suited to preventive and dispensary work, because of her knowledge of domestic situations and difficulties, and

her real interest in her patients is invaluable in social diagnosis and treatment.²²

Some women argued that women doctors were better suited to dealing with minor ailments, which could be detected and dealt with at welfare clinics. Marion E. Mackenzie, for instance, in a letter in the BMJ on the need for women doctors at infant welfare clinics, stated that the mother's health would not interest a man, unless the woman was 'very obviously ill'.²³

Certainly many aspects of women's health and well-being had been sorely neglected, and women doctors were able to make important contributions. Research by the Woolwich Hospital for Mothers and Babies into the care of breasts during lactation provides one example of the value of such work,²⁴ and the Marie Curie Hospital's work on cancer of the

uterus another.²⁵ The Royal Free set out to specialise in obstetrics and gynaecology, arguing that women should have a separate unit, where specialist training could be provided. For this reason, plans were formulated in 1919 to extend and modernise the Royal Free, placing emphasis on research.²⁶ It was anticipated that this specialisation would lead to a major breakthrough in the campaign to reduce maternal mortality and morbidity. In 1921, the hospital created the first obstetric and gynaecological unit, and Dame Louise McIlroy was awarded the chair. In 1928, the hospital appealed for funds to extend its maternity unit, an aim which was enthusiastically endorsed by Time and Tide.²⁷

A few women general practitioners treated only women patients, but there is no indication of how widespread the practice became nor how long it was maintained.²⁸ In 1925, an issue of the Magazine of the London (Royal Free) School of Medicine for Women was devoted to general practice. The editor speculated on why few women had gone into this branch of medicine, and concluded that a general practitioner needed a wife to look after the house and the telephone, and that to be successful a general practitioner needed a business sense, which came instinctively to men but not to women. She discussed the possibility of extending national health insurance cover to women and children, but feared that, unless provision was made to enable women and children to have a separate doctor, women would be cut out of the work.²⁹ The magazine sent a circular to medical women, known to be in general practice, to obtain information on their experience. Some of the replies, all of which were anonymous, were reproduced in the magazine.³⁰ It is apparent that

much of their work was for women and children. Several referred to the need for significant capital to start with, and others warned that the capital would need to tide a general practitioner over until the practice was established. Women were advised to adhere strictly to medical etiquette, as a medical man would forgive another man but never a woman. They were advised that the work was very hard, necessitating the forfeiture of all social life. One respondent remarked

I almost feel my advice to the average woman starting in practice is don't.³¹ (italics in the original)

Others, however, were more encouraging. In 1926, Dr. Ethel Williams, a general practitioner for thirty years, argued that women were especially suited to the work because their

cast of mind fits them to deal with individuals, specially with the helpless and infirm.³²

Moreover, she maintained that family organisation made women the guardians of the family's health, and a woman could talk more easily to a fellow woman.³³

I feel that it is a role for which women are peculiarly well fitted and where they can find a useful and satisfactory career not as a stepping stone to specialism but as a career in itself.³⁴ (italics in the original)

She referred to the problems caused by the hostility of male colleagues.³⁵ It is true that medical men were less ready to acknowledge women's suitability for general practice. They suggested that women were not strong enough to withstand the 'rough and tumble' of general practice,³⁶ an assertion denied by the London School of Medicine for Women.³⁷

The lay women's press assumed that women doctors would

specialise. The Women's Leader argued that it was the emergence of preventive medicine as a separate discipline which had encouraged women to enter the profession, as this work appealed to women more than curative medicine.³⁸ In 1928, the journal referred to the need for women doctors in India and other Mohammedan countries, as well as for the growing demand at home. Furthermore, although the right of married women to continue to work was acknowledged, it saw advantages if women did resign.

But perhaps it is not altogether a waste that a number of women, trained for medicine, should not be actually absorbed in practice. The fight against disease and ignorance is not carried on entirely in the sickroom or public offices. Such women, especially if they are among the more able of their sex, can find work enough to do. It is one of the dangers of our society that as the technique of sciences grows more formidable the ordinary citizen even when he sits on public bodies or the innumerable committees which direct our private charities and other efforts towards reform, become less and less able to keep in touch with the developments of knowledge. Practising doctors are among the busiest of men. They should be glad to think that the community at large contains members qualified and willing to support them in their unending struggle with indifference and prejudice.³⁹

The WCG wanted women to run welfare and maternity clinics, and undertake midwifery work, but presumed that members would remain under a male general practitioner.⁴⁰ Similarly, the National Conference of Labour Women, in 1935, was told by Mary Sutherland, the Chief Woman Officer of the Labour Party, that it would be beneficial if midwifery became a specialism of women.⁴¹ Maternity and Child Welfare also emphasised the aptitude of women doctors for welfare work,

and noted the satisfaction it gave women to see another woman. For instance, in an article on the workings of a welfare centre, Bertha A. Keene argued that the mothers would be pleased to see a female doctor

who is, naturally, interested in babies more than any man can be expected to be. Women are accustomed to detail and the study of little things, and I find nothing escapes the notice of this doctor.⁴²

Some middle-class feminists advocated women should be attended by a woman doctor, but their remarks generally referred specifically to childbirth. Vera Brittain, for example, insisted a woman doctor would be more sympathetic to the difficulties.⁴³ Naomi Mitchison, who had children during the 1920s, was attended by a woman doctor, declaring she would have 'acutely' disliked a man.⁴⁴ It is possible, however, that many women were used to male doctors and did not envisage being treated by a woman, whom they perhaps saw as being no different from themselves, and hence not competent to do scientific work.

The 'Glut' of Women Doctors

After the war, a surplus of doctors was anticipated. Articles in The Times in October, 1919, reported a 'flood' of medical students. In Edinburgh three hundred students could not be admitted until the following spring, while in London attendance of day students had gone up from 1,500 before the First World War to 2,000.⁴⁵ In Manchester numbers had increased from 269 before the war to 633 in 1919, of which 373 were women.⁴⁶ Dr. Harold Cox, the General Secretary of the BMA, feared that the

supply of doctors would shortly exceed the demand: women gave the chief cause for concern, because they went into public health work, in which there were unlikely to be any new appointments.⁴⁷ Sir Humphrey Rolleston addressed the Royal Free Hospital on 'The Problem of Success for Medical Women'. He assumed that women would enter either public health work or go to India, and he regretted that there was severe overcrowding in the public health sphere.⁴⁸ Public health officers were also convinced that women doctors exceeded the demand. Dr. James Fenton, in a major article in the Medical Officer, declared that the profession was flooded by women, and each official post was sought by large numbers of women.⁴⁹

This discussion of the surplus women doctors and their willingness to accept low-paid employment was siezed upon by those who argued against the employment of women. The Men's Defence League published a pamphlet on women's invasion of men's jobs, in which the medical profession was taken as the example.

As a result of the influx of women into the medical profession - there are now more than 6000 women doctors in this country - it has reached saturation point, and many men who have studied for years and incurred heavy expenses are now finding themselves in the position of not being able to get jobs, or the incomes derived from their practices are diminished owing to female competition This incursion of women has become a real menace, not only to the livelihood of men doctors and their dependents, but also to the high standard of efficiency of the British medical profession. Furthermore, as the responsibilities of the women doctors are not like those of men doctors they are able to obtain a comfortable living with a smaller practice than a man requires, and they are also in a position of being able to charge lower fees.

What is likely to happen in the medical profession if the invasion is not stemmed is happening in all trades, professions and occupations which women have invaded, viz., a lowering of the standard of remuneration and a decline in efficiency. Women doctors would be better employed as nurses, of which there is a shortage.⁵⁰

The concentration of women in a limited number of occupations tended to result in fairly large numbers of women applying for the low-status and poorly-paid jobs. Some local authorities took the opportunity to attempt to obtain qualified medical officers at lower rates of pay, following the example of the civil service which paid its female staff less than men doing similar work. The Post Office adopted a policy of paying different rates to men and women medical officers, which the MWF campaigned to alter,⁵¹ with little success, for, in 1929, the Post Office announced a plan to employ part-time women doctors at low salaries, without sick pay or inclusion in the pension scheme, although they were to be granted an annual holiday.⁵² Other government agencies followed this example. Janet Campbell initially was offered a job at the Board of Education at a reduced salary, but she refused to accept, and George Newman, subsequently, was able to offer the post to her at the full salary.⁵³ The demarcation of men's and women's work made it difficult to apply the principle of equal pay for equal work. For example, advocates of the scale of salaries used in the Post Office argued that the men had greater responsibility, as they had to cover for the temporary absence of a superior, something the women were never requested to do.⁵⁴

In order to overcome the problem of low pay, the BMA and the MWF decided to collaborate in an attempt to establish

standard rates for public health work, while the BMA and the Soc.MOSH worked out minimum rates of pay.⁵⁵ Advertisements for jobs offering a salary lower than their agreed minimum were banned.⁵⁶ Nevertheless, such jobs continued to be advertised in the lay press, and some women, who were not members of the MWF, had accepted them.⁵⁷ In 1923, readers of the Medical Officer were warned to be wary of jobs which were advertised only in the lay press, and were informed that the BMJ published lists of jobs which should be avoided because of low pay.⁵⁸ The BMJ regularly urged women not to accept low paid jobs.⁵⁹ The MWF News-Letter carried similar appeals. Dr. Christine Murrell, in her 1926 presidential address, appealed for cohesion amongst women to resist lower pay.⁶⁰ In 1928, in a leaflet to be distributed to all newly-qualified women and to those applying for under-paid posts, the MWF asked women to remember that their whole position in the profession depended upon their complete loyalty. They were warned that the spread of this practice would lead to discord between men and women, and would mean holders of such posts would have a lower status and prestige. Furthermore, women were warned that acceptance of low-paid posts would result in the sweating of women doctors, would cut them off from further advancement, and would result in forfeiture of support from professional colleagues in the future.⁶¹

The Soc.MOSH was especially anxious to establish minimum rates.⁶² Immediately after the war comparatively large numbers of medical practitioners were seeking work in public health, thus placing employers in a strong position, a position which was strengthened in the mid 1920s, when the econ-

omic crisis prevented the development of the public health services on the scale that had been anticipated.⁶³ Moberly Bell describes how some local authorities attempted to obtain doctors with the Diploma in Public Health qualification cheaply by advertising a post of an assistant who would not need the qualification, confident that shortage of jobs would compel women with a diploma to apply for the post.⁶⁴

In 1923, the Secretary of the MWF, Violet Kelynack, sent a letter to the Medical Officer to assure the public health workers that the MWF aimed to discourage women from accepting low-paid appointments.⁶⁵ Nevertheless, in 1928, the president-elect of the Soc.MOsH accused women of undercutting men

With comparatively few exceptions these women assistants in the public health service are unmarried and their financial responsibilities are generally less than those of male medical officers and they can afford to accept smaller salaries, whilst a considerable number find it difficult to obtain work owing to the limited number of appointments available. Consequently when local authorities advertise appointments at salaries which are quite inadequate . . . some are tempted to apply and accept such appointments to the ultimate disadvantage of the profession generally. Such appointments lead not only to the loss of the respect of their colleagues, but also to the lowering of the standard of self-respect which every professional man and woman should maintain.⁶⁶

Meanwhile, editorials in Public Health complained that it was generally women who applied for low-paid posts.⁶⁷ A letter in the journal accused women of working only for pin money.⁶⁸

Statistics quoted in the press backed up the assertions that it was women who applied for low-status and low-paid positions. For instance, in 1925, both The Times and

the Lancet said that seventy-eight women had applied for a post of junior resident medical officer (female) at a children's hospital in Sunderland, and claimed this as evidence of the glut of women doctors.⁶⁹ Two years later, another correspondent in the Lancet reported that there had been forty-eight applicants for two posts as senior and junior medical officer at a children's hospital in the North of England, offering a salary of £120 and £100 respectively. This correspondent wanted the numbers entering the profession to be limited.⁷⁰ Articles also appeared in Public Health on a similar theme, suggesting that women's professional loyalty was not any lower than men's, but the stress of circumstances forced them to apply for these jobs.⁷¹ An editorial, published in 1924, declared that young women and their parents had been misled by the press about the opportunities for women in medicine.

For the average medical woman the cost of medical training represents an unsatisfactory and unremunerative investment, and both business and the teaching profession, to mention two obvious alternatives, appear to offer a far better field for the employment of money and time in the building up of a career.⁷²

The journal had received letters from medical women expressing disillusionment; they reputedly found general practice both unremunerative and sufficiently arduous to damage their health.⁷³

The leaders of the medical women sought to refute these claims. They pointed out that, although there had been a large number of doctors who qualified after the war, by 1924 numbers were returning to the pre-war level.⁷⁴ There were 25,000 men and 2,000 women in the profession: women suffered only by being excluded from the majority of posts.⁷⁵

The London School of Medicine for Women reported that its students experienced no difficulties in finding employment.⁷⁶ A questionnaire was sent out to women who graduated between 1923 and 1925 to substantiate this assertion, and, from 216 replies, thirty-three reported to be unemployed.⁷⁷ In a letter to The Times, A.G. Anderson, of the London School of Medicine for Women, remarked that women would not flood the lower-paid ranks of the profession if they were allowed to take up hospital appointments and post-graduate training places.⁷⁸ Meanwhile, the MWF consistently sought to extend employment opportunities for women.⁷⁹

In 1929, Lady Barrett, who had replaced Dame Aldrich-Blake as Dean of the London School of Medicine for Women, in her address to the students at the start of the new session, announced that the school had the highest number of students since the war, and asserted that the demand for women doctors exceeded the supply.⁸⁰ There were reports in the press both of the popularity of women's hospitals and of the plans to appoint women doctors in general hospitals.⁸¹

The Controversy over the Marriage Bar

The problems, however, were exacerbated by the practice of requiring women to resign on marriage. This discouraged employers from promoting women and provided a justification for paying women lower salaries. Women themselves frequently wanted to continue to work, but many employers retained the marriage bar, and, in some cases, introduced it after the First World War. The MWF steadfastly campaigned for married women's right to continue to work.⁸² Lady Barrett, writing on behalf of the MWF in the Medical Officer, pointed

out that childbearing took up a small proportion of a woman's working life, as married women could afford to employ household servants. Furthermore,

a loss of time is more than compensated for by the experience gained in understanding the nature of those with whom the medical woman has to deal.⁸³

The Medical Officer agreed, arguing that a first-hand knowledge of pregnancy would be valuable in maternity and child welfare work: the doctors would understand the point behind the question and expectant mothers would be more likely to follow their advice.⁸⁴ The BMA agreed to support the campaign,⁸⁵ no doubt aware that this would strengthen the case for equal pay. Such arguments, however, tended to reinforce the view that women doctors should specialise in maternity and child welfare work. Furthermore, the assumption that a woman doctor could employ domestic help at home strengthened the separation between the generally middle-class women in a fairly well-paid profession and the working-class women who entered the less lucrative occupations.

Considerable publicity was given to the case of Dr. Gladys Miall-Smith, who was dismissed from her post as Assistant Medical Officer for Maternity and Child Welfare by St. Pancras Borough Council on her marriage. Dr. Miall-Smith publicised her case well by her refusal to resign, forcing the Council to dismiss her. Her reasons for not resigning were published in The Times. She argued, first, that resignation on marriage did not form part of her contract; secondly, that there was no council resolution demanding the resignation of women on marriage; thirdly, she saw no reason why she should be singled out from other doctors for special inquiry and treatment;

fourthly, she called attention to the Sex Disqualification (Removal) Act; and, lastly, she enclosed a letter from the WCG stating that it would like to see more married women doctors at maternity centres.⁸⁶ Dr. Miall-Smith won considerable support for her case. The Women's Local Government Society forwarded a resolution to the Council deploring the decision.⁸⁷ The Council of the MWF published a letter in The Times on this case and a similar one in Glasgow, pointing out that the Council was acting against the Sex Disqualification (Removal) Act. A desire to continue to work indicated a devotion by women who were particularly well-qualified for the work. The Council should wait to see if the work was adversely affected, or; alternatively, men with private means also should be dismissed.⁸⁸ An anonymous correspondent in The Times accused St. Pancras Borough Council of acting as if it was a charity, rather than aiming to employ the best woman for the job.⁸⁹ Meanwhile, the Medical Officer also condemned the decision.

A medical qualification represents years of study and a large expenditure. In our opinion it almost amounts to a confiscation of capital to require a lady doctor to give up her chosen occupation because of a private contract which in no way diminishes her professional capacity.⁹⁰

St. Pancras Borough Council, however, remained unmoved by these arguments, the decision to dismiss Dr. Miall-Smith being passed by forty-five votes to three. Councillor Tibbler, speaking for the Labour Party which controlled the Council, described the campaign to reinstate the doctor as a stunt to camouflage the doctor's desire to retain a job.

Nothing was ever heard when the Council took similar action with regard to married scrubbers and charwomen in their employ, and it was only

when they came to an officer holding a professional position that there was an outcry.⁹¹

Those who supported Dr. Miall-Smith did achieve a minor success. The Vote reported that the Council intended to replace Dr. Miall-Smith by a male medical officer.⁹² The Council, however, was prevailed upon to appoint another woman. The person finally selected was Dr. Stella Churchill, who subsequently became a Labour councillor on the LCC and an outspoken critic of the government's handling of maternity and child welfare.

Shortly after the controversy over Dr. Miall-Smith, the LCC decided to prohibit the employment of married women doctors, to comply with the Council's policy on married women workers in other occupations.⁹³ Not until the 1930s did local authorities begin to revise their opinions on the employment of married women, and then they justified it in terms of these women's personal knowledge of maternity and the contribution they could make in this field of work. In 1931, Birmingham Corporation Public Health Committee decided to allow women doctors in maternity and child welfare work to continue in employment after marriage. This decision followed a report produced by the National Council of Women and the Birmingham and District Medical Women's Association.⁹⁴ In the same year, however, a resolution sent by the MWF to the LCC General Purposes Committee on the employment of married women doctors failed to persuade the Council to amend its policy.⁹⁵ It was not until 1935 that the LCC lifted its ban, but this only applied to women doctors and teachers and not to other workers. The General Purposes Committee argued

that the change would exclude from work a number of women who were dependent on their earnings in favour of an equal number who were not, but the Committee went on to argue that, in some jobs, marriage would enhance the value of the officer. The Committee decided that, in the public interest, the latter consideration should influence it, while the fact that public money was spent on their training reinforced the case.⁹⁶

The justification for retaining professional married women and not all women workers, which the medical women themselves accepted, served to reinforce the divisions between educated middle-class women and the unqualified working women (see pp. 46-51).

The Separation of Medical Education

Ideas about the different specialisms of men and women, coupled with the desire to reduce the total number of medical students, and in particular women students, led to suggestions that the co-education of medical students should be curtailed in London. Although the women students acquitted themselves well, often surpassing the men in examinations, after the First World War, when applications from men began to increase, the 'experiment' in co-education was reviewed. St. George's Hospital was the first to act, imposing a ban on women students in 1919.

In 1922, the London Hospital, which at the time had approximately one hundred women students, decided to stop accepting women. Lord Knutsford, the chairman of the hospital, said that the hospital did not object to women students, but there were certain subjects which could not be taught

satisfactorily in mixed classes.⁹⁷ The hospital declared that it was reluctant to lose the women, who had brought credit to the school, and denied that the decision was a symptom of rivalry between the sexes. Lord Knutsford, however, remarked that many men refused to attend a school which took women, so the hospital had to decide whether it was worthwhile to run the chance of ruining the school for the 'problematic benefit' of taking a limited number of women students. He went on to argue that, as a result of taking women, women would be appointed as resident house surgeons and physicians, and this would create difficulties with discipline. He quoted the example of a captain in the First World War, who returned to medical school and was placed under the jurisdiction of a woman obstetrician probably younger than the captain. Furthermore, Lord Knutsford considered that many men coming into a hospital would forego treatment, if it necessitated being examined by a woman. He believed that a 'moment's thought' would allow readers to realise that many examinations and treatments

cannot possibly be made by women doctors on men patients. I know the converse happens every day; but this is the outcome of habit and customary practice.⁹⁸

The other problems itemised by Lord Knutsford were the expense of providing separate accommodation and the unsuitability of giving lectures on medical jurisprudence and certain demonstrations to a mixed audience. He anticipated that the Royal Free Hospital would be glad of the extra students.⁹⁹

The decision of the London Hospital raised no comment in the medical press, and seemed to be ignored also in the

feminist journals, perhaps because, at the time, the other London teaching hospitals and the provincial hospitals retained co-education.¹⁰⁰ The subject, however, was discussed at length in the correspondence columns of The Times. Reference was made to the fact that out of politeness women students acquired the best vantage points during demonstrations. Social difficulties were alluded to: the fact that men and women wanted different social facilities, the problems of chaperoning the women, and sportsmen's dislike of attending a mixed college. Women had their own colleges in London; but none was reserved for men.¹⁰¹ Esprit de corps and discipline were undermined by the presence of women.¹⁰² The Vice-Chancellor of the University of London, Sir Sydney Russell-Wells, expressed his sympathy for the women but refused to criticise individual colleges.¹⁰³ Several letters, mainly from women, were received arguing that mixed lectures presented no problems, as it was possible to deal with all subjects in a scientific way, while both men and women benefited from association with the opposite sex.¹⁰⁴ The correspondence was concluded by Cecil Webb-Johnson, who argued that there was a need for medical women, but their education, as at school and university, should be separate; it would be expensive to provide separate domestic facilities, and men and women would require different clubs and societies. He recommended that women raise money for their own hospitals and medical schools, where women doctors could specialise in the diseases of women and children.¹⁰⁵

In 1924, St. Mary's Hospital followed the example of the London, declaring that men preferred single-sex schools and

that women had adequate facilities in other hospitals.¹⁰⁶ The men students at St. Mary's petitioned the management to exclude women.¹⁰⁷ In response, a memorandum from past and present women students at St. Mary's was sent to the members of the Board of Management. In the course of their argument to justify the presence of women, they pointed out that King's College Hospital, a mixed school, had reached the 1924 final of the Hospital Rugby Cup Tie, and that at least four international players had recently joined King's College Hospital Medical School.¹⁰⁸

The MWF also sent a letter to the members of the Board of Management, arguing that the decision would seriously damage the reputation of past and present students, and would reflect on the honour of an authority, which, in 1920, had used the adoption of co-education as a reason for support for its appeal for public funds.¹⁰⁹ There was no immediate public response from the MWF. Initially, the MWF decided not to give the text of this letter to the press, because it thought it was not wise to draw the public's attention to St. Mary's decision, as it would deter parents from applying for a place for their daughters to a school where they were unwelcome and where numbers were being reduced.¹¹⁰ Meanwhile, May Thorne, the Honorary Secretary of the London School of Medicine for Women, wrote to The Times extolling the virtues of the women's school.¹¹¹ The MWF's silence was criticised by a number of members who argued that it appeared the MWF welcomed St. Mary's plans as students would be encouraged to apply to the London School of Medicine for Women, which required more students.¹¹² As a result, the Federation decided

to publish the text of its letter to the Board.¹¹³ Subsequently, Louisa Martindale told a meeting of the London Association of the MWF that the St. Mary's women felt that the MWF had not done enough; and, in response, a further letter was sent to The Times describing the St. Mary's decision as a retrograde step.¹¹⁴ The MWF also refused to support Graham Little, a senior physician at St. Mary's, when he stood in a by-election for the University of London seat in 1924.¹¹⁵ Graham Little, however, went on to defend women's rights to equal education (see pp. 219 and 220).

Meanwhile, the St. Mary's plans were attacked by women's societies. In September, 1924, Lady Rhondda called a meeting of women's societies to protest against the decision.¹¹⁶ A letter was published criticising the decision, arguing that it was a retrograde step and would be against the public interest.¹¹⁷ Both the Vote and Time and Tide condemned the decision,¹¹⁸ while the WCG passed a resolution deploring it.¹¹⁹ The Women's Leader declared the glut of women doctors would be temporary, owing to the extension of infant welfare work and the demand for women doctors in India.¹²⁰ The lay women referred to the need for women doctors to fulfil a particular, limited role in the profession.

Prominent members of the medical profession, however, proclaimed the advantages of a separate education. Sir Walter Fletcher, in his address to the London School of Medicine for Women, declared that the women's medical education should be different from that of men. He argued that parallelism was initially necessary, but should now be abandoned because it was wasteful. Men and women should work only in their best

spheres.¹²¹ In 1927, the address was given by Robert G. Hogarth, Senior Surgeon at the General Hospital, Nottingham, and a past president of the BMA, who told students that he disliked the 'neuter gender'. He hoped in future the debate would be about what men could do best and what women could do best.¹²²

In 1928, Charing Cross, King's College and the Westminster hospitals announced their intention to ban women students, an action which would limit co-education in London to the twelve places allocated per annum to women by University College Hospital. This scheme was opposed by some senior members of the University. Walter E. Spencer, the Vice President of the Westminster Hospital, and Dr. Graham Little, the MP for the University of London, put a resolution, calling for an inquiry into the ban, before the Senate of the University.¹²³ As a result, the Senate announced the appointment of a committee to investigate, headed by the Vice-Chancellor, Sir William Beveridge. Of the eleven members of this committee, two were women, both of whom were principals of girls' educational establishments.¹²⁴

Sir James Purves Stewart, a senior physician at Westminster Hospital, wrote to The Times claiming that Walter Spencer was speaking against his colleagues, and was in a minority of one. Sir James had nothing against women students

but they are occupying spaces which, candidly speaking, would be more usefully filled by men.¹²⁵

He maintained that 100% of men remained in the profession, while 50% of the women left to marry. He went on to argue that the presence of the opposite sex was a distraction to

work and had an effect upon the standard of athletics. It would be in the best interests of both men and women students for them to be kept separate.¹²⁶

One correspondent to The Times, Sir Charters J. Symonds, suggested that women students could be accommodated at the various non-teaching hospitals in London, and could meet at a convenient site for lectures, which would be given by retired lecturers and those lecturers prepared to give some time to women. He went on to suggest that morbid anatomy could be covered in a museum, while the special women's hospitals and the charities could provide midwifery training, and experience of ante-natal work could be gleaned from maternity and child welfare centres.¹²⁷

Once again, the women's organisations attempted to influence the hospitals' decision. The Six Point Group sent a resolution to the governors of the three hospitals concerned, arguing that the exclusion of one sex would reduce the likelihood of obtaining the best possible students. It argued that the demand for women doctors was growing.¹²⁸ The NUSEC organised a conference on the subject, addressed by Dr. Graham Little.¹²⁹ Following the conference, the Joint Committee of Women's Societies was set up to promote equal opportunities in medicine.¹³⁰ A deputation, which included members of the NUSEC and the WCG, visited the hospitals.¹³¹ The Joint Committee, which organised the deputation, produced a memorandum to justify co-education. Six reasons were given for the expected growth in demand for women doctors: the increased population of London; a likelihood that National Health Insurance would be extended to cover women and children, or that

a national health service, covering these classes, would be created; the expansion of maternity and child welfare work by local authorities; parents wanted their daughters to be examined by a woman doctor at the school medical inspections; this contact with women doctors led to demands for female general practitioners; and the need for women doctors in India. Furthermore, patients would not have faith in the ability of doctors to deal with delicate matters in a scientific way if they could not do so during their education, and, as others had pointed out, no one raised any objection to the presence of nurses during all forms of treatment and examination.¹³²

Letters in The Times refuted the arguments of Sir James Purves Stewart. Isabel Elmslie Hutton, a married medical woman, pointed out that women were not permitted to remain in public appointments after marriage, and were not given honorary appointments at general hospitals. She considered that all medical matters could be discussed in a scientific manner, and she maintained that the future of medicine demanded cordial co-operation between the sexes, and the ability of women to gain access to the great masters of the profession.¹³³ Lady Astor, Dorothy Balfour of Burleigh, Eleanor Barton, Margery Corbett-Ashby, Elizabeth Macadam and Lady Rhondda jointly supported this argument, pointing out that the Royal Free was always full. They asked where the displaced students were expected to go.¹³⁴

A leading article in Time and Tide condemned the decision of the medical schools, arguing that many women would like to continue to work after marriage. Women's contribution to

maternity work was discussed, and special reference was made to the obstetric and gynaecological work of the Royal Free. The journal, however, did not want obstetrics and gynaecology to become purely a women's branch of medicine.

It is in the interest of women that the science of medicine, and particularly of all those branches of medicine which concern maternal and infant welfare, should be perfected as far as possible. It is in the interests of men, who all have to get born somehow, that this great interest of women should be served. It is in the interest of humanity that the best doctors, men or women, should receive the best training possible.¹³⁵

It is perhaps not surprising that Time and Tide should hold this opinion as the journal was committed to the old-feminist concept of equality, based on the elimination of all restrictions on work imposed on the grounds of sex alone. Some of the leaders of the profession, however, did not share this desire. A suggestion that the Royal Free should accept male students at the same time as the men-only schools accepted women was rejected by the women.¹³⁶ Women would always need their own school, even if all the schools were open to women.¹³⁷

The MWF conducted a survey to test Sir James Purves Stewart's assertion that 50% of women doctors retired to marry. A questionnaire was sent to 1,000 members, and it was found that 9% had retired, while 4.5% failed to respond. 15.6% of the respondents were engaged in public health work, and 40.6% were in general practice.¹³⁸ This survey, however, did not necessarily provide an accurate picture, as not all women doctors were members of the MWF, and the members were not necessarily a cross-section of women doctors. Furthermore, no indication was given of when the respondents graduated.

In January, 1929, the report of the Committee set up by the Senate of the University of London was published which recommended that the men's schools should operate a quota system for women, as was the custom at University College Hospital. It estimated one hundred places would be required for women, excluding those provided by the Royal Free. The Committee pointed out that the University had co-education in all other departments, although there were a few women-only colleges, and that new university statutes aimed to recognise no disabilities on the grounds of sex. It anticipated difficulties as to accommodation and mixed classes could be overcome. Moreover, the Committee found little evidence of wastage amongst women doctors. Co-education would be beneficial to women, and would help towards subsequent co-operation in the profession. The Committee felt that difficulties arose because of the multiplicity of medical schools and the competition for students, and the feelings against co-education expressed by some men in the profession, by men students and by some members of the public, with all the schools convinced that men preferred single-sex schools. It was recognised, however, that the schools would be concerned about economic considerations. For this reason, the Committee felt that the schools should make their decisions voluntarily, and that there should be no question of withholding grants.¹³⁹

Dr. Graham Little, writing in the Nineteenth Century, expressed a preference for the quota system. He did point out, however, that the University had little power to influence the medical schools over matters relating to finance, and that the

schools were largely dependent upon the fees of students. He recognised that the men's schools attracted more students, but he argued that the education of women should be the responsibility of all the schools, and he warned that a failure to accommodate women, for which there was a public demand, would play into the hands of those who wanted a state medical service.¹⁴⁰

The women students also received support from other quarters. An editorial in The Times urged the medical schools to follow the recommendations of the Senate Committee. The newspaper urged the schools not to consider just the immediate convenience and expense.

The woman doctor is no longer on her trial. Her place in the service of the community is now an assured one, and her record of work entitles her, fully, to the esteem in which she is held. But it will hardly be denied that her activities will be crippled if in her student days she fails to enjoy the widest possible opportunities of gaining and perfecting knowledge.¹⁴¹

Previously, The Times had pointed out that the Royal Free would not be able to accommodate the extra students, and to go to the provinces might impose real hardship on those students who wished to attend a co-educational medical school.¹⁴²

The BMJ also condemned the medical schools for excluding women, arguing that the glut of female practitioners had passed. It reported a demand for women in general practice, but it did specify that they were needed as assistants and to do midwifery work.¹⁴³

The Lancet was more sympathetic to the medical schools, although it too advocated co-education as the long-term ob-

jective. A leading article, published in the wake of the Senate Committee's report, remarked that the antipathy to co-education on the part of male students was the result of deep-seated tradition. It argued that academic or economic jealousy and rivalry on the playing fields were not the real motives but were merely means of fortifying this attitude. Following the invasion of women into many spheres during the First World War, a reaction was inevitable. The Lancet declared it could detect signs of the reaction passing, but argued that medical schools should not be coerced to change their views.¹⁴⁴

The government declined to intervene. In 1922, when the London Hospital decided to exclude women, the government had refused to interfere in such matters, and the government of 1928 did not amend this policy.¹⁴⁵

The medical schools were unaffected by the criticism, confident of their ability to maintain their reputations and to attract sufficient students from among the male population. Consequently, from 1928, apart from the women's school at the Royal Free, the only clinical training available to women in London was twelve places reserved for them each year at University College Hospital.

It is perhaps not surprising that women sought to establish themselves independently from the old-established medical schools in London. The positive advantages of separate education were discussed. Lady Rhondda, in a letter to The Times, rejected the quota system recommended by the Senate Committee, declaring that equality would not be achieved that way: it would be acceptable only if women

were prepared to accept a position of inferiority. She argued that, if women could not obtain true co-education, they should strengthen and support their own school, and in that way achieve equal opportunity.¹⁴⁶ In the opening address given at the start of the 1930 session of the London School of Medicine for Women, Miss Chadburn, Senior Surgeon at the South London Hospital for Women, told her audience that it meant nothing that some medical schools had closed their doors to women, as these doors had been only half open.¹⁴⁷ In March 1929, a meeting was organised by Lady Barrett, Dean of the School, to arrange for the provision of extra accommodation, for the women denied entry to the men's schools.¹⁴⁸

Furthermore, women doctors argued that women's hospitals, staffed by women, were necessary not only to enable women patients to be treated by a woman, but also so that women doctors could become consultants and overcome feelings of inferiority.¹⁴⁹ Louisa Martindale, however, who became president of the MWF in 1930, considered such hospitals would be a temporary phenomenon, until more medical schools and hospitals were open to women.¹⁵⁰

Meanwhile, women continued to be encouraged to set themselves apart from their male colleagues. Professor L.N.G. Filon, the vice-chairman of the University of London, when presenting the prizes to women at the Royal Free, stated that he believed the Royal Free had been successful. He remarked that no individual or group could gain success until it was master of its own destiny, and so long as women kept to the methods of men, they had to accept a position of inferiority. He anticipated that, as women developed their

own manner and methods of education, which were best suited to their natural bent, they would take their rightful place in the education sphere.¹⁵¹

The Status of Women in the Profession in the 1930s

In 1930, the MWF was reasonably pleased with progress. Membership of the Federation was increasing, and by 1930 had reached 1,314, and the following year it was 1,400. The MWF was becoming more confident of its position within the profession. In the previous year, a suggestion had been made to the BMA that there should be an additional representative for England on the General Medical Council. The Federation did not go as far as to say that this person should be female, but it did wish to be associated with any such representation to the General Medical Council.¹⁵² Violet Kelynack, the medical secretary of the MWF and editor of the Federation's newsletter, wrote an article on women in the profession, in which she claimed that distinctions between men and women were rarely made, and that it was becoming less common for married women to be asked to resign on marriage, while more fields of work were becoming available to women.¹⁵³ She welcomed the election of the first medical woman to parliament in 1929. Although Dr. Ethel Bentham's parliamentary career was short,¹⁵⁴ she was soon followed by Dr. Edith Summerskill, who also belonged to the Labour Party. The fact that two of the Labour women MPs during the inter-war period were members of the medical profession perhaps provides further evidence of the deference of the working class for the profession, which was referred to in the previous section (see

pp. 103-105).

Certainly, individual women achieved notable success in the profession, particularly commendable in view of the restrictions placed upon them, while the number of women qualifying rose steadily throughout the decade.¹⁵⁵ In 1930, King's College Hospital announced its intention to readmit a limited number of women to its medical school. The hospital described the decision, taken in 1928, to ban women as a temporary measure, to avoid an 'undue invasion' of women students.¹⁵⁶ Dame Louisa Aldrich-Blake and Dame Louise McIlroy were acknowledged leaders of the profession. Indeed, Louise McIlroy was the only woman to sit on the Council of the British College of Obstetricians and Gynaecologists, when it was formed in 1929.¹⁵⁷ Medical women were receiving high civil honours. In 1929, Lady Barrett, the Dean of the London School of Medicine for Women, became the third member of the profession, and the first woman, to be admitted to the Order of Companions of Honour. In the same year Louise McIlroy became a Dame, a distinction which had previously been conferred on Louisa Aldrich-Blake, Janet Campbell and Mary Scharlieb. The profession did go some way towards accommodating women on comparable terms with men. In 1925, the Royal College of Surgeons, which had previously refused to allow women to vote or to sit on its Council, agreed to admit women on the same terms as men.¹⁵⁸ In 1934, Dr. Helen Mackay, who trained at the Royal Free, was made the first woman fellow of the Royal College of Physicians. Some leading men in the profession spoke in favour of a united profession. Dr. Thomas Watts Eden, for example, told

the MWF in 1931 that he hoped the medical profession would become 'one large happy family in which there would be no need to segregate the sexes'.¹⁵⁹ In its annual review of opportunities for medical students, the BMJ consistently deplored the absence of co-education in London.¹⁶⁰

During the 1930s, the Ministry of Health agreed to remove the restrictions relating to the interchange of jobs amongst the doctors it employed. Previously, although women had been employed in the Maternity and Child Welfare Department, their jobs were not considered to be interchangeable with their male colleagues in the Ministry.¹⁶¹

Local authorities began to employ women in a greater diversity of roles, but often women continued to be restricted to junior posts. For example, in 1929, the Mental Hospitals Committee of the LCC reported that the appointment of a woman medical officer had been a success. The Committee, therefore, decided that the assistant medical staff of these hospitals should be increased from three to four, to accommodate a woman.¹⁶²

Prejudice against employing women remained evident. For instance, in 1929, the Vote reported that Manchester Board of Guardians had re-advertised a post in a mental institution rather than employ a woman.¹⁶³ Some hospitals, including those catering for children, which had employed women doctors on the same terms as men, changed their policy.¹⁶⁴ Some hospitals were quick to penalise women. Birmingham General Hospital, for instance, refused to employ any married women doctors, following the request by one woman for four months' leave of absence for personal reasons.¹⁶⁵

This decision, however, was subsequently reversed.¹⁶⁶ In 1931, the Royal East Sussex Hospital decided to revert to its old practice of employing only male house surgeons.¹⁶⁷

As, in many cases, women were denied hospital appointments, they did not have the opportunity to gain the necessary experience to become eligible for membership of the colleges. The new college for obstetricians and gynaecologists decided that only those teaching in approved hospitals were eligible to become fellows, while only those occupying staff appointments at approved hospitals would be entitled to become members of the college.¹⁶⁸ In 1934, the College, recognising that some doctors, interested in this branch of medicine, were prevented from joining the College owing to lack of opportunities for further training and the inability to obtain hospital appointments, agreed to award diplomas.¹⁶⁹

Similarly, few women achieved leading positions in public health work. Women were directed into maternity and child welfare work, which was recognised to be a dead-end job in terms of promotion prospects.¹⁷⁰ Women MOsH were rare. The first woman MOH was appointed by Ampthill Urban District Council in 1926.¹⁷¹ Women were poorly represented on the Council of the Soc.MOsH. No woman held any of the key offices during the inter-war period. Women achieved office in the maternity and child welfare section, and, when regional branches were set up, women sometimes held office, but there were never more than three women on the forty-two member national council.¹⁷² Both of the journals controlled by the Soc.MOsH, the Medical Officer and Public Health, were written largely by and for men, with the assumption that

women in public health work invariably would be engaged in health visiting.

Meanwhile, the problem of the shortage of places in London for the clinical training of women remained. Nine of the twelve London teaching hospitals continued to exclude women. In 1937, the BMJ revealed that a large number of women either had to wait for clinical training or go to the provinces. King's College Hospital kept its own women students waiting between eighteen and twenty-four months before they could commence their clinical training.¹⁷³ From 1937, the West London Post-graduate College at the West London Hospital agreed to take undergraduates and external students, to accommodate those who could not obtain a place at the Royal Free.¹⁷⁴ The school had thirty-eight women students in 1938, but it was never popular and did not attract any male students.

In 1937, Time and Tide published a letter from a group of Cambridge medical students complaining about the difficulty of obtaining a place at a London teaching hospital. They considered that a woman had to be outstandingly good to obtain a place, while a man obtained a place unless he was outstandingly bad.¹⁷⁵ A letter also appeared in the BMJ complaining that women students from Cambridge were discriminated against.¹⁷⁶ This impression was shared by teachers at the Royal Free, who found that women needed to be better than men in order to gain appointments.¹⁷⁷ In 1938, Eva McCall, who began her medical career in the 1890s, wrote to the BMJ about the opportunities for women in medicine:

.... women, as a rule, are tolerated not welcomed,

in the medical profession, or, with a few outstanding exceptions, in its lower ranks only [Honorary appointments] naturally go to the alumni of the hospitals, most of which are closed to women graduates.¹⁷⁸

The Ministry of Health did not commit itself to establishing co-education until 1944, when the Goodenough Report on the organisation of medical schools was published.¹⁷⁹

NOTES AND REFERENCES

- 1 Reported in the Lancet (1923) ii, pp. 765-768
- 2 e.g. in June, 1920, Sir Donald MacAlister, the President of the General Council of Medical Education, praised women's war work, but warned that women doctors currently were not in such demand because of the returning men. These men had to be given special consideration, reported in The Times 2 June, 1920
- 3 There was some correspondence in The Times and the medical press, including a professor teaching in Dundee, who wished to see women excluded from the profession, but none of the leaders of the profession expressed such extreme views in print.
- 4 Reported in the Lancet (1922) ii, p. 785
- 5 Reported, ibid. (1926) ii, pp. 740-742
- 6 Statement on the General Medical Council regulations and the opportunities for training, BMJ (1923) ii, p. 383; (1924) ii, p. 432
- 7 Report on opportunities for women in medicine, ibid. (1925) ii, p. 438; (1927) ii, p. 416
- 8 Article in the Medical Officer (1926) 36, p. 282
- 9 Celia Davies (1982) 'Little Credit and Less Cash: the Maternity and Child Welfare Doctors of the Inter-war Years', unpublished paper
- 10 Medical Officer (1923) 30, p. 101
- 11 Campbell (1924) op. cit., pp. 69-70
- 12 Dr. Harold Scurfield, in his Presidential address to the Maternity and Child Welfare Group of the Soc.MOSH, reported in Public Health (1924) 37, p. 248
- 13 Medical Officer (1924) 32, p. 25
- 14 Leading article in The Times 3 October, 1924
- 15 Letter in response to the leading article quoted above, ibid., 6 October, 1924
- 16 Louisa Aldrich-Blake was the first woman to obtain the M.S. degree. She became a full surgeon in 1902 and went on to become the first woman surgical registrar. In 1914, she became a consultant surgeon at the Royal Free Hospital.
- 17 Reported in the Lancet (1919) i, p. 989
- 18 Quoted, ibid., ii, p. 714
- 19 Address given at the opening session of the London School

- of Medicine for Women, reported in The Times 4 October, 192
- 20 Martindale (1922) op. cit., p. 137
- 21 ibid., p. 136
- 22 ibid., p. 146
- 23 BMJ (1921) ii, p. 171
- 24 The Woolwich work on the care of breasts overcame the problem of inflammation, reported in The Times 8 June, 1939
- 25 Discussed by Louisa Martindale at the annual meeting of the MWF, BMJ (1931) i, p. 864
- 26 Reported in The Times 27 March, 1919
- 27 Time and Tide (1928) 9, pp. 353 and 675-676
- 28 In 1921, the London Insurance Committee informed four women doctors that they would lose 7½% of their share of the practitioners fund because they had stated their intention to treat only women patients, reported in the Lancet (1921) i, p. 1036
- 29 Magazine of the London (Royal Free) School of Medicine for Women (1925) 20, pp. 1-2
- 30 Extracts from fifteen replies were published, ibid., pp. 7-30
- 31 ibid., p. 14
- 32 Article in the MWF News-Letter, July 1926, pp. 52-53
- 33 ibid., p. 53
- 34 ibid., p. 57
- 35 ibid., p. 55
- 36 Dr. Cox, general secretary of the BMA, quoted in an editorial on overcrowding in the medical profession, The Times 4 August, 1921; Sir Walter Fletcher, address to the London School of Medicine for Women, quoted in the Lancet (1926) ii, pp. 740-742
- 37 In response to The Times editorial, the Dean of the School, Louisa Aldrich-Blake, claimed many women general practitioners were doing well and had more patients than they could cope with, The Times 6 August, 1921. This statement was quoted by the Vote, in an article on women doctors, Vote (1921) 22, p. 573
- 38 Women's Leader (1920) 12, p. 59
- 39 ibid. (1928) 20, p. 63

- 40 Wilkin et al. (1917) op. cit., p. 3. Resolutions were often passed at the annual conference calling for women doctors to run clinics, e.g. WCG (1934) 51st Annual Report, p. 27; (1935) 52nd Annual Report, pp. 29-30
- 41 Reported in The Times 17 May, 1935
- 42 Maternity and Child Welfare (1919) 3, p. 199
- 43 This was a theme in her novel, Honourable Estate, Brittain (1936) op. cit., p. 32 et passim
- 44 Mitchison (1979) op. cit., pp. 31-32
- 45 The Times 13 October, 1919
- 46 ibid., 14 October, 1919
- 47 Quoted, ibid., 4 August, 1921
- 48 Reported in the BMJ (1923) ii, p. 591
- 49 Medical Officer (1926) 36, p. 281
- 50 Men's Defence League (n.d.) Men's Jobs for Men, Markham Papers, Section 9/1
- 51 Reported in the Lancet (1923) i, p. 403; ii, p. 1013; The Times 10 May, 1929
- 52 Reported in the BMJ (1929) i, p. 929
- 53 E. Moberly Bell (1953) Storming the Citadel, the Rise of the Woman Doctor (London: Constable) pp. 179-180
- 54 Anonymous letters in the Lancet (1923) i, pp. 511 and 821-822
- 55 A scale of salaries was recommended by the Soc.MOSH and put before the BMA in June, 1920, reported in the Medical Officer (1920) 24, p. 2
- 56 Editorial in the MWF News-Letter, July, 1926, pp. 24-25
- 57 ibid., p. 25
- 58 Medical Officer (1923) 29, p. 288
- 59 e.g. BMJ (1923) ii, p. 383; (1925) ii, p. 438; (1927) ii, p. 416
- 60 MWF News-Letter, November, 1926, pp. 19-20
- 61 Quoted in Public Health (1928) 41, p. 102
- 62 e.g. editorial in the Medical Officer (1920) 24, p. 202
- 63 editorial, ibid. (1922) 28, pp. 226-227

- 64 Moberly Bell (1953) op. cit., p. 183
- 65 Medical Officer (1923) 29, p. 94
- 66 Article, ibid. (1928) 40, p. 89
- 67 e.g. Public Health (1924) 37, pp. 156-157 and 270-271
- 68 ibid. (1924) 38, pp. 71-72
- 69 The Times 15 January, 1925; Lancet (1925) i, p. 157
- 70 Lancet (1927) i, p. 846
- 71 e.g. Public Health (1924) 37, pp. 156-157
- 72 ibid., p. 101
- 73 ibid. Dr. E.K. Mackay also claimed women general practitioners failed to make an adequate living, letter in The Times 31 October, 1924
- 74 The total number of women students in England and Wales declined steadily from 1,410 in 1923/4 to 892 in 1927/8, and a more dramatic decline in numbers occurred in Scotland, where student numbers fell from 610 to 254. Taken from the returns of the University Grants Committee, and published in the BMJ (1928) ii, p. 1071
- 75 Letter from Dr. Mabel L. Ramsay in response to the evidence of large numbers of women applying for junior posts, Lancet (1925) i, p. 207
- 76 Information given by Dr. May Thorne, honorary secretary of the London School of Medicine for Women, reported in The Times 5 November, 1924
- 77 234 questionnaires were sent out. Of those employed, 50 were general practitioners, 16 in assistant practice, 53 in hospital posts, 12 in public health, 10 were missionaries and 20 were in the Indian medical service or married and working abroad, and 6 were abroad to gain experience, quoted in The Times 2 October, 1926
- 78 ibid., 30 January, 1929
- 79 e.g. in 1929, a unanimous resolution was passed by the MWF recommending that women patients at venereal disease clinics be able to consult a woman doctor, letter from Violet Kelynack, honorary secretary of the MWF, BMJ (1929) ii, p. 694
- 80 Reported, ibid., p. 639
- 81 e.g. in 1929, the Elizabeth Garrett Anderson Hospital reported an increased demand for beds, letter from Miss Imogen H. Murphy, secretary of the hospital, The Times 11 February, 1929. Naomi Mitchison reported that a great number of

- women in Oxford were demanding the appointment of the first woman doctor to the Radcliffe Infirmary, Time and Tide (1929) 10, p. 622
- 82 e.g. in 1922, the MWF joined a deputation to the Prime Minister, organised by the Six Point Group, to campaign for this right, reported in the Lancet (1922) ii, p. 889
- 83 Medical Officer (1922) 27, p. 25
- 84 ibid. (1925) 33, p. 183
- 85 BMA resolution passed on married women's right to work, reported in the Vote (1927) 28, p. 228
- 86 The Times 18 October, 1921
- 87 ibid.
- 88 The signatories were Mary D. Sturge, the President, Florence E. Barrett and Frances Ivens, the Vice-presidents, Louisa Aldrich-Blake, the treasurer, and F. May Dickinson Berry, the secretary, The Times 6 December, 1921
- 89 ibid., 28 December, 1921
- 90 Medical Officer (1921) 26, p. 156
- 91 Quoted in The Times 20 October, 1921
- 92 Vote (1922) 23, p. 132
- 93 The three married women already employed were permitted to continue in view of the experience they had gained, reported in The Times 22 October, 1924
- 94 Reported, ibid., 24 January, 1931
- 95 Reported, ibid., 2 December, 1931
- 96 The Times reported that the General Purposes Committee had been under pressure from the Open Door Council, the SJC, the London and National Society for Women's Service and the Six Point Group, ibid., 15 and 17 July, 1935
- 97 Reported in The Times 2 March, 1922
- 98 ibid., 3 March, 1922
- 99 ibid.
- 100 The opinion of teachers in other hospitals was sought by The Times, and eleven, with the exception of Dundee, reported no difficulties in lecturing to mixed audiences, ibid., 3 March, 1922
- 101 ibid., 4 March, 1922
- 103 ibid., 8 March, 1922

- 104 ibid., 6, 7, 8, 9 and 11 March, 1922
- 105 ibid., 13 March, 1922
- 106 The plan was mooted in September, 1924, reported ibid., 27 September, 1924, and a decision was taken the following month, reported, ibid., 18 October, 1924
- 107 Reported in the Vote (1924) 25, p. 316
- 108 Memorandum to Members of the Board of Management of St. Mary's Hospital, April, 1924, p. 3, MWF Archive, St. Mary's Hospital File
- 109 Text of a letter sent in October, 1924, MWF Archive, St. Mary's Hospital File
- 110 This reason was given in a letter to Dr. Kettle from Violet Kelynack, 6 October, 1924, MWF Archive
- 111 The Times 7 October, 1924
- 112 Letters from Dr. Kettle and Isabel Ramsay, 8 October, 1924, MWF Archive
- 113 A letter was sent to The Times, the Morning Post, the Daily Telegraph, Time and Tide, the Women's Leader, the Vote and the Press Association, MWF Archive, St. Mary's Hospital File
- 114 The Times 21 October, 1924
- 115 The Federation wrote to ask him his opinion of the exclusion of women students. Little declared his disapproval but refused to speak against his colleagues. The MWF considered this reply to be unsatisfactory, MWF document, September, 1924, and a letter from Graham Little, 9 September, 1924, MWF Archive, St. Mary's Hospital File
- 116 This meeting was attended by Margaret Tuke, President of the British Federation of University Women, J.W. Fisk, President of the Federation of Women Civil Servants, M.G. Fawcett, President of the London Society for Women's Service, E.C. Morgan, President of the National Council of Women, Eleanor Rathbone, President of the NUSEC, E.E. Froud, Secretary of the National Union of Women Teachers, L.A. Nott-Bower, President of the National Women's Citizen Association, Kathleen Fitzgerald, of the St. Joan's Social and Political Alliance, Elizabeth Knight, Treasurer of the WFL, and Flora Drummond, of the Women's Guild of Empire, and was chaired by Lady Rhondda, representing the Six Point Group, reported in The Times 27 September, 1924
- 117 Signed by E.M. White (Federation of Women Civil Servants), E. Louie Acres (League of the Church Militant), Philippa Strachey (London Society for Women's Service), E.C. Morgan, Eva Hubback (NUSEC), E.E. Froud, L.A. Nott-Bower, Kathleen Fitzgerald, Lady Rhondda, Elizabeth Knight and Flora Drummond, The Times 30 September, 1924

- 118 Leading article in the Vote (1924) 25, p. 316; Time and Tide (1924) 5, pp. 976-977
- 119 WCG (1925) 42nd Annual Report, p. 10
- 120 Leading article in the Women's Leader (1924) 16, p. 288
- 121 Reported in the Lancet (1926) ii, pp. 740-742
- 122 Reported in The Times 4 October, 1927
- 123 Reported, ibid., 19 March, 1928
- 124 The Committee members in addition to Beveridge were Prof. Loney (Chairman of the Convocation), Dr. Filon (Chairman of the Academic Council), Dr. Graham Little MP, Sir Holburt Waring (Chairman of the Finance Committee), Mr. W.E. Spencer, Dr. W.R. Matthews, Dr. Halliday (Principal of King's College), Sir Andrew Taylor, Miss Ethel Strudwick (Principal of St. Paul's Girls' School) and Miss Margaret Tuke (Principal of Bedford College for Women), reported in The Times 23 March, 1928
- 125 ibid., 22 March, 1928
- 126 ibid.
- 127 ibid., 5 February, 1929
- 128 Reported, ibid., 10 April, 1928
- 129 Reported, ibid., 9 May, 1928
- 130 Reported in the BMJ (1928) ii, p. 544
- 131 The members were Mrs. Adrian Corbett (NUSEC), Miss Beard (Association of Headmistresses), Dr. E.M. Higgins (St. Joan's Social and Political Alliance), Mrs. Barton (WCG), and Mrs. G. Horton (Secretary of the Joint Committee of Women's Societies), reported in The Times 6 July, 1928
- 132 Quoted in The Times 16 August, 1928; BMJ (1928) ii, p. 544
- 133 The Times 26 March, 1928
- 134 Letter, ibid., 30 March, 1928
- 135 Time and Tide (1928) 9, p. 353
- 136 Dr. Graham Little suggested that, if women wanted co-education in all schools, then the Royal Free should also be co-educational, letter to The Times 12 February, 1929
- 137 e.g. Prof. Winifred Cullis, statement made at the meeting organised to devise means of increasing the capacity of the Royal Free, ibid., 22 March, 1929
- 138 Figures quoted in The Times 31 May, 1928

- 139 Quoted in The Times 28 January, 1929
- 140 This article first appeared in the Nineteenth Century in June, 1928, and subsequently formed the basis of a letter to The Times 10 January, 1929
- 141 ibid., 28 January, 1929
- 142 Leading article, ibid., 20 March, 1928
- 143 Editorial in the BMJ (1928) ii, p. 406
- 144 Editorial in the Lancet (1929) i, p. 241
- 145 Sir Alfred Mond, the Minister of Health, in a reply to a question in parliament, had declared that the government was not prepared to interfere, Lancet (1922) i, p. 973. The Minister of Health made no statement in 1928.
- 146 The Times 1 February, 1929
- 147 Reported, ibid., 2 October, 1930
- 148 Reported, ibid., 22 March, 1929
- 149 Five general hospitals, the Elizabeth Garrett Anderson, the South London Hospital for Women, the New Sussex Hospital in Brighton, and two in Scotland were staffed by women, and there were six specialist hospitals: Clapham Maternity Hospital, East Anglia Sanatorium and Children's Sanatorium, Lady Chichester Hospital for Nervous Diseases in Hove, the Manchester Babies' Hospital, and one in Edinburgh, listed in the MWF News-Letter, July, 1930, pp. 21 and 24
- 150 ibid., p. 25
- 151 Reported in The Times 12 July, 1934
- 152 Reported in the BMJ (1929) ii, p. 924
- 153 MWF News-Letter, March, 1930, pp. 55-58
- 154 Dr. Ethel Bentham was elected as a Labour MP in 1929, but unfortunately she had little impact in the Commons as she was already elderly. She died eighteen months after the election.
- 155 In 1928-9, 838 women qualified and by 1937-8 1,344 women qualified. Similarly, in Scotland numbers rose from 270 in 1928-9 to 569 in 1937-8, figures quoted in the BMJ annually from the returns of the University Grants Commission
- 156 Reported in the BMJ (1930) ii, p. 789
- 157 It was an all male group which signed the articles of association when the College was formed. The signatories were Dr. Henry Russell Andrews, Prof. William Blair Bell, Mr. Comyns Berkeley, Sir Francis Champneys, Dr. Thomas Watts

- Eden, Prof. John Martin Munro Kerr, Prof. Charles Gibson Lowry, Sir Ewen John Maclean and Prof. William Fletcher Shaw, reported in the BMJ (1929) i, p. 462. Also, the officers and executive committee of the new College were all men. The President was Prof. Blair Bell, with Munro Kerr the Vice-president, Dr. Comyns Berkeley treasurer, while Sir Francis Champneys was made a vice parton in recognition of his services during the formation of the College
- 158 Reported in the Vote (1925) 26, p. 261. Women had been eligible for entry to both Royal Colleges since 1909.
- 159 Quoted in the BMJ (1931) i, p. 864
- 160 The BMJ published these reviews at the start of each academic year.
- 161 Hilda Martindale (1938) Women Servants of the State 1870-1938, a History of Women in the Civil Service (London: George Allen and Unwin) pp. 117-118
- 162 An amendment, designed to prevent women being confined to the junior posts was defeated, reported in The Times 26 June, 1929
- 163 Vote (1929) 30, p. 318
- 164 Dr. Stella Churchill complained that women were refused house posts in all but two of the children's hospitals in London, although, during the First World War, all had women on their residential staff, letter in The Times 26 June, 1929
- 165 Reported in the Vote (1929) 30, p. 364
- 166 Reported, ibid. (1931) 32, p. 100
- 167 Reported, ibid., p. 148
- 168 Reported in the BMJ (1929) i, p. 462
- 169 Reported in Public Health (1934) 47, pp. 151-152
- 170 Comments on career prospects in the public health service, Public Health (1928) 42, pp. 15-21; Medical Officer (1919) 22, p. 79; (1921) 26, pp. 95 and 99-100; (1922) 28, pp. 97-99
- 171 She was Dr. Margaret Joyce Proctor, reported in the Medical Officer (1926) 36, pp. 281-282. In the 1930s, York and Stepney also had women MOsH, Moberly Bell (1953) op. cit., p. 184
- 172 Three women achieved places on the Council in 1938. The members' names were published in the columns of Public Health.
- 173 Reported in the BMJ (1937) ii, pp. 1124-1125

- 174 The proposal had first been made in 1934, when the hospital failed to become the site of the British Post-graduate Medical School, letter from Maurice E. Shaw, Vice-dean of the Post-graduate College, in the BMJ (1937) ii, p. 374. Maurice E. Shaw wrote to The Times suggesting that women should apply to the College, The Times 26 April, 1937
- 175 Time and Tide (1937) 18, pp. 429-430
- 176 Anonymous letter in the BMJ (1937) ii, p. 1305
- 177 Dr. Jane Walker, in her address at the opening session of the London School of Medicine for Women, quoted in The Times 2 October, 1929. Again, in 1932, the women students were told they had to be better than men in order to overcome prejudice, ibid., 5 October, 1932
- 178 Letter to the BMJ (1938) i, p. 96
- 179 The Goodenough Committee was set up by the Ministry of Health and the Department of Health for Scotland in 1942, to inquire into the organisation of medical schools, and its report was published in 1944. The Committee considered the 'grudging admission of a few women' to be unsatisfactory. It recommended that the payment of the exchequer grant should be dependent on co-education, and it hoped women students would form about one third of the total. At the same time, it wanted every effort to be made to end discrimination against women at the post-graduate level, Report of the Inter-Departmental Committee on Medical Schools (1944) the Goodenough Report (London: HMSO) pp. 97-100

C H A P T E R E I G H T

THE DEMISE OF THE INDEPENDENT MIDWIFE

During the early years of this century, the majority of births were conducted by a midwife. Some worked for a nursing association, the most notable being the Queen Victoria Jubilee Institute for Nurses, which subsequently became the Queen's Institute for District Nurses (QIDN);¹ others worked for the maternity hospitals, some working in the wards, while others undertook the care of the hospitals' district patients, the out-patients; and others worked as independent midwives, seeking to establish a practice which would provide them with an adequate income, while some of this latter group also worked for charitable institutions, for a fixed fee for each case. Those who worked for a hospital or for a nursing association generally were assured a reasonable livelihood, but those in independent practice often found it difficult to maintain themselves by midwifery work alone. It had become fashionable for the more affluent to engage a doctor for their confinements, so midwives were employed mainly by those unable to pay more than a small fee. Jean Donnison has traced the history of the midwife from the seventeenth

century until the passage of the first Midwives Act in 1902, and has provided ample evidence to account for the low status accorded to the occupation prior to the introduction of government legislation. Although the church had licensed midwives, this had never been complete, and was for social and religious purposes only, providing no instruction for midwives.² From early in the seventeenth century, men began to take an interest in midwifery work, and immediately sought to curtail the midwife's role, forcing her to call on a man to deal with difficult cases by denying her access to the information on the newly-acquired knowledge of anatomy and the use of forceps. The women's inability to read Latin prevented them from reading the medical textbooks on obstetric techniques.³ During the eighteenth century, the introduction of the use of forceps, which midwives were prohibited from using, gave men the opportunity to expand their practice. These male practitioners charged higher fees, and it became a sign of affluence to be attended by a man.⁴ At the same time, lying-in hospitals were being founded, where midwives could receive instruction, but the fees were high thus excluding many prospective midwives.⁵ In the nineteenth century, when the registration of doctors was introduced, midwives were not included.

Donnison refers to the links between midwives and disreputable practices, including abortion; prostitution and the disposal of unwanted infants. She argues that, by the late nineteenth century, the 'Sairey Gamp' image of the midwife predominated: they were deemed to lack knowledge and to drink in excess, thus the word midwife itself was hardly respectable in Victorian society.⁶ It is possible, however, that Donnison herself has

been influenced by the male obstetricians' endeavours to discredit the midwives, and, as a result, has overlooked the skill and dedication of some midwives, who learnt from fellow midwives and benefited from the knowledge gleaned from regular practice and from the expertise handed down from one midwife to another.⁷ Nevertheless, it is evident that, by the beginning of the twentieth century, the position of the independent midwife was believed to be untenable, with registration seen as essential. Consequently, the 1902 Midwives Act, which established a register for midwives and ensured that, in the future, midwives would be required to undergo a minimum period of training was deemed to be a notable advance. This registration, however, placed midwives in a unique position in relation to the other professions in the health service. First, their governing body, the Central Midwives' Board (CMB), was in the control of the medical profession, which had been consistently hostile to the advancement of midwives. Secondly, the midwives were subject to numerous regulations, which covered not only their conduct at work, but also their private lives, a result of the association of some midwives with disreputable practices. Finally, the midwives were to be subject to local-authority supervision.⁸

Subsequently, the future of the midwife seemed to be assured. Successive governments assumed that all normal confinements would be attended by midwives, working in the woman's own home.⁹ In November, 1918, a second Midwives Act was passed, which aimed to improve the midwives' financial position and further curtail the practice of unqualified women. The CMB, or a local authority, was given the right, if they thought

fit, to pay compensation to a midwife, who was suspended from practice and then found to be innocent, or who had been suspended to prevent the spread of infection. Local authorities were given the right to aid training, by providing grants to institutions, and were allowed to pay the fees of a doctor, called by a midwife in an emergency. The Act prohibited a woman who had been suspended from the Midwives' Roll from attending childbirth in any other capacity, unless it was an emergency, and those found contravening the Act were subject to a fine of ten pounds.

Despite this legislation, midwives failed to become established as a professional body, perceived by their fellow professionals and by the general public as responsible and able to take charge of home births. In order to establish midwifery as an independent profession, it would have been necessary to improve and extend the training so midwives were accepted as competent to take charge of normal confinements including the administration of pain relief during labour. In the event this did not occur. Increasing numbers of women chose to be attended either by a doctor or to go into an institution. Independent midwives found it more and more difficult to earn a viable income. Moreover, efforts to exclude unqualified women were not entirely successful. The status of the occupation therefore remained low, and the better educated were not attracted to the work. Although many midwives had carried out additional procedures, such as forceps deliveries, the administration of anaesthetics and the insertion of stitches, during the First World War, midwives were not permitted to retain this work. The numerous

regulations and supervision which was often merely disciplinary undermined confidence. The number of occasions when a midwife summoned a doctor rose significantly, even amongst the QIDN midwives, generally considered to be the most competent group of midwives.¹⁰ Although, during the 1920s, midwives were asserting their right to remain independent, and had the backing of leading maternity and child welfare workers and some obstetricians, by the mid-1930s, it was accepted that a salaried service was essential.

The Midwives' Aims during the 1920s

In 1919, Nursing Notes, the journal of the Midwives' Institute, was optimistic about the future. A leading article noted that the shortage of doctors made midwives necessary, while their close association with mothers would make them ideal members of maternity and child welfare committees. It acknowledged, however, that midwives needed to unite to fight against low fees, inadequate inspection, jealousy between midwives and friction with other health workers.¹¹ Nursing Notes observed an increase in the employment of municipal midwives, particularly in the rural areas, but anticipated the independent midwife would remain popular, as there was a prejudice against 'Town Hall officials'.¹² Moreover, Nursing Notes claimed that municipal midwifery would not attract those best suited to the work.¹³ It anticipated that municipal midwives would move around to gain promotion, and would, by association with health visitors, be encouraged to leave the profession, to earn a higher salary, and thus would not offer continuity of service comparable to the independent midwife.¹⁴

Meanwhile, the independent midwives were unable to forge links with the health visitors, despite the fact that they shared a number of common grievances relating to autonomy at work and their status vis a vis male colleagues in the health services, because midwives felt threatened by the intrusion of the health visitors, who were sometimes employed to inspect midwives and who were regarded as employees of the municipalities, likely to undermine the authority of the midwife and encourage women to desert the midwife in favour of the hospital-based maternity services (see pp. 325-326).

The Midwives' Institute was anxious to establish the professional status of the midwife. Comparisons, therefore, were made with doctors rather than nurses. For this reason, the Institute opposed affiliation to the TUC, arguing that midwifery was not a trade.¹⁵ The following year, the wearing of uniforms and badges, like nurses, was deprecated because medical practitioners did not wear badges.¹⁶

Rosalind Paget, a midwife who had been one of the leading campaigners for the registration of midwives at the end of the nineteenth century, and who represented the QIDN on the CMB until 1927, argued that better-educated women must be attracted to the occupation, so it could remain independent.¹⁷ Alice Gregory, the honorary secretary of the British Hospital for Mothers and Babies, and herself a teacher of midwives, advocated that midwifery should cease to be regarded as an interesting postscript to a general nursing training. She wanted the occupation to be complete in itself, and considered that a training of two years would be reasonable.¹⁸ Eva Pye, who was president of the Mid-

wives' Institute in the 1930s, shared these beliefs. In 1933, for example, she argued against midwifery falling into the hands of trained nurses, because they were taught to rely on a doctor for a lead, whereas a midwife was expected to rely on herself.¹⁹ The same point was made in an editorial in Nursing Notes: a nursing training was not the best way to develop common sense, resourcefulness and adaptability.²⁰

The standard of inspection was considered to be one of the principal reasons deterring the better educated from practising midwifery.²¹ Complaints were published regularly in Nursing Notes.²² Particular criticism was levelled at a memorandum issued by the Ministry of Health in 1925 to all maternity and child welfare authorities. Nine specimen forms were included, of which one dealt with the inspection of midwives' homes. Information was required on the number of rooms, the number of occupants, the bathing and sanitary facilities, the midwife's bedroom, her general health, cleanliness and the condition of her hands.²³ The Midwives' Institute thought an independent professional woman should not be asked such questions: inspection was necessary, but it should be done in such a way as to increase prestige in her own eyes, and that of her patients and the general public.²⁴ The lack of uniformity in the administration of the rules was also a problem. Nursing Notes complained that some areas punished a small error of judgement as severely as a major infringement of the rules.²⁵

Midwives, however, found it difficult to mount effective campaigns. The officials of the Midwives' Institute found that their desire to take action to raise the status, pay and

working conditions of independent midwives was thwarted by the apathy of the membership. The Institute often complained that midwives were too meek.²⁶ Women who were often poorly educated, geographically separated, and forced to work long hours in order to earn a meagre living, were in a weak position to organise. Their self-confidence was perhaps stifled by the widespread failure to value the knowledge and skills midwives had acquired through experience, and which had been handed down by word of mouth. There was a tendency to value only technical knowledge imparted by the medical profession. McCleary, for example, in his review of the development of the midwifery service, published in 1935, described it as 'the Cinderella of medicine', which had for centuries been left 'in the hands of untrained ignorant women'.²⁷ The lack of support from lay women no doubt helped to undermine the midwives' confidence (see the discussion of lay women's deference to the obstetricians and their enthusiasm for the medicalisation of childbirth, pp. 99-116).

Moreover, the midwives received only limited support from lay women's organisations, because of their association with the working class (see p. 71). Consequently, it was mainly the working-class women's organisations which campaigned for better working conditions and improved training for midwives, while even their support was limited by their assumption that, ideally, women should be attended by a doctor as well as a midwife (see pp. 103-105). Midwives sought the support of the middle class, but failed to persuade middle-class women to use a midwife. Katherine Gillet-Gatty, a midwife, in a letter to Time and Tide, wrote

Indeed, with a sinking birth rate and a rising fear of labour pains, I would stress the point that to connect so purely physiological a condition as childbirth with the pathological concept of an institution would have a considerably depressant effect.²⁸

Two years later, a midwife complained in the columns of the Women's Leader that the public too readily identified the midwife with a 'Sarah Gamp' image, and criticised the middle class for making the midwife unfashionable.²⁹ The midwives' case never became a major issue for the middle-class feminists, although, in 1934, the Maternal Mortality Committee called for the separation of nursing and midwifery.³⁰

Moreover, midwives were given little opportunity to express their views by the Ministry of Health. When the CMB was set up, there were two midwives on the nine-member Board, the others all being leading members of the medical profession. Subsequently, the size of the CMB was increased to fourteen, but the number of midwives never rose above three during the inter-war period. At this time, the representatives of the Ministry of Health and the municipalities formed the largest group on the Board, with six members; but the medical profession maintained its dominance, as there were four representatives from medical organisations, while the Ministry of Health always included doctors amongst its nominees. The Board was always chaired by a member of the Royal College of Physicians, first Sir Francis Champneys, followed by Dr. J.S. Fairbairn and, from 1936, Sir Comyns Berkeley. The QIDN was entitled to nominate one person, and it chose a midwife, first Rosalind Paget, and, after her retirement in 1927, Elena Richmond. The Midwives' Institute was permitted to nominate

three persons, and, throughout the period, Dr. J.S. Fairbairn, an obstetrician and gynaecologist at St. Thomas's Hospital and a prominent member of the Royal College of Physicians, was one of the representatives, the other two being midwives.³¹

The fact that the Midwives' Institute elected to be represented by a member of the medical profession perhaps indicates an acceptance by midwives of their low esteem in the eyes of physicians, surgeons and the Ministry of Health, and a lack of confidence in their ability to achieve a status comparable to that accorded to a doctor.

Similarly, midwives were poorly represented on the Bolam Committee which investigated the training and employment of midwives (see pp. 124-125). Dr. J.S. Fairbairn and Mrs. Elena Richmond, who were the two members of the CMB on the Bolam Committee, complained that practising midwives were given little opportunity to express their opinions.³² Furthermore, in a discussion of the Bolam Report, organised by the Section of Obstetrics and Gynaecology of the Royal Society of Medicine, Fairbairn referred to the hostility of the Ministry of Health to the CMB. He complained also about the composition of the Committee, and described much of the evidence as hearsay and opinion, which could not have been used in a court of law.³³

Despite the change of government in 1929, the Ministry's attitude to midwives remained unaltered. In 1930, when negotiations were being conducted over the proposed national maternity service, Arthur Greenwood, the Minister of Health, was censured in the Commons by Sir Francis Fremantle for his failure to consult the Midwives' Institute or the QIDN.³⁴ Greenwood's behaviour provides an example of the Labour Party's

inclination to defer to the opinion of the medical profession, referred to in the previous section (see pp. 103-105).

Voluntary and Professional Support for the Independent Midwife

The independent midwives, however, received support from a significant number of maternity and child welfare workers and from the obstetricians, anxious to separate maternity work from general practice.

Maternity and child welfare workers regarded the midwife as a vital worker in the service, and, therefore, wished standards to be raised. Maternity and Child Welfare argued that midwifery should be more financially rewarding, in order to attract educated women and to encourage those who had trained to practise. To achieve this goal, the midwife should remain independent, and should run ante-natal clinics with a medical woman to consult in case of need.³⁵ The journal recommended that midwives should conduct all normal births because they did not rush their cases.³⁶

Indeed, in 1930, a leading article in Maternity and Child Welfare described midwifery and medicine as sister professions.

The time is surely ripe for a more general appreciation of the midwife's importance by the public as a whole and by the other branches of the public health service.³⁷

The support of the voluntary element of the maternity and child welfare movement, however, would have done little to inspire working-class women's groups to take up the midwives' case. Rather it reinforced the view that the working class was being offered an inferior service to that available to the middle class (see pp. 71 and 79-81).

MOsH were also anxious to improve the standard of work of the midwives. The Soc.MOsH set up a committee to investigate the workings of the Midwives Acts and the rules of the CMB. Its report, published in 1923, recommended tighter controls against handywomen, and uniform training for nurses.³⁸

The Medical Officer was a consistent advocate of the need to establish the midwife as an independent professional. This journal wanted incomes to rise, so educated women would be attracted to the occupation.³⁹ Comparisons were made with Scandinavia, where the midwife was accorded a higher status and was independent of the medical profession. The journal wanted childbirth to be treated as a normal physiological function, which women did not face with apprehension, complaining

In England, the position of the midwife is deplorable, her status is that of an inferior servant, her pay below that of a charwoman. Until recently she has, generally speaking, been badly educated, inadequately trained, generally despised, and in consequence, necessarily grossly over supervised.⁴⁰

In 1934, however, the journal was worried about the capabilities of some practising midwives, recommending that women consult a doctor, before engaging a midwife, to ensure that the midwife was properly qualified: there was still a long way to go before the country had a satisfactory service. Midwives needed adequate pay, so they could afford proper training and could give sufficient time to each case. The journal warned

In short, we cannot get professional work at the wages of unskilled labour.⁴¹

The low maternal mortality rate in Sweden was quoted as an example of what could be achieved by a maternity service which used well-trained midwives to conduct normal labour.⁴² An efficient service of midwives was deemed to be essential to those seeking to eliminate the fear of childbirth (see pp. 155-160) and those who opposed interference during labour.⁴³ Grantly Dick Read told the Midwives' Institute that the midwife should make childbirth seem a happy, natural event. Sterilisers, white gowns, forceps and the paraphernalia of surgery made mothers anxious.⁴⁴

A correspondent in the BMJ, who had a public health qualification, considered that general practitioners did not have enough time, were exposed to other infections, and did not have sufficient cases to become expert. He advocated, therefore, that the work should be undertaken by midwives, backed up by obstetricians.⁴⁵

Many obstetricians shared this opinion, and were anxious to demonstrate that the work could not be left in the hands of general practitioners. Some, Dame Louise McIlroy being one, wanted the problem to be overcome by creating a panel of general practitioners with a special interest in midwifery.⁴⁶ The fact that a woman obstetrician should want general practitioners to have midwifery work perhaps indicates a desire to secure a niche for women doctors, who, it could be argued, were particularly suited to this work. Such an attitude precluded support for the midwives' campaigns. Other obstetricians, however, wanted general practitioners to be excluded entirely from midwifery work, with the work being performed by midwives and obstetric specialists. They believed

that medical students did not have sufficient midwifery training,⁴⁷ and argued that general practitioners were more likely to spread infection.⁴⁸

Several obstetricians recommended that midwives receive more training. Sir Ewen Maclean, the Emeritus Professor of Obstetrics and Gynaecology at the Welsh School of Medicine, for instance, wanted midwives to have longer training, declaring that the midwife was the most important member of the team.⁴⁹

Dr. W.H.F. Oxley, the Honorary Medical Officer and Teacher of Midwifery at the East End Maternity Hospital, regretted the trend towards allowing normal births to take place in hospital. He wanted to reverse this trend by raising the competence of midwives.⁵⁰

Most obstetricians, however, anticipated that the midwife would be supervised by a consultant. Professor Munro Kerr, the Regius Professor of Midwifery at Glasgow University, argued that midwives should be closely supervised by a consultant, while there should be institutional accommodation for all problem cases, ante-natal cases and the primiparae.⁵¹ Oxley wanted a doctor to examine all midwives' cases at least twice during pregnancy.⁵² An obstetric surgeon at the Middlesex Hospital, Louis Carnac Rivett, however, was adamant that midwives could cope with normal complications, do simple tests, and diagnose the position of the child.⁵³

The Ministry of Health's Analysis

The Ministry was aware of the difficulties experienced by midwives in their endeavours to make a living, and was

conscious of the shortcomings of available training, coupled with the problems associated with the continued presence of untrained women working in the occupation.

In 1917, Dr. Janet Lane-Claypon published the results of a survey, undertaken for the LGB, on midwifery services in London. Dr. Lane-Claypon considered that an independent midwife required an income of £150 per annum. Her analysis of the income of the midwives in the London area, however, revealed that it was quite exceptional for a midwife to earn this sum. She estimated that the average income was approximately £60 per annum. Furthermore, she discovered that many midwives did not actually collect this amount, owing to bad debts, and the fact that some women threatened to go to a free institution, if the midwife did not agree to attend them for a reduced fee. Dr. Lane-Claypon acknowledged that some midwives worked for private charities, because they were guaranteed a fee, and a certain prestige was attached to the work, but the charities usually paid a fee of only six shillings per case. Her conclusion was that, if the midwife gave adequate attention to her cases, it was impossible for her to make an adequate living.⁵⁴

There seems little evidence, however, that the government took this report into account when the 1918 Midwives Act was drafted, as the clauses dealing with compensation and the payment of doctors' fees did little to relieve the midwife's financial difficulties. The payment of fees for necessitous women remained a problem.⁵⁵ A survey of municipal maternity and child welfare services, conducted by the Maternal Mortality Committee in 1928, found that the boroughs investigated paid

doctors' fees for necessitous women, but few paid the fees of midwives.⁵⁶ In 1934, Nursing Notes found only 105 of the 433 local authorities paid the fees of midwives.⁵⁷

The training of midwives was investigated by the Ministry of Health, as part of a larger survey into the causes of maternal mortality. Janet Campbell suggested that training should be extended and that the number of places offering training be restricted, while there should be a check on those teaching midwifery.⁵⁸ She recognised that many trainees had poor general education, making it difficult for them to accomplish the theoretical training, and that the conditions of practice were not conducive to attracting the better-educated women. She referred to the problems of ensuring the adequate distribution of midwives, and the need to place further restrictions on the work of handywomen.⁵⁹ She acknowledged that Britain lagged behind other European countries, and she considered that it was the duty of the state and the local authorities to ensure that the midwife was a

competent and safe practitioner, and in view of this responsibility it is suggested that she should receive such official encouragement and financial help as may be necessary to enable her to follow her profession under conditions of reasonable comfort and security.⁶⁰

She anticipated difficulties, however, if the training period was extended to one year, currently under consideration by the CMB, as longer training might deter village women, who were mainly married or widows, from taking up the work. These women were thought to be essential, because they were prepared to remain in rural areas, and, as they were willing

to tolerate the poor conditions, they were popular with the mothers.⁶¹ Moreover, she pointed out that any increase in fees for training would deter a number who were currently prepared to finance themselves.

The government, therefore, was cautious about introducing legislation. The CMB did extend the training period to six months for trained nurses and twelve months for other pupil midwives, but the course remained inferior to that envisaged by those wanting midwives to be competent to take complete charge of all normal midwifery work. Moreover, there was no restriction imposed upon the numbers entering for training, nor was there any attempt to induce those who had trained to practise. There was no reduction in the number of institutions offering midwifery training,⁶² and, until 1930, the CMB continued to list a number of doctors and midwives who gave private tuition.⁶³ No action was taken to ensure an equitable distribution of qualified midwives. Consequently, some areas, notably the sparsely-populated areas where it was difficult for a midwife to make a living, had insufficient qualified midwives.⁶⁴

Unqualified midwives continued to practise. Under the 1902 Midwives Act bona-fide midwives were permitted to register. In 1905, the midwives' roll contained 22,308 names, of which 7,465 held the Obstetric Society Certificate, 2,322 had hospital certificates, and the remaining 12,521 were classified as bona-fide midwives.⁶⁵ It was anticipated that the untrained would gradually retire and be replaced by qualified women.⁶⁶ In some areas, however, a significant number of bona-fide midwives remained in practice. Some mid-

wives continued to take a few cases until well into old age, as no upper age limit was placed upon their practice, and the absence of any pension scheme gave some women no alternative. These women hindered the practice of the younger, more highly trained midwives. For example, in 1924, sixteen of the fifty-two midwives in Hull were elderly and untrained.⁶⁷ In the same year, the MOH for Monmouthshire reported that fourteen of the midwives in the county were illiterate.⁶⁸ Ethel Cassie, the maternity and child welfare officer in Birmingham, in an article in Public Health, published in 1929, revealed that Birmingham still had thirty-six bona-fide midwives, which represented 18% of the total, and that handywomen continued to flourish.⁶⁹ As both the Ministry of Health and lay women were convinced that formal training under the guidance of the medical profession was essential to raise midwifery standards and thereby combat maternal mortality (see pp. 123-125), the presence of these untrained women did nothing to enhance the status of the profession.⁷⁰ Indeed, in 1930, the WCG passed a resolution calling for the retirement of midwives at sixty years, to make way for those with higher qualifications.⁷¹

Moreover, the problem was compounded by the difficulties experienced in the attempts to eliminate the practice of handywomen as midwives. Handywomen had been popular with many of the poorer women, because their charges were low, they were used to the domestic conditions, and they were willing to perform domestic tasks. Also, general practitioners found them useful, as they enabled the doctor to avoid waiting at the bedside. Some doctors claimed untrained women were

preferable. Dr. Vernon Davies, for example, told the House of Commons, in 1930, that he used to prefer the motherly type to the trained nurse for midwifery work.⁷² In theory, the doctor was supposed to be summoned before the birth, but in many cases he did not arrive until after the event. Although some doctors ensured that these handywomen abided by the rules of cleanliness, others were less particular.⁷³

The General Medical Council was slow to put pressure on its members to abide by the 1902 legislation, not actually censuring failure to comply with the regulations until 1916.⁷⁴ After the First World War, some doctors continued to assist handywomen.⁷⁵ Prior to 1926, it was difficult to prosecute handywomen, as it had to be established that they worked 'habitually and for gain', and they could escape prosecution entirely if they were working 'under the direction' of a medical practitioner. An endeavour was made to curtail the practice of these handywomen in 1926. The Midwives and Maternity Homes Act contained a clause stipulating that uncertified midwives had to be 'under the personal supervision and direction' of a medical practitioner, and it ceased to be necessary to establish that they worked habitually or for gain. The legislation, however, was not entirely successful, as it did not cover maternity nurses, despite the fact that it was known that the role of maternity nurse was often abused. Maternity nurses were supposed to attend during the puerperium, but, in practice, as the doctors had so many cases, the maternity nurse attended the labour as well, but failed to notify the local authority that she was practising as a midwife. In this way the midwife

avoided supervision, and did not have to abide by the rules of the CMB.⁷⁶ The BMA, in its evidence to the Bolam Committee, opposed inspection of maternity nurses on the grounds that nothing should be done to undermine or lessen the responsibility of a doctor in charge of a case. The Association went on to deprecate the use of the term 'handywoman', as many of these women, who were not fully-trained midwives, were competent to act as maternity nurses, under the direction of a doctor.⁷⁷ It is evident that handywomen continued to be employed during the 1930s.⁷⁸

In 1929, the Bolam Committee furnished the government with more information on midwifery practice. The Committee recommended that recruits to the occupation should have a good general education, with selection for training depending on a preliminary examination. Post-certificate courses were advocated.⁷⁹ The Committee also argued that midwives should spend more time with patients, particularly during the post-natal period, and that, to achieve this, the number of cases should be limited and the income per case raised.⁸⁰

The government, however, failed to act as, at the time, proposals for a national maternity service were under review (see p. 126). The government's plans for midwives were also perhaps influenced by the BMA, which unlike the obstetricians and some MOsH, wished to restrict the work of the midwives.

The Controversy with the BMA over the Role of the Midwife

The BMA was defending the right of the general practitioner to do midwifery work.⁸¹ Its attitude to the midwives, therefore, was different to that of the obstetricians

and the maternity and child welfare workers. The BMA set out to establish that the midwife was the doctor's assistant, and argued against the extension of the training to enable midwives to learn the procedures necessary to administer pain relief and to deal with minor complications.

The BMA's vision of the role of the midwife in relation to the general practitioner was set out in its evidence to the Bolam Committee.⁸² The Association stated that a midwife could never replace a doctor, and it denied that general practitioners no longer wanted midwifery work. It reiterated its belief in the desirability of general practitioners taking responsibility for ante-natal examinations, and recommended that all pregnant women made contingency arrangements with a doctor before the confinement.⁸³ A number of recommendations were made, designed to limit the authority of the midwife. A midwife should not be recalled to a case if a patient became ill, as it was not up to a midwife to decide whether an illness was the result of the confinement. Twenty-eight days was the maximum time for the attendance of a midwife. The midwife should be prohibited from administering any drug, except for a simple aperient or ergot after delivery. The CMB rules should not list the abnormalities, which would require the presence of a doctor, because this would imply that the list was exhaustive. The midwife should be commanded to call for a doctor in the event of 'any abnormality'; and a doctor be summoned if a patient's temperature rose by one degree, rather than two degrees as was currently the case. A doctor would be required for all cases of still birth. The Association, however, was

opposed to any collusion between a midwife and a doctor: patients were to have complete freedom in their choice of medical attendant, and midwives were criticised for recommending a particular doctor. Furthermore, a consultant should be summoned only by a general practitioner and not by a midwife, and similarly it should be the doctor who made the decision about whether a patient should be sent to hospital.⁸⁴ The Association concluded

The midwife must be regarded as an auxiliary to the doctor, for though she is allowed to practice midwifery independently, and, indeed, is protected from competition by unqualified persons (a protection not extended to, or asked for by, the medical profession), her practice must be carried out in accordance with the rules which enjoin the calling in of the doctor whenever any abnormality is noticed. The midwife then is a practitioner in normal midwifery who is dependent on the help of the doctor in all cases of abnormality.⁸⁵ (*italics in original*)

When the Bolam Report was published, the BMJ expressed sympathy for the desire of Dr. Fairbairn and Mrs. Richmond to ensure that the occupation was self-governing, but pointed out that it would always be dependent upon the medical profession.⁸⁶

In 1933, Thomas Watts Eden, the obstetric surgeon at Queen Charlotte's and president of the Royal Society of Medicine, wanted general practitioners to do ante-natal and most post-natal work, and to be the 'consultant at the first instant to the midwives'.⁸⁷ Indeed, Dr. Fairbairn during his term as chairman of the CMB, told the 1934 conference that ante-natal work should be in the hands of the general practitioner, helped by a midwife, working under his direction, to undertake observation, education and mother-

craft services.⁸⁸ E. Farquhar Murray, the Professor of Midwifery and Gynaecology at the University of Durham College of Medicine in Newcastle, in an article on midwifery in the BMJ, advocated that general practitioners do all ante-natal work. His reason for disapproving of ante-natal clinics was that they tended to make midwives more independent of the general practitioner.⁸⁹

In 1929, the BMA produced its plans for a national maternity service, in which midwifery would be undertaken by midwives, with the doctor conducting at least one ante-natal examination not later than the thirty-sixth week. The midwife was to call a general practitioner in the event of any abnormality.⁹⁰ Dr. J.W. Bone, when discussing this scheme, argued that it should be up to the general practitioner to decide at the ante-natal examination whether the case was suitable to be attended by a midwife.⁹¹ In 1935, when the BMA modified its scheme, this suggestion was incorporated.⁹²

There were some doctors who wanted midwives to retain a sense of responsibility. For example, a correspondent to the BMJ, R.K. White, wanted midwives to do their own ante-natal work, sending a patient to a doctor only in the case of an abnormality.⁹³ More typical of the BMA's stance, however, was a letter, which appeared in The Times, signed by a doctor, W.N. Leak, which argued that general practitioners should be more involved in obstetric work, and that midwives should not attempt to exclude them.⁹⁴

The Use of Anaesthetics and Analgesics by Midwives

The controversy over the ability of midwives to use

anaesthetics and analgesics provides further evidence of the BMA's desire to control and limit the work of midwives. As anaesthetics and analgesics began to be used more widely to relieve pain in childbirth and became more popular with women (see pp. 109-110), the question was raised as to whether midwives could administer these drugs in the patients' homes.

The 1930 BMA conference discussed the various methods, and concluded that each had problems and could be administered only by an expert.⁹⁵ Dame Louise McIlroy, who gave the address, confessed to a real dilemma over what to do about the 60% of women who were attended by a midwife in their homes. She considered there were three alternatives. Either these women could be left without this service, or an anaesthetist could be provided, or midwives could be trained in surgery and medicine, so they were competent to administer sedatives.⁹⁶

The BMA, however, published a report stating that midwives should not be permitted to use any of the available products.⁹⁷ Sir Ewen Maclean defended the BMA's conclusions. He argued that only registered nurses should give anaesthetics. As midwives were not necessarily registered nurses, and the occupation could not be split in two, midwives must be prohibited from administering sedatives.⁹⁸

The MWF was less dogmatic in its views. The Federation heard the opinion of the President of the Midwives' Institute, Miss Eva Pye, who wanted midwives to be permitted to give women pain relief during labour. Mrs. Ivens-Knowles, a consulting surgeon at the Liverpool Maternity Hospital, argued that midwives should be taught to give sedatives, while Lady Barrett, the Dean of the London School of Medicine

for Women, hinted at the possibility that midwives might be able to use nitrous oxide and oxygen.⁹⁹ These views were clearly at variance with the BMA and also many obstetricians. It was certainly unusual for the MWF to express an alternative opinion to the majority of the male medical practitioners. Perhaps these women were less concerned with the interests of the general practitioners, as few women were in general practice, and were more anxious to represent the interests of women doctors in the public health service, who would conceivably benefit from a midwifery service which was based on the services of a midwife backed up by ante-natal clinics and maternity centres, while association with maternity and child welfare clinics may have made these women doctors more alive to the needs of working-class women. Whilst there may have been some solidarity with fellow women workers, it seems unlikely that this would have motivated the MWF, as other opportunities to align with women workers in the other branches of the health services were not pursued. It is evident, moreover, that not all women doctors wanted to promote the interests of the midwives over those of the general practitioners (see, for example, Louise McIlroy's advocacy of the use of general practitioners for midwifery work, p. 255).

Meanwhile, middle-class campaigners were anxious to ensure that working-class women could benefit from the pain relief being given to middle-class women in private nursing homes. Mrs. Lucy Baldwin, on behalf of the National Birthday Trust Fund, undertook to raise funds specifically for the provision of anaesthetics for working-class women.¹⁰⁰ This money was used for tests on analgesics, to determine whether they would

be safe for midwives to administer. In 1933, the Fund published the results of tests on the use of chloroform capsules in various hospitals.¹⁰¹ Dr. Fairbairn, however, warned the National Birthday Trust Fund not to be too impetuous by making claims regarding the safety of these capsules without carrying out proper scientific tests.¹⁰² A debate ensued on the safety of the capsules.¹⁰³

In 1934, new nitrous oxide and oxygen equipment became available, which simplified the administration of analgesics. The equipment was designed by Dr. R.J. Minnitt, in association with Dr. Hilda Garry, at the Liverpool Maternity Hospital. It became known as the Minnitt gas and air apparatus. It provided a constant mixture of gas and air, which was available for intake by the patient only on inspiration. The National Birthday Trust Fund arranged for the apparatus to be tested at the Wellhouse Hospital in Barnet and in Liverpool. Mr. Louis Carnac Rivett was one of the first to predict that it would be used by midwives in domestic practice.¹⁰⁴ Initially, however, the apparatus was cumbersome and prone to breakdowns, while its cost of seventeen guineas put it beyond the reach of the average practitioner.

Despite the introduction of the new equipment, the Ministry of Health remained cautious. Hilton Young, the Minister of Health, told the House of Commons, in 1935, that medical opinion was still divided, so that it was not possible for him to make general recommendations on the use of anaesthesia in childbirth.¹⁰⁵

Meanwhile, the BMA maintained its opposition to the use of analgesics by midwives. At the BMA's 1934 conference in

Bournemouth, Professor Picken, who chaired the public health committee, remarked that the profession viewed with apprehension plans of the Ministry of Health to allow midwives to administer drugs in their own right. Sir Ewen Maclean stated that the

indiscriminate use of anaesthetics and drugs by midwives would result in a very serious handicap to the patient.¹⁰⁶

Sir Henry Brackenbury, however, revealed that tests were being undertaken on the use of gas and air, to see if it could be made 'fool-proof' so the patient could use it herself.¹⁰⁷

The National Birthday Trust Fund arranged for the British College of Obstetricians and Gynaecologists to undertake research into analgesics suitable for administration by midwives. 10,000 cases were analysed, and the results were divided into three categories: gas and air, chloroform and paraldehyde. Chloroform was found to be potentially dangerous and paraldehyde too unreliable. The use of gas and air, however, involved no risk to the mother or baby, and 77% of women found it helpful. The Committee concluded that the apparatus was suitable for use by a midwife, providing the patient previously had been examined by a doctor, and the midwife was trained in its use. As some patients became excitable, it was deemed desirable to have another attendant present. The Committee, however, noted that the equipment was both costly and difficult to transport, and that some mechanical improvements were desirable to overcome the breakdown problem. The report was signed by Sir Ewen Maclean on behalf of the Council

of the College.¹⁰⁸ The Medical Officer was cautiously optimistic about the use of the equipment, pointing out that its effectiveness would not be established until midwives had used the apparatus unsupervised. It anticipated that, when it became more widely used, costs would go down.¹⁰⁹ The BMA, however, continued to oppose the midwives using any form of analgesic. A leading article in the BMJ stated that administration should remain in the hands of doctors.¹¹⁰

Shortly after publication of the report, a new portable model of the Minnitt apparatus was produced. The total weight, including the cylinder, was twenty pounds, and it was expected that the improved, simple style would be more reliable.¹¹¹ Furthermore, the National Birthday Trust Fund reported that the apparatus would shortly be on the market at between eight and twelve guineas, with the gas at three shillings and sixpence a cylinder. The actual cost of the gas used at the Wellhouse Hospital was approximately two shillings and three pence per patient.¹¹²

Meanwhile, the CMB passed a resolution on the use of the Minnitt apparatus. Midwives should be entitled to use it, provided they had undergone instruction at an approved institution, the patient had a written statement from a doctor, who had examined her within one month of the confinement, and another person, either a nurse, a fellow midwife, a senior medical student or pupil midwife, was in attendance.¹¹³

From 1937, midwives were permitted to use the apparatus, and local authorities were empowered to provide training. The majority of local authorities, however, were slow to take advantage of this right, and the Ministry of Health had no

powers of direction over them. The BMJ reported, in 1939, that twenty-nine out of the 188 supervising authorities had trained midwives in the use of the apparatus.¹¹⁴ In August, 1940, Ministry of Health records showed that forty-four local authorities had made arrangements for the training of their midwives. The Ministry did not issue a circular to local authorities on the matter, although the House of Commons was told that the Ministry hoped the authorities would make the necessary arrangements.¹¹⁵

It is interesting to note that it was the doctors, and not the Midwives' Institute, who undertook an investigation into the use of the gas and air apparatus, perhaps providing an indication that the midwives no longer regarded themselves as an independent profession.

The Advent of the Municipal Midwives

While the debate over whether midwives should use analgesics was being conducted, hospital births were becoming more common (see pp. 99-103 and 109-112) and the birth rate was declining (see Table Two). The number of cases available to midwives was diminishing, but there had been no reduction in the number of women qualifying as midwives.¹¹⁶ The women who trained, and then failed to use their qualification, were accused of taking patients away from medical students, thus hindering their midwifery training.¹¹⁷ Inevitably, some midwives found it difficult to obtain more than a few cases per annum and their financial plight was considerable. In 1926, Nursing Notes, when discussing the paucity of cases available for independent midwives, attributed the decline to the reduction in the

birth rate, the popularity of hospital confinements, and the undercutting by training institutions and hospitals, anxious to attract sufficient patients to fulfil their teaching commitments.¹¹⁸

The debate over the extent to which midwives could be held responsible for the high maternity mortality rate continued.¹¹⁹ The Bolam Committee's report, published in 1929 (see p. 262), stimulated discussion on the need to raise the status of the occupation and to improve training and working conditions.

Following publication of the report, the Midwives' Institute set up a joint committee, with representatives from the Association of Inspectors of Midwives, the Association for Promoting the Training and Supply of Midwives, the College of Nursing and the QIDN. This committee accepted the Bolam Report, with the exception of the section relating to the function of the CMB, and the aim of the committee was to secure an improvement in the midwifery service.¹²⁰

Concern over the plight of midwives began to be discussed more widely, with suggestions made for the alleviation of their problems. Some minor proposals were made. In 1931, the Countess of Iveagh, in a parliamentary question, asked the Post-Master General if midwives could be provided with free telephones. This request was refused, on the grounds that it was the responsibility of the local authorities to assist midwives.¹²¹ The question of payment for ante-natal work was considered by the CMB. The Board decided, however, that the only way to pay midwives for this work

would be to raise fees.¹²²

More radical proposals were formulated. At the 1930 congress of the Royal Sanitary Institute, Dr. J.E. Spence, the MOH for Eccles, argued that there was a need to improve pay, so that a full-time service of midwives could be built up.¹²³ In an article in National Health, Dr. D.C. Lamont, the MOH for Lincoln, argued in favour of a salaried service of midwives, employed by the maternity and child welfare committees of the local authorities.¹²⁴ Miss Eva Pye, the President of the Midwives' Institute, recognising the effects of the poor distribution of midwives, suggested that midwives be paid a retaining fee.¹²⁵ A leading article on midwifery in the Medical Officer noted that the majority of midwives attended the poor, who could not afford to pay the higher fees necessary for midwives to earn a reasonable income. It recommended that midwives should receive a subsidy, and that a scheme, similar to that which guaranteed doctors' fees under the 1918 Midwives Act, should be employed. The Journal criticised the existing law relating to midwives, which, it considered, was mainly penal: the state required much, but gave little in return. Readers were warned that the country would receive only what it paid for.¹²⁶

In October 1933, the Minister of Health opened a joint headquarters for the National Birthday Trust Fund, the QIDN and the Midwives' Institute. It was intended as a national centre for the co-ordination of voluntary effort to advance the maternity services, and as a club and hostel for midwives. The National Birthday Trust Fund announced that one of the aims was to raise the status of the midwife.¹²⁷

The following January, a Joint Committee on Midwifery was set up, under the chairmanship of the Earl of Athlone. The National Birthday Trust Fund provided the accommodation and the secretariat. Representatives from the Commons and the Lords, the British College of Obstetricians and Gynaecologists, the Midwives' Institute, the QIDN, the National Birthday Trust Fund, the College of Nursing, the British Hospitals Association and the Soc.MOsH formed the membership of the Committee.¹²⁸ The first meeting discussed the extreme overcrowding in the profession, the payment of fees in necessitous cases, the provision of training in the use of analgesic drugs, and the preparation of a pension scheme to enable midwives to retire at a reasonable age.¹²⁹ Later in the year, the Committee changed its name to the Joint Council of Midwifery. A resolution was passed recommending a scheme for the enlistment of midwives throughout the country in an organised service, suited to the needs of the district, and having regard to the retention of the mother's freedom of choice of attendant. The Council discussed the payment of fees for necessitous women, but argued that the entire remuneration of midwives should be reviewed.¹³⁰

In 1935, the Joint Council published a report on a salaried midwifery service, which had been compiled by a committee under the chairmanship of Thomas Watts Eden, an obstetrician, with Sir Francis Fremantle MP and another obstetrician, Dr. J.S. Fairbairn, as vice chairmen. The terms of reference were

That further consideration of the whole question of the remuneration of midwives, as bearing on the efficiency of the midwifery service, is ur-

gently required, and that a detailed scheme should be prepared for the enlistment of midwives throughout the country in an organised service, suited to the needs of each district, and having due regard to the retention of the mother's freedom of choice of attendant.¹³¹

The Committee reviewed the figures, and estimated that 60% of cases were attended by a midwife. It accepted that domiciliary midwifery should continue, based on the recommendations of the BMA memorandum of 1929. The Committee, however, considered that the status and the pay of the midwife should be raised, while training needed to be lengthened, improved and standardised, and should be supplemented by compulsory post-certificate courses. Supervision needed to be undertaken by senior members of the profession. The Committee found midwives' pay to be totally inadequate, with some midwives receiving only £50 per annum, out of which they were expected to pay for equipment, drugs, disinfectant and sometimes dressings. Many midwives lived in lodgings which 'militated against the maintenance of high professional standards.'¹³²

The Committee found three main causes of low pay. First, the economic position of those receiving the service; secondly, some midwives worked part-time or were merely supplementing another income, and they tended to accept fees below the average (it was estimated that about 40% of independent midwives took fewer than fifteen cases a year); and thirdly, there was an excessive number of qualified midwives, owing to the short training and the low educational standards required of entrants. The Committee considered there were three options: the number of midwives in practice

could be restricted, pay could be increased other than by creating a salaried municipal service, or there could be a salaried service under the control of the local authorities. The Committee favoured the last option, as it thought this would attract a better class of candidate, would aid co-ordination and prevent overlapping with health visitors, and would make it possible to effect economies in ante-natal clinics and allied services. It anticipated that it would provide scope for promotion, and would enable midwives to cover for one another during holidays, while a pension scheme would stop women in their seventies and eighties from practising. It suggested that training could be extended to three years.¹³³

The Committee devised a scheme under which local authorities would provide a salaried service or would aid voluntary associations to provide the service. It emphasised that neither the voluntary associations nor the individual relationship between midwives and patients should be upset. It suggested midwives should receive the same pay as health visitors. It estimated that a midwife would be able to cope with eighty cases per annum, and less in rural areas, and it anticipated that about 4,000 midwives would be needed. In the first instance, local authorities were to recruit from midwives already in the area. Practising midwives, who were not required, would be given compensation during the first two years, and those too old or feeble to practise should receive an immediate pension. Supervision should be undertaken by a senior midwife in practice, possibly with a medical practitioner as the chief inspector. Midwives would

attend refresher courses every seven years. Independent midwives would be permitted to continue, as the scheme was intended mainly for those who could not afford to pay adequate fees.¹³⁴

The BMJ approved of the scheme.¹³⁵ A correspondent in the BMJ, Malcolm Donaldson, favoured the introduction of a salaried service, on the grounds that, when they could make an adequate living, midwives would be more ready to seek the advice of a doctor.¹³⁶ The Medical Officer was effusive in its praise

For years we have insisted that midwifery in this country can never be satisfactory until we have a profession of midwifery; that we cannot have a profession of midwifery without a professional training of midwives; that we cannot have this professional training and status unless its remuneration and prospects are sufficient to attract women to enter it, and that adequate remuneration cannot be commanded by the profession without the aid of public money.¹³⁷ (*italics in original*)

It hoped that the report would form the basis for legislation. Subsequently, the Medical Officer predicted that the majority of confinements would continue in the home, and, therefore, it would be necessary to have a salaried service of midwives, because the general practitioners did not really want the work. The journal mentioned the need to limit the number of women training.¹³⁸ Janet Campbell, who had retired from the Ministry, in a letter to the Lancet, declared that a salaried service was the only way to escape the existing unsatisfactory state, and she too called for some control over the number of entrants.¹³⁹

The LCC voted to support the recommendations. An amend-

ment, suggesting that it should be incorporated with other changes to the maternity service, was defeated on the grounds that such action would lead to further delays.¹⁴⁰

According to The Times, the BMA was concerned primarily to counter any claims that general practitioners were inefficient, and to ensure that any salaried service of midwives was not organised by lay administrators, to the exclusion of the doctors. The BMA wanted to work with the specialists, to formulate a scheme to pre-empt any fait accompli by the state.¹⁴¹

In the wake of the Joint Council's report, the Minister of Health, Kingsley Wood, announced, in September, 1935, that proposals for a salaried midwifery service were to be sent to local authorities for their comments.¹⁴² The following month, in an election address, Kingsley Wood committed the national government to a salaried midwifery service.¹⁴³

The proposals received a cautious response from midwives. Nursing Notes, in its initial comment, declared that a new era of anxiety for those in independent practice had begun.¹⁴⁴ A subsequent article asked midwives to consider whether the scheme would appeal to mothers, whether they would want to limit the number of cases they could take, whether they wanted to work for an authority that could report them to the CMB. They were urged to investigate the promotion prospects, and to consider whether they could maintain intimate relations with their patients.¹⁴⁵ The journal went on to speculate as to whether general practitioners would be willing to work for a municipal employer.¹⁴⁶ Thomas Watts Eden, however, declared that the journal had

misinterpreted the report: there was no intention to interfere with the practice of independent midwives. The proposals, he argued, would strengthen the voluntary services and provide for the needy,

while leaving to the independent midwife the classes who are able to pay her adequately for her services. That these proposals should result in placing all midwives under the state is quite incomprehensible.¹⁴⁷

These remarks inspired a heated debate in the columns of Nursing Notes on the advantages and disadvantages of a salaried service.¹⁴⁸ Eva Pye, in her presidential address to the Midwives' Institute, defended the report of the Joint Council. The aim, she assured midwives, was to keep freedom of choice, to retain the QIDN and the County Nursing Associations and to allow independent midwives to continue to practise. She urged the Institute to work to ensure the best possible terms for compensation for those midwives who would not be accommodated in the scheme and for superannuation.¹⁴⁹

Meanwhile, the Midwives' Institute carried out its own survey into the work experience of independent midwives. A questionnaire was sent out to all those midwives thought to be in independent practice, and the answers given by 3,447 midwives were analysed.¹⁵⁰ It found independent midwives had been adversely affected by four events. First, there had been a substantial fall in the birth rate. Secondly, the number of hospital births had gone up. Thirdly, there was undercutting and overlapping in domiciliary practice, as a result of the midwives who were given free training taking cases as part of their course and the nursing associations, which charged very low fees, extending their services.

Finally, some local authorities were slow to pay the fees for necessitous women, while some paid only part of the fee and nothing if the woman went into hospital. Handywomen remained a problem in some areas. Women engaged a doctor, because they wanted an anaesthetic, and then could not afford to pay a midwife.¹⁵¹

The Institute estimated that, of the midwives who had been in practice for over ten years, just over 40% had more than fifty cases in 1934; and, of those who had been in practice for less than ten years, only 25% had more than fifty cases. Fees varied according to the area,¹⁵² but generally a midwife with under fifty cases earned less than £100 per annum. The Institute estimated that the midwife's expenses, which included laundry, upkeep of the bag, fares, telephone rental and, sometimes, domestic help, were necessarily high, and were not reflected in the fees received.¹⁵³ A salaried service seemed the only remedy, and the Institute worked out a scale of compensation and a pension scheme.¹⁵⁴ Eva Pye wrote to The Times stating that the Institute was broadly in agreement with the proposed legislation, because of the financial difficulties encountered by many independent midwives.¹⁵⁵

In 1936, Lady Forber (formerly Dr. Janet Lane-Claypon) published an article in the BMJ, based on the findings of the Midwives' Institute inquiry. She claimed that midwives, who previously had in excess of 200 cases per annum, currently barely made a living. On average, she thought a midwife earned about one shilling an hour.¹⁵⁶ Lady Forber wrote a similar article for the Medical Officer.¹⁵⁷

The bill which was introduced into parliament followed closely the proposed scheme of the Joint Council of Midwifery. It became law in July, 1936, and local authorities were given one year to comply with the requirements. The principle of choice was upheld, and midwives were permitted to continue in independent practice. Local authorities were entitled to assist voluntary associations, rather than set up their own service. This clause was criticised in the House of Commons, and Ellen Wilkinson proposed an amendment, but it was defeated.¹⁵⁸

The Minister of Health declared in the Commons that legislation was introduced, based upon the Joint Council's report, without delaying for the findings of the Ministry's investigation into the high maternal mortality in certain areas, as it was considered essential to combat the high maternal mortality rate.¹⁵⁹ When he introduced the second reading of the bill, Kingsley Wood stated that the object was to ensure that every mother had access to a trained midwife, and to raise the status of the profession. He remarked that the QIDN had demonstrated what could be achieved by a salaried service. Legislation was necessary because the profession was overcrowded and badly paid, and there were too many women practising part-time or were too old for the work.¹⁶⁰

The Midwife after 1936

In 1937, following the Midwives Act, the training period was extended to twelve months for qualified nurses and twenty-four months for other pupil midwives. Further-

more, in line with the recommendations of the Bolam Committee, the training was divided into two parts. The first part, to be undertaken in an institution was largely theoretical, and the second part was designed to allow pupils to put their knowledge into practice in the district, to gain confidence and to learn to work with the other public health workers. There was, however, no mention of reducing the number of institutions offering training.¹⁶¹

In the same year, the Ministry of Health satisfied another of the midwives' demands by stipulating that supervision must be undertaken by a person with actual midwifery experience. They were to be known as supervisors and not inspectors.¹⁶² Indeed, the CMB, in its report for 1937, noted with approval that the circular issued by the Ministry of Health in the wake of the legislation recommended that the supervisor should be seen as 'a councillor and friend of the midwife rather than a relentless critic'.¹⁶³

The efficiency of the midwifery service was enhanced in 1938, when agreement was reached with the BMA for the creation of a panel of general practitioners who were willing to be called in an emergency.¹⁶⁴

Rules for post-certificate training, however, were not introduced until January, 1939. In the previous March, the Ministry of Health approved a scheme whereby each midwife would attend a four-week residential course every seven years, or more regularly if the local authority felt able to make the arrangements.¹⁶⁵

Thus, by 1939, many of the demands made by those wanting to raise the status and improve the working conditions of the

midwives had been met. Nevertheless, limitations preventing the creation of an autonomous, self-governing profession remained. Midwives continued to be more stringently regulated than the medical profession, while membership of the CMB was not altered.

Criticisms continued to be voiced about several aspects of the midwifery service. The County Medical Officer for Somerset, William G. Savage, for example, listed several shortcomings of the system. He criticised the training of midwives, which he described as specialised technical training, based on poor general education. The fact that doctors were called out in about 40-50% of cases was evidence of the unsatisfactory situation. He recommended that the rules of the CMB relating to the summoning of a doctor be amended: midwives were so worried about complying with the rules that their efficiency was impaired.¹⁶⁶

Standardisation was hampered, as local authorities retained autonomy with regard to salaries, and to the training given in the use of the Minnitt apparatus. Some local authorities failed to make use of their powers to request the retirement of those midwives surplus to requirements until July, 1939. Some midwives, therefore, continued to take a few cases a year for pin money.¹⁶⁷ At the same time, the voluntary organisations continued to flourish. In 1938, for example, the LCC reported that 160 midwives would be employed under the new scheme, of which forty-seven were employed directly by the Council, and the remainder by 'upwards of forty voluntary organisations'.¹⁶⁸ Standardisation must also have been hindered by the failure to reduce

significantly the number of institutions offering training.

The midwives continued to be attacked by the BMA. At the BMA's annual meeting in 1936, Sir Henry Brackenbury criticised the Midwives Act. He warned that the Act might do more harm than good, as some local authorities might use midwives and specialists, excluding the general practitioner. Maternity could not be isolated from the whole health history of women, and, therefore, it should be handled by general practitioners.¹⁶⁹ In 1939, the BMA again voted against midwives using anaesthetics. This action was criticised in a letter to The Times from Lady Eileen Gormanston.¹⁷⁰ In a reply, H.J. McCurrich claimed that the BMA had voted in the public interest, and not on mercenary grounds. He remarked that, with the patient under anaesthetic, the midwife might be tempted to carry out manoeuvres for which she had neither skill nor training.¹⁷¹ The vote was criticised by Louis Carnac Rivett, who reminded readers that the British College of Obstetricians and Gynaecologists had investigated the matter, and had decided that midwives could use the Minnitt apparatus. He urged midwives not to be alarmed by the vote, but to remember they were under the control of the CMB and not the BMA.¹⁷² This reassurance, however, may have done little to allay the fears of those midwives who still envisaged an autonomous midwifery profession, as the CMB, although not in the control of the general practitioners, was nevertheless predominantly medical in composition. The matter was raised also in the House of Commons, and the Minister of Health assured the House that the College of Obstetricians and Gynaecologists had established that midwives could use the equipment with safety.¹⁷³

In an article on the BMA vote Time and Tide claimed that some doctors in South Wales had refused to sign the certificate confirming that a woman was fit to use the Minnitt apparatus.¹⁷⁴ A doctor, C. Watney Roe, replied to this article, suggesting that the journal would do better to campaign for a doctor to attend all births. He declared that midwives already had too much responsibility.¹⁷⁵

The war intervened before the effects of the extended training and the improved arrangements for supervision could be assessed, but it would seem that any changes came too late to reverse the desertion from the independent midwife. The number of hospital cases were steadily mounting. In 1938, the LCC reported that it had to dissuade people from requesting a hospital confinement owing to the pressure on the accommodation in the maternity wards. The following year, the Council reported that 389 women, who had applied for admission to a hospital, had been persuaded to use the domiciliary service.¹⁷⁶ There is no indication that middle-class women began requesting a midwife to attend them. The midwife continued to be considered as an attendant for those who could not afford a doctor. Inevitably, the stigma of inferiority clung to domiciliary midwifery, an impression the the medical profession, including the women doctors, did nothing to dispel. There was, therefore, little scope for the independent midwife to continue to practise. The independent midwives had failed in their attempt to establish themselves as the professional equals of general practitioners. Despite the extension of training, several procedures, including the ability to use stitches after a birth, remained outside the scope of the

midwife. Moreover, the introduction of the salaried service reinforced the domination of the medical profession. These midwives were not only represented and disciplined by a Board controlled by doctors, but were also employed by an MOH. Such a development effectively completed the medical take over of midwifery. The move towards the contemporary organisation of midwifery was underway by 1939. Meanwhile, it seems likely that the midwifery service failed to attract recruits from amongst the middle class. The failure to raise the status of the occupation or to convince middle-class women that a home birth attended by a midwife would be safe for both the mother and the baby probably helped to maintain the social-class differences between recruits to the medical profession and to the midwifery service. There is, however, scope for further research to substantiate this point.

NOTES AND REFERENCES

- 1 The Institute will be referred to in the text as the QIDN, although the name did not actually change until 1930. There appears to have been no alteration in the work following the change in name.
- 2 Jean Donnison (1977) Midwives and Medical Men, a History of Inter-Professional Rivalries and Women's Rights (London: Heinemann) pp. 3-7
- 3 ibid., pp. 10-18
- 4 ibid., pp. 21-24
- 5 e.g. the British Lying-in Hospital would take only married or widowed women over twenty-five years of age for a minimum stay of six months, and charged fees of about thirty pounds, quoted ibid., p. 27
- 6 ibid., pp. 33-34 and 60-61
- 7 see David Harley (1981) Ignorant midwives - a persistent stereotype, The Society for the Social History of Medicine, Bulletin 28, pp. 6-9; and Margaret Stacey's discussion of the male medical profession's success in usurping the work of the midwife, Margaret Stacey (forthcoming) The Sociology of Health and Healing (London; George Allen and Unwin)
- 8 Donnison (1977) op. cit., pp. 33-34
- 9 By the end of 1918, the position of the midwife had been strengthened, as the 1918 Maternity and Child Welfare Act was based on a domiciliary service of midwives, see Appendix One.
- 10 In 1926, the QIDN midwives called a doctor in 19% of their cases. This percentage rose steadily throughout the period and, in 1938, medical aid was summoned in 36.7% of the cases, figures quoted in the BMJ (1938) i, pp. 89-90. Dr. J.S. Fairbairn, an obstetrician and a member of the CMB, said that women were demanding a doctor in order to obtain pain relief and a speedy end to labour. He did acknowledge, however, that some midwives, anxious to take on more cases, to increase their earnings, were calling a doctor to avoid a long labour, article, ibid (1927) i, p. 48
- 11 Nursing Notes (1919) 32, p. 1
- 12 Editorial, ibid. (1920) 33, p. 1
- 13 ibid., p. 29
- 14 ibid. (1923) 36, p. 39

- 15 This discussion was generated by the attempt of some London boroughs, led by Bermondsey, to persuade the midwives in their area to join a trade union, reported, ibid. (1920) 33, p. 84
- 16 ibid. (1921) 34, p. 84
- 17 It is interesting to note that she came from a family with a tradition of work in public service. She was a niece of William Rathbone.
- 18 Letter to The Times 14 August, 1934
- 19 Address given at the Royal Institute of Public Health Congress, quoted in Maternity and Child Welfare (1933) 17, p. 159
- 20 Nursing Notes (1925) 38, pp. 115-116
- 21 Leading article, ibid. (1919) 32, p. 91
- 22 e.g. ibid. (1920) 33, pp. 117-118; (1921) 34, pp. 1 and 16; (1924) 37, pp. 3-4
- 23 Ministry of Health (1925) Memorandum MCW/100, intended as a guide to record keeping.
- 24 Leading article in Nursing Notes (1925) 38, p. 99
- 25 ibid., (1926) 39, pp. 291-292
- 26 e.g. leading article, ibid. (1922) 35, p. 1; (1929) 42, p. 52. In the nineteenth century, it had frequently been people outside the profession who had campaigned for registration, Donnison (1977) op. cit., p. 99
- 27 McCleary (1935) op. cit., p. 122
- 28 Time and Tide (1922) 3, p. 769
- 29 Women's Leader (1924) 16, pp. 79-80
- 30 This demand was made by May Tennant and endorsed by Alice Gregory, reported in The Times 12 December, 1934
- 31 In the inter-war period, the appointing bodies to the CMB were the Royal Colleges of Physicians and Surgeons (one representative each), the Ministry of Health (four representatives), the Society of Apothecaries (one representative), the Midwives' Institute (three representatives), the Association of County Councils and Municipal Corporations (one representative each), the QIDN (one representative), and the Soc.MOsH (one representative). E.g. in 1925, the Board comprised Sir Francis Champney, the Chairman (Royal College of Physicians), Dr. W. Griffiths (Royal College of Surgeons), Mr. E. Sangster (Society of Apothecaries), Dr. West (Association of County Councils),

Dr. R.A. Lyster (Soc.MOSH), Dr. J.S. Fairbairn, Miss M.E. Pearson and Miss A.T. Pollard (Midwives' Institute), Dr. Douglas Drummond, Miss Olive Haydon, Dr. Kay Menzies and Miss Greaves (Ministry of Health) and Mrs. Elena Richmond (QIDN).

- 32 Ministry of Health (1929) op. cit., p. 88
- 33 Reported in the BMJ (1929) ii, p. 967
- 34 PP (1930) 246, col. 1423
- 35 Maternity and Child Welfare (1919) 3, pp. 383-384
- 36 ibid. (1928) 12, pp. 113-114
- 37 ibid. (1930) 14, p. 115
- 38 The members of the Committee were Dr. T. Eustace Hill, Dr. T.W. Naylor Barlow, Dr. Joseph Cater, Dr. J.M. Clements, Dr. R.A. Lyster, the editor of Public Health, Dr. L.E.S. Fleming and Dr. J.W. Bone of the BMA, reported in Public Health (1923) 36, p. 343
- 39 e.g. leading article in the Medical Officer (1926) 35, p. 253
- 40 ibid. (1928) 40, p. 34
- 41 ibid. (1934) 51, p. 251
- 42 Maternity and Child Welfare (1928) 12, p. 241; Medical Officer (1931) 46, p. 31
- 43 e.g. Dr. W.M. Ash, the MOH for Derbyshire, regretted the rise in the number of occasions when a midwife summoned a doctor, as this generally resulted in a forceps delivery, article in the Medical Officer (1931) 46, p. 113
- 44 A lecture to the Midwives' Institute, quoted in Nursing Notes (1934) 47, pp. 6-7
- 45 John Lishman, letter in the BMJ (1936) i, pp. 446-447
- 46 Comments made at a joint meeting of the Section of Obstetrics of the Royal Society of Medicine and the Maternity and Child Welfare Group of the Soc.MOSH, quoted in Maternity and Child Welfare (1929) 13, pp. 147-149
- 47 e.g. this was the opinion of Mr. Louis Carnac Rivett, a gynaecologist and obstetric surgeon at the Middlesex Hospital, quoted, ibid. (1933) 17, p. 163
- 48 Henry Jellet (1929) The Causes and Prevention of Maternal Mortality (London: J. and A. Churchill) pp. 11-13
- 49 Comments made at the Royal Institute of Public Health Congress, quoted in Maternity and Child Welfare (1933) 17, p. 159

- 50 Oxley recommended that women entered the profession directly and that training should be for three years, which would include some general nursing training. He wanted the numbers training to be restricted and the training given only by a few well-equipped hospitals, article in the Medical Officer (1933) 50, pp. 5-6
- 51 Munro Kerr outlined these proposals at a joint meeting of the Section of Obstetrics of the Royal Society of Medicine and the Maternity and Child Welfare Group of the Soc,MOsH, reported in Maternity and Child Welfare (1929) 13, pp. 147-149
- 52 Quoted in the BMJ (1933) i, pp. 257-260
- 53 Article on ante-natal care in Mother and Child (1936) 6, pp. 470-473
- 54 Janet Lane-Claypon (1917) Report on the Provision of Midwifery Service in the County of London, Reports to the LGB on Public Health and Medical Subjects, New Series No. 111 (London: HMSO) pp. 28-41
- 55 There were frequent complaints in Nursing Notes, e.g. (1922) 35, p. 71; (1923) 36, p. 39
- 56 Reported in the Woman Health Officer (1928) 3, p. 7
- 57 Nursing Notes (1934) 47, p. 36
- 58 Campbell (1923b) op. cit., pp. 31-32
- 59 ibid., pp. 34-40
- 60 ibid., p. 45
- 61 ibid., pp. 17-18
- 62 in 1925, there were 209 training institutions in England and Wales, and, although the following year the number dropped to 190, this rate of decrease was not maintained. In 1936, when the new legislation was introduced there were 180 institutions giving midwifery tuition, and at the outbreak of war in 1939, the number was 172, figures taken from the Reports of the Work of the CMB, published annually by HMSO
- 63 During the 1930s, private teachers ceased to be listed by the CMB, although a number of independent midwives continued to provide the necessary district training, figures given annually in the Report of the Work of the CMB
- 64 In 1923, when economic difficulties forced the Ministry of Health to review its budget, a survey was undertaken of the existing maternity and child welfare services, as defined under the 1918 Act. It estimated that in Lincolnshire less than 50% of the population was covered by a

qualified midwife, while in the East Riding there were five midwives when 97 were needed. Overall it was estimated that another 1,400 midwives were required in rural areas, Special Notes on Districts without Centres, Deficiency of Midwives and Health Visitors, prepared for the Extensions Committee, 7 September, 1923, PRO MH55/225

- 65 Figures quoted by Donnison (1977) op. cit., p. 181
- 66 In 1925, 86.5% were trained. In 1936, of those practising, 97.2% were trained, and, two years later, only 237 women, 1.3% of those practising, were untrained, statistics published annually, Reports of the Work of the CMB
- 67 Article by Katherine Gamgee, assistant MOH for maternity and child welfare in Hull, Medical Officer (1924) 31, p. 146
- 68 Reported, ibid., 32, pp. 282-283
- 69 Public Health (1929) 42, pp. 329-330
- 70 This is Donnison's justification for the introduction of registration, see Donnison (1977) op. cit., p. 99
- 71 WCG (1930) 47th Annual Report, p. 19
- 72 PP (1930) 237, cols. 1022-1023
- 73 e.g. see Edith Summerskill's recollections of her father's medical practice prior to the First World War, Edith Summerskill (1967) A Woman's World (London: Heinemann) pp. 5-6
- 74 Reported in the BMJ (1916) ii, p. 60
- 75 There were some prosecutions: e.g. in 1923, two general practitioners were taken to court in Hastings and Surrey for aiding uncertified midwives, reported in the Medical Officer (1923) 29, p. 314. Such cases, however, were rare.
- 76 Editorial in Public Health (1923) 36, pp. 181-182 and 297-298; (1924) 37, p. 242
- 77 BMJ (1929) Appendix IV, Supplement 20 April, 1929, p. 123
- 78 e.g. complaint made by Dr. P. Stanley Blaker, MOH for Dudley, in Mother and Child (1933) 4, p. 139
- 79 Ministry of Health (1929) op. cit., pp. 14-22
- 80 ibid., pp. 70-71
- 81 The BMA believed midwifery work was important to the general practitioner, as it helped to build up a practice. It argued that the general practitioner was particularly competent to do the work because he or she knew the home circumstances and the woman's medical history, and could visit

- her at home. Plans to make midwives independent, or to replace general practitioners by municipal clinics and maternity homes were therefore opposed, see Palmer (1978) op. cit., pp. 35-36
- 82 BMJ (1929) Appendix IV, Supplement 20 April, 1929, pp. 122-125
- 83 ibid., pp. 123-124
- 84 ibid., pp. 122-123
- 85 ibid., p. 123
- 86 BMJ (1929) ii, p. 594
- 87 BMA lecture on midwifery in the home, quoted, ibid (1933) i, p. 403
- 88 Quoted in The Times 26 July, 1934
- 89 BMJ (1936) i, pp. 375-377
- 90 ibid. (1929) i, Supplement, p. 260
- 91 J.W. Bone, Chairman of the Public Health Committee of the BMA, article in National Health (1930) 22, pp. 204-205
- 92 BMJ (1935) ii, Memorandum Regarding the National Maternity Service, Supplement, 7 December, p. 248
- 93 ibid. (1933) i, pp. 389-390
- 94 The Times 29 March, 1935. W.N. Leak worked in Cheshire, where his local authority employed general practitioners to do the ante-natal work, see a previous letter, ibid. 28 December, 1934
- 95 Dame Louise McIlroy had analysed six methods of anaesthesia: chloroform, ether, nitrous oxide and oxygen, morphine-based drugs, ethylene and oxygen, and spinal anaesthesia. Although wary of the possible harmful effect on the foetus by using anaesthesia and thus prolonging labour, McIlroy argued that many maternal deaths could be avoided by the use of an anaesthetic, as the mother would be less fatigued and less likely to suffer from shock, and, therefore, recommended their use, but only by an expert, address given to the BMA conference, quoted in the BMJ (1930) ii, pp. 549-550
- 96 ibid., pp. 550-551
- 97 BMJ (1930) i, Appendix X, Supplement, 19 April, p. 163
- 98 Remarks made at a meeting of the Maternity and Child Welfare Section of the Royal Institute of Public Health at its annual conference, reported, ibid. (1933) i, pp. 1015-1016

- 99 Reported, ibid. (1932) i, pp. 660-661
- 100 Reported in Maternity and Child Welfare (1932) 16, p. 303
- 101 6,000 capsules were administered. There were no deaths and 90% of the women found them helpful, reported in The Times 28 February, 1933
- 102 ibid.
- 103 Louis Carnac Rivett published a report on chloroform capsules, in which he advocated their use by midwives in an institution, Medical Officer (1933) 49, p. 97. His opinion, however, was challenged by W.H.F. Oxley, who thought them unsafe, correspondence between Oxley and Rivett, BMJ (1933) ii, pp. 894, 895 and 942. Maternity and Child Welfare also published opinions for and against the use of chloroform, Maternity and Child Welfare (1932) 16, pp. 254 and 281-282
- 104 The equipment was described in the BMJ (1934) i, pp. 501-502
- 105 Reported, ibid (1935) i, p. 628
- 106 Quoted in The Times 23 July, 1934
- 107 ibid.
- 108 British College of Obstetricians and Gynaecologists (1936) Investigation into the Use of Analgesics Suitable for Administration by Midwives, PRO MH55/625
- 109 Leading article in the Medical Officer (1936) 55, p. 103
- 110 BMJ (1936) i, pp. 267-268
- 111 Announcement, ibid. (1936) ii, p. 630
- 112 ibid., p. 887; The Times 23 October, 1936
- 113 Reported in the BMJ (1936) ii, p. 887
- 114 ibid. (1939) ii, p. 317
- 115 Written answer from Mr. MacDonald, the parliamentary secretary to the Minister of Health, in reply to a question from Edith Summerskill, minute dated 1 August, 1940, PRO MH55/625. The Ministry compiled statistics on the number of local authorities providing instruction for their midwives for the years 1938, 1939, 1940 and 1941. Of the 170 supervising authorities in England, 30 gave training in 1938, 42 in 1939, 47 in 1940, and 41 in 1941. Two authorities in Wales also provided instruction during this period. In 1939, the Ministry estimated that 465 midwives in England and 23 in Wales had been trained, and that 19

- English and 2 Welsh authorities provided apparatus. It estimated that 690 domiciliary cases in England and 339 in Wales had received analgesia from a midwife, PRO MH55/625
- 116 In 1925, there were 59,791 names on the Midwives' Roll, and, in 1936, the number was 62,064, but it was estimated approximately 16,000 were practising, figures quoted in the annual Reports on the Work of the CMB
- 117 e.g. Louis Carnac Rivett at the Royal Institute of Public Health Congress in 1933, reported in Maternity and Child Welfare (1933) 17, p. 163; letters in the BMJ (1935) i, pp. 387 and 225-226
- 118 Nursing Notes (1926) 39, pp. 214-215
- 119 Controversy over responsibility for the high maternal mortality rate had been evident since 1923, e.g. see Nursing Notes (1923) 37, pp. 76-77; Lancet (1924) i, pp. 809-810 and 977. Statistical evidence, however, remained inconclusive, as doctors could claim they had to cope with failed midwives' cases.
- 120 Reported in the BMJ (1930) i, pp. 758-759
- 121 Reported, ibid. (1931) ii, p. 80
- 122 Reported, ibid. (1930) ii, pp. 929-930
- 123 Reported, ibid., p. 24
- 124 National Health (1930) 22, pp. 207-208
- 125 Reported in Maternity and Child Welfare (1933) 17, p. 159
- 126 Medical Officer (1935) 53, p. 11
- 127 Reported in The Times 21 October, 1933
- 128 The full membership was: Lords Aberdare and Strathcona (House of Lords), Sir Francis Fremantle, Megan Lloyd-George and Arthur Greenwood (House of Commons, one member from each of the main parties), Dr. T. Watts Eden, Dr. J.S. Fairbairn and Mr. L. Carnac Rivett (British College of Obstetricians and Gynaecologists), Misses Pye, Burnside and Carter (Midwives' Institute), Sir William Hale-White, Mrs. Elena Richmond and Miss Wilmshurst (QIDN), Sir Julien Cahn, Mrs. Lucy Baldwin and Lady Williams (National Birthday Trust Fund), Miss E.M. Doubleday (College of Nursing), Mr. R.H.P. Orde (British Hospitals' Association) and Dr. John Buchan (Soc.MOSH), quoted in The Times 12 January, 1934
- 129 Reported, ibid.
- 130 Reported in the BMJ (1934) i, p. 1041

- 131 Quoted, ibid. (1935) i, p. 371
- 132 ibid.
- 133 ibid., p. 372
- 134 ibid., pp. 372-373
- 135 Editorial, ibid., p. 364
- 136 ibid., pp. 225-226
- 137 Editorial in the Medical Officer (1935) 53, p. ⁸¹
- 138 ibid., 54, p. 251
- 139 Lancet (1935) ii, pp. 1145-1146
- 140 Reported in The Times 24 July, 1935
- 141 ibid., 23 July, 1935
- 142 Reported, ibid., 10 September, 1935
- 143 Reported, ibid., 29 October, 1935
- 144 Nursing Notes (1935) 48, p. 34
- 145 ibid., pp. 35-38
- 146 ibid., p. 54
- 147 ibid., p. 53
- 148 ibid., pp. 55-58, 71-72, 128-129 and 151; (1936) 49, p. 20
- 149 Reported, ibid. (1935) 48, pp. 61-62
- 150 Precise figures were not known; about 15,000 midwives were practising, but it was not known how many were salaried. 7,565 questionnaires were sent out, and 4,064 replies were received, of which 3,447 could be used for the purpose of the survey, Midwives' Institute (1936) The Midwife in Independent Practice To-Day, a pamphlet published by the Midwives' Institute, p. 7
- 151 ibid., pp. 8-19
- 152 The average fees in the North were 35 shillings for first births and 30 shillings or 27 shillings and 6 pence for subsequent births, while in the South the fees were generally 42 shillings and 35 shillings, although in London they could be as high as 63 shillings for first births, ibid., p. 21
- 153 Expenses were estimated to be: uniform, £5-8 per annum;

- laundry, 2 shillings and 6 pence to 3 shillings per case; upkeep of the bag, 2 shillings and 6 pence to 3 shillings, depending on whether the patient provided dressings; telephone, £6 per annum; and no estimate was given for the cost of transport and domestic help, ibid., pp. 22-23
- 154 ibid.
- 155 Letter to The Times 22 April, 1936
- 156 BMJ (1936) i, p. 490
- 157 Medical Officer (1936) 55, pp. 107-108
- 158 The amendment was proposed by Ellen Wilkinson on the grounds that voluntary associations would prevent the standardisation of the service, and that they would hinder co-ordination, PP (1936) 314, cols. 1056-1057. Opponents argued that the experience of the voluntary associations should not be lost, ibid., cols. 1059-1109
- 159 PP (1936) 311, cols. 1127-1129. The Ministry's findings were published the following year, Ministry of Health (1937a) Report on an Investigation into Maternal Mortality (London: HMSO); (1937b) Report on Maternal Mortality in Wales (London: HMSO)
- 160 ibid., cols. 1117-1119
- 161 In 1938, there were 172 institutions providing training, and 101 midwives giving district training, Report of the Work of the CMB, 1938
- 162 Reported in The Times 8 May, 1937
- 163 Report on the Work of the CMB (1937) p. 11
- 164 The Ministry had lengthy discussions with the BMA over this panel. The BMA refused to contemplate any scheme which would prevent a general practitioner from doing midwifery work, BMJ (1937) i, Supplement, 8 May, pp. 269-271. The BMA proposed a self-selecting list of general practitioners who were willing to be called out to maternity cases, with an advisory committee, made up of two general practitioners, two obstetricians and the MOH to co-ordinate the work of the obstetricians and general practitioners and to arrange for post-graduate training for general practitioners, letter from C.C. Anderson, Secretary of the BMA, to Sir George Chrystal at the Ministry of Health, 18 November, 1937. A conference to discuss the scheme was held on 21 February, 1938, and a circular was published in June, Circular 1705, issued to all Local Supervising Authorities under the Midwives' Acts (England) PRO MH55/682. There was a report in The Times 16 June, 1938
- 165 Report on the Work of the CMB (1938) pp. 13-14

- 166 Article in Public Health (1937) 50, pp. 317-321
- 167 Comyns Berkeley, Chairman of the CMB, in a paper published in Public Health (1938) 51, pp. 257-260
- 168 Quoted in the BMJ (1938) i, p. 89
- 169 Reported in The Times 21 July, 1936
- 170 ibid., 7 August, 1939
- 171 ibid., 15 August, 1939
- 172 ibid., 29 August, 1939
- 173 PP (1939) 350, cols. 1651-1652
- 174 Time and Tide (1939) 20, p. 1011
- 175 ibid., p. 1088
- 176 Reported in the BMJ (1938) ii, p. 1387 and (1939) i, p. 791

C H A P T E R N I N E

THE MOULDING OF A WOMAN'S OCCUPATION:
THE CASE OF THE MUNICIPAL HEALTH VISITOR

By the end of the First World War, health visiting had become a recognised and important part of the maternity and child welfare service. Voluntary workers and those MOsH who wished to develop maternity and child welfare services believed that visits to educate mothers and to assess home conditions provided a valuable way of tackling maternal ignorance and fecklessness.¹ The Schools for Mothers sent out visitors, and those local authorities, which took a special interest in infant welfare, began to employ health visitors, who were to advise mothers on the care of their infants. The number of health visitors rose after 1907, following the Notification of Births Act, which enabled local authorities to organise schemes for the registration of births in their area. By 1914, local authorities employed 600 visitors, and their numbers grew rapidly during the war, especially after the Notification of Births (Extension) Act of 1915 had made the previously permissive legislation mandatory. In 1918,

there were 2,577 municipal health visitors, which included 1,044 district nurses, who acted as part-time health visitors. In addition, there were 320 salaried health visitors employed by voluntary agencies, and 'numerous unpaid voluntary visitors working in co-operation with the local authorities'.²

Davies observes that the employment of health visitors by local authorities marked an important change in health visiting. Whereas previously it had been located in the private sphere, with the lady superintendents providing a charitable service, and the working-class visitors living in the community and providing an example for others to follow, once the health visitors became public health employees, they moved into the public sphere.³ Furthermore, opinions as to the type of woman most likely to make a good health visitor were changing. Once MOsH became involved, criticism was voiced of the 'cottager type' of woman. Davies quotes the influential County Medical Officer for Warwickshire, Dr. Bostock Hill, who argued that a health visitor should be a refined woman with good education.⁴

The LGB's model maternity and child welfare scheme, published following the 1918 Maternity and Child Welfare Act, incorporated the work of health visitors (see Appendix One). It was estimated that one health visitor per four hundred births would be required, and, by the late 1930s, this estimate was revised and it was calculated that one visitor would deal only with 200 to 250 births. During the 1920s, health visiting became the largest single item of expenditure in the maternity and child welfare budget.⁵

MOsH were convinced of the importance of the health visit-

ing service,⁶ and health visitors never encountered the hostility meted out to women doctors seeking work in the public health service (see pp. 230-231). Health visitors were expected to reach those women who were not in the habit of attending meetings or going to the Schools for Mothers and the clinics run by the local authorities. One MOH, Dr. G. Clark Trotter of Islington, described the health visitors' work as the education of the public in personal hygiene, and he anticipated that they would contact the 'residuum' who would never be reached by public exhibitions and other attractions.⁷ MOsH regarded the health visitor as an important link between themselves and the mothers: the health visitor could not only ensure official policy was followed, but could also keep the MOH informed. Dr. T. Eustace Hill, the MOH for County Durham, pointed out that a public employee would, if necessary, be in a position to become unpopular.⁸

The Medical Officer noted that a woman could enter a wide variety of jobs, but argued that

there are certain directions in which a woman's talents may be more appropriately employed than in others, such are those more immediately related to health and home.⁹

The welfare of the nation and the race was dependent on the mothers, who needed help and assistance from outside. The health visitor was important because she could enter homes without being regarded as an intruder.¹⁰ Dr. C.W. Hutt, the MOH for Holborn in London, when representing the Soc.MOsH at a conference organised by the Women Sanitary Inspectors' and Health Visitors' Association (WSI) told his audience

The foundation on which success [in public health

work] rests is the wider acceptance of Public Health teaching by the general public - by the people themselves.

The ultimate guardians of the health of the nation's children are the mothers of the nation, and the only people who can reach and teach every mother are the health visitors. The attendance of mothers at Maternity and Child Welfare Centres is a most valuable supplement to the visits to the homes, but it cannot and should not take the place of home visiting, and any development in Maternity and Child Welfare work on the lines of sacrificing home visiting for the sake of increasing the scope and variety of work undertaken at the Centres, valuable as that may be in itself, is, in my opinion, a mistaken policy.¹¹

Nevertheless, although it is evident that the health visitor was accepted as an essential element of the maternity and child welfare service, much remained to be resolved with regard to duties, qualifications, pay and supervision, and the health visitor's place in relation to other workers in the health services.

The Ministry's Desire to Control Training

The primary concern of the Ministry was to regulate the training of health visitors. As the visitors were employed by a number of organisations, both municipal and charitable, their work tended to vary, and there was no agreement on the qualifications necessary to undertake the work. Moreover, as the municipalities varied considerably in size, both geographically and numerically, their requirements differed. Many of the maternity and child welfare authorities in rural areas, and those responsible for a small population, found it convenient to employ one person to undertake a number of duties, often arranging for the sanitary inspector to do this health visiting work, or to employ a woman who worked as a district

nurse or midwife for a nursing association on a part-time basis. Consequently, some visitors were employed to do work for which they had no training, while some were required to do a variety of tasks, necessitating diverse skills.

The LGB anticipated that health visitors would be primarily educators, aiming to reduce preventable infant mortality, and this definition of the work was accepted by the Ministry of Health and by MOsH. Following the Maternity and Child Welfare Act, the LGB issued a circular itemising the duties of a health visitor. The health visiting staff should be sufficient to supervise expectant and nursing mothers and children under five years, and they should make special visits to children with infectious diseases and help at the infant welfare centre.¹² From the outset, it was established that health visitors would be concerned with women only as mothers, and even their post-natal care was given superficial treatment in the occupation's manuals,¹³ while health visitors, until the 1930s, were forbidden to give birth control information, often an important aspect of recuperation.¹⁴ Health visitors had no dealings with men, except with regard to infectious diseases. It was a service to benefit children.¹⁵ There were, however, differences of opinion on the appropriate qualifications for this work.

In 1908, the LGB had introduced regulations governing the employment of health visitors, but these applied only to the LCC. To comply with these regulations, a health visitor had to have one of five qualifications: a medical degree, full nurses' training and a CMB certificate, some training in nursing and a health visitor's certificate of a society ap-

proved by the LGB, or previous experience in similar work for another local authority. Following the Maternity and Child Welfare Act, the Board extended the regulations to all local authorities.¹⁶

The Ministry of Health, in conjunction with the Board of Education, decided to take steps to regulate the public health training for health visitors. All courses had to be approved by the Ministry, and this approval was normally given only to courses associated with a university.¹⁷ Syllabuses were submitted by various universities, which were carefully scrutinised by the Ministry.¹⁸ Ministry officials made periodic visits of inspection.¹⁹ In 1925, the Royal Sanitary Institute was appointed as the examining body for the health visitors' course.²⁰

In February, 1925, a memorandum was sent to the local authorities on the training of health visitors. Although duties varied according to the area, training should be uniform. The position of existing health visitors was safeguarded, but, after April, 1928, all first-time appointments must hold the health visitors' certificate. Two schemes for qualification were listed. A health visitors' certificate would be awarded to those who were trained nurses, with the CMB certificate, and who had completed a six month course in public health work, or to those who had completed a two-year approved public health course, and held the CMB certificate and had spent six months in a general hospital. To safeguard those already in employment, certificates could be awarded to those who had been in employment for three years.²¹ In 1930, following the Local Government Act, which gave the local authorities more autonomy, another circular

was issued by the Ministry, to ensure that local authorities continued to abide by the rules governing the employment of health visitors.²²

The Ministry was concerned also about the age of those embarking on health-visitor training. Approval had to be sought from the Ministry by all those over thirty-five years who wished to enrol on a course.²³ Most of those applying for courses had already worked for a number of years as a nurse, perhaps a reflection of the problem of raising sufficient funds to finance the lengthy training, or perhaps because the sometimes lonely occupation did not appeal to younger women.²⁴ In an endeavour to ease the financial burden, local authorities were permitted to help students. A scheme was devised whereby local authorities could pay students a proportion of their salary during the last six months of training, which was then recouped during their first year of full employment. This scheme, however, was open only to trained nurses doing the six-month public health course.²⁵

During the 1930s, the Ministry reviewed the two schemes for training. The two-year public health course was not proving popular. MOsH expressed a preference for health visitors with a full nursing qualification.²⁶ Dr. George F. Buchan, the MOH for Willesden, in his presidential address to the Health Visitors' Section of the 1936 Congress of the Royal Sanitary Institute, explained the preference of the MOsH. A health visitor, who was also a trained nurse, could put leading questions relative to an inquiry, and could select and report facts. She would detect and refer

to the MOH any cases which required further examination, and could correct any wrong impressions of a doctor's instructions. MOsH wanted a health visitor to be in a position to be able to demonstrate how treatment, ordered by a doctor, could be carried out, to direct the mother with regard to the nursing of a case, to note the progress of a patient irrespective of the parents' reports, and to be able to deal with the occasional emergency, prior to the doctor's arrival.²⁷

The cost of training of the two-year public health course was considerably greater than for those who entered the occupation via nursing training.²⁸ Many of those who did the two-year course did not go on to become health visitors. Of the nineteen students on the course at King's College for Women, seven planned to do social work, two had transferred to teaching courses, and several planned to return home to do voluntary work.²⁹ There were, however, criticisms of the training given to those with a nursing qualification. In 1934, the Joint Consultative Council of Training Institutions recognised by the Ministry of Health published a survey of the six-month public health training. Comparisons of the institutions offering this course showed wide variations: one gave 256 hours of lectures and another only 79 hours, while two set no written work. One course failed to cover venereal disease, despite the fact that it was an examination subject. Considerable variation occurred in the teaching of domestic hygiene and sanitation: one course allocated 52 hours, while another covered the topic in seven hours. The two-year course had obvious advantages in terms of thorough-

ness, but the tacit preference of MOsH made it difficult for those with this training to obtain appointments. The Committee also criticised the failure to define what was meant in the entry requirements by 'suitable previous experience'. It did not want rigid standardisation, but thought there should be some general agreement on the type of preparation required for the responsible duties of a health visitor. The Woman Health Officer, the official journal of the WSI, welcomed this survey.³⁰

There were suggestions that the six-month course be extended to nine months, but these were dismissed because of the length of time it would take to qualify. The General Nursing Council refused to countenance a shortened nursing course for prospective health visitors.³¹ Also, action was delayed, as it was known that midwifery training was under review, and the Ministry wanted to await legislation on midwifery.³² In December, 1938, Miss O. Baggallay, one of the health visitors on the Royal Sanitary Institute Board of Examiners, produced a report for the Ministry on the training of health visitors. The existing position was not satisfactory because there were two distinct trainings. The supervision of very ill tuberculosis patients or children with broncho-pneumonia was given by those with little nursing training, while assessments of a family's ability to pay for extra nourishment or maternity care were being made by nurses with little knowledge of family case work. Neither was satisfactory, as both were patched together out of training for other work. One training course specifically for health visitors was proposed, which would be based on

two years' preliminary training followed by nursing training,³³ but the Ministry thought the scheme was too big to contemplate at that time.³⁴ In the event, no further action was taken, although, when the revised midwifery training was introduced, trainee health visitors were required to complete only the first, theoretical, part of the course.³⁵

The Ministry of Health's action on training was welcomed by MOsH and the voluntary societies. A recognised training was considered necessary to raise the status of the occupation. There were some suggestions that the training did not go far enough. The Medical Officer, for example, advocated post-graduate training, as health visitors had constantly to learn and to extend their knowledge.³⁶

Dr. A.F.G. Spinks, a medical officer for maternity and child welfare in Newcastle, anticipated that, in future, health visitors would have medical degrees.³⁷

There was concern that the attributes required of a nurse were not the same as those wanted of a health visitor. Dr. Eustace Hill, for instance, pointed out that a district nurse was trained to treat and cure, whereas a health visitor should be concerned with prevention. He maintained that county councils should administer the Maternity and Child Welfare Act, except for areas large enough to merit the appointment of a full-time health visitor by an urban or rural district council.³⁸

Some commentators in the medical profession, however, considered academic training to be of secondary importance. In 1920, the BMJ pointed out that a health visitor's greatest qualification should be sympathy and consideration, and that

too much emphasis should not be placed on technical training.³⁹ Ten years later, Dr. Vernon Davies, in a supply debate for the Ministry of Health, told the House of Commons that certificates did not necessarily make a woman a good health visitor. A health visitor needed to be a motherly type, possessing kindness and tact.⁴⁰

Others argued that it would not be practical to extend training. Health visitors, like other women workers, were expected to retire on marriage. Women who trained for an occupation were thus caught in a dilemma. On the one hand society expected women to marry, while marriage was held to inspire men to greater diligence at work, but on the other hand women who had participated in a course of training for a profession could be criticised for wasting resources. Dr. C.L. Williams, the MOH for Barking, urged the 1928 WSI conference

to remember that women workers show a very high casualty figure from the dire disease of matrimony in which circumstance her period of earning power was limited, so that it was not an economic possibility to expend large sums of money on her training, and it would never be economically sound to train her for lengthy periods.⁴¹

Women were blamed for marrying, and the fact that a man was a party to the decision and that it was invariably men who required married women to relinquish their professional employment was overlooked.

There was some criticism of the decision to allow two types of training, suggesting that this implied indecision about the role of the health visitor. An editorial in the Lancet, in 1926, described the health visitor's role as 'nebulous'.⁴²

Differences over training were still evident by the outbreak of the Second World War. In 1939, Dr. J. Greenwood Wilson, the MOH for Cardiff, pointed out that there were two types of training permitted under the current Ministry of Health regulations. He argued that these alternatives were incompatible, and this situation occurred because no decision had been taken about what was wanted from the finished product. His own view was that health visitors should be educators rather than nurses.⁴³

The voluntary organisations were less critical of the Ministry. They shared the Ministry's desire to ensure that the unqualified were eliminated from practice.⁴⁴ In 1922, National Health argued that district nurses and midwives, working for nursing associations, had not received appropriate training to act as health visitors, and that administrative problems were created by such appointments.⁴⁵

The Response of the WSI

Health visitors had, from the 1890s, been represented by the WSI, which was formed by women workers in the public health service who were employed as sanitary inspectors and health visitors. Initially, the Association wanted the two roles to be combined, but it quickly perceived that health visiting offered particular promise for women, as it did not involve competition with men, whereas women sanitary inspectors had to compete with men and were involved in work which could not be classified as especially suitable to women's aptitudes. MOsH were in favour of keeping the two occupations separate, arguing that women could enter working-class homes as the

mothers' friend and could thus fulfil a particular educational role which could not be accomplished by an inspector.⁴⁶ It is perhaps not surprising that attempts to enable women to train as sanitary inspectors and health visitors were quickly dropped, although it was not until 1930 that the Association changed its name to the Women Public Health Officers' Association (WPHOA).

The WSI believed that one of its principal objectives should be to raise the status of health visiting to encourage the better educated to enter the occupation. It was supported in this endeavour by those seeking to extend employment opportunities for women. During the nineteenth century, health visiting did not suffer from the disadvantages of midwifery, because it had no links with disreputable practices, and those seeking suitable employment for respectable women claimed that its practice did not necessitate work during unsocial hours, and did not require visitors to go out unattended at night, although, in the event, this was not always the case.⁴⁷ Florence Nightingale, writing in 1891, anticipated that it would become a 'new profession for women'.⁴⁸ Health visitors were ready to acknowledge that, as the work was concerned mainly with mothers and babies, it was particularly apt for women. Hester Viney, a health visitor in Battersea, for example, anticipated that the work would

awaken in her [the health visitor] the finest and deepest instincts of womanhood.⁴⁹

A keen interest was taken in the Ministry's plans to regulate the qualifications demanded, with an acceptance of the need for lengthy training. The WSI complained that the

function of the health visitor varied according to the size of the local authority, and that, as a consequence, some health visitors were asked to do work for which they had not been trained.⁵⁰ In 1925, the WSI undertook a survey of 326 local authorities, which revealed that 1,974 health visitors had twenty-two different certificates, or varieties of experience, held in eighty-eight combinations, while the number of certificates held by individual health visitors varied from none to five, and the duration of previous experience and training varied from nothing to eight years.⁵¹ A superintendent health visitor, writing in Maternity and Child Welfare, in 1920, advocated a three-year training period,⁵² while others were anxious that girls should go into training straight from school, rather than turn to health visiting after a job in nursing.⁵³ There were, however, few concrete proposals for the content of training. Opinion was divided as to whether health visitors should be trained nurses. One superintendent health visitor in St. Helens, for instance, considered a nursing training to be useful, as it would help to develop discipline, self-control, self-reliance, precision, observation, tact and loyalty, and to be part of a team.⁵⁴ This opinion, however, was not shared by many of her colleagues. Phyllis Armitage, a former health visitor, school nurse and midwife in West Suffolk, who published a book on health visiting, considered that health visiting was purely social work, and that a practical, rather than a theoretical, knowledge of illness was required. She recommended that nursing training be undertaken in a children's hospital, because the health visitor would be dealing mainly with children, and she thought

six months would be adequate for this part of the training.⁵⁵ She thought health visitors might become public health nurses. Although she recognised that this could overcome the problems of the overlapping of visitors to the home, she did not consider this to be desirable, as the infant welfare side of the work might be neglected.⁵⁶

During 1925, Maternity and Child Welfare published a number of letters from health visitors, discussing the need for nursing training, in which opinion was divided between the two points of view.⁵⁷ The correspondence concluded with a leading article which argued that the problem arose because the job was not clearly defined.⁵⁸

A health visitor, writing in Time and Tide in 1923, claimed that health visitors were in danger of becoming only sick nurses instead of educators. State preventive medicine was becoming the state treatment of disease.⁵⁹

The WSI, however, did not present the Ministry with any specific demands regarding training. The subject received little attention in the Woman Health Officer. In 1932, a resolution moved at the annual conference of the WSI, by then known as the WPHOA, asserted the need for the two means of entry to the occupation.⁶⁰ The Association was much more anxious to tackle the problems of low pay and the lack of promotion opportunities, which, it argued, discouraged able women from choosing the occupation.

The Campaign to Raise Salaries

Rates of pay varied widely. Voluntary societies, which employed a significant number of health visitors, tended to

pay low wages. Local authorities generally expected to pay their health visitors considerably less than sanitary inspectors. Davies observes that the segregation of health visiting from sanitary inspection occurred during the early years of this century. The nineteenth-century notion that the health visitor was a mother's friend was retained, and, for this reason, it was argued that a health visitor could not also be an inspector. Furthermore, arguments were used to suggest that most of the work of a sanitary inspector was not suitable for a woman, whereas health visiting was suitable only for a woman. The WSI attempted to resist the segregation of the two occupations, asserting that women should hold a dual qualification, and should be able to do both jobs. This endeavour, however, was unsuccessful. Although a health visitors' bill, introduced in 1910, which made provision for local authorities to employ health visitors and to determine the qualifications they would require, was abandoned, it became increasingly common for local authorities to employ women as health visitors and not as sanitary inspectors.⁶¹ It is perhaps not surprising that the salary offered was significantly lower than that of the sanitary inspector. In 1930, the WSI decided to change its name to the WPHOA, stating that the existing title did not incorporate those who were neither sanitary inspectors nor health visitors.⁶² Perhaps the decline in the number of members who were working as sanitary inspectors precipitated the decision. Certainly a perusal of the Woman Health Officer suggests that, by the late 1920s, health visitors predominated in the Association, but unfortunately the journal did not encourage debate, and

there was no correspondence from readers on the change of name while the editorials were consistently bland and optimistic. The work of women sanitary inspectors is beyond the scope of this study, but it would be interesting to analyse their role in the public health service and their relations with male colleagues as well as to probe the links between the sanitary inspectors and the health visitors.

The WSI devoted much of its time to a campaign to standardise health visitors' pay at an acceptable level. It soon found, however, that the Ministry was reluctant to take positive action. The WSI published recommendations for a minimum scale of salaries in 1920,⁶³ but ten years elapsed before the Ministry of Health made a positive commitment to the need to standardise conditions of service for health visitors.

Health visitors, like midwives, found it difficult to assert themselves. The WSI was faced with the problem of having a membership generally unused to collective action. Many health visitors did not belong to the Association.⁶⁴ The difficulties were exacerbated because many of them were employed by voluntary organisations, and also, after the First World War, there was a surplus of nurses. For example, in 1923, Marion Phillips, the Chief Woman Officer of the Labour Party, told the National Conference of Labour Women that the WSI was not yet strong enough to resist low pay. She quoted the example of a complaint to Brighton over a salary of £160 per annum for a health visitor, but the Association was told that Brighton paid higher salaries than other local authorities and had no difficulty in fill-

ing vacancies.⁶⁵

Furthermore, the campaign for an adequate wage was curtailed by the widely-held belief that all forms of social work were vocational, and that participants should not expect their reward to be purely monetary. It was not uncommon to presume that all recruits would come from the middle class.⁶⁶ For them, and especially for those employed by a voluntary organisation, the rate of pay was considered to be of secondary importance. Phyllis Armitage described health visiting as a work of love, stating that, although salary and status were important, the service itself stood first in the minds of those who gave their lives for it; the work could never be paid for in 'coins of the realm'.⁶⁷ In 1935, the Ministry of Labour published a pamphlet on social work, which described the pay as suitable for those 'who regard the remuneration as less important than the work itself'.⁶⁸

Phyllis Armitage attributed the low pay and poor working conditions to the voluntary origins of the occupation.⁶⁹ At the same time, the lack of central control over local authorities in such matters meant that conditions varied amongst municipal employers. Salaries varied between £150 and £350 per annum;⁷⁰ salary scales varied between the metropolitan and county boroughs, the county councils and the county districts, and within each category salaries could vary by over £100 per annum.⁷¹ Moreover, the salaries bore no relation either to the health visitor's qualifications or to the nature and size of the locality.⁷² Some authorities provided assistance for uniforms and travel, some operated superannuation schemes, arrangements for sick leave and pro-

motion varied, and holiday entitlement ranged from ten days to six weeks.⁷³

The WSI, like the Midwives' Institute, was anxious to attract the better-educated women to the occupation, who would be able to cope with the training. Women going into people's homes should be of a particular type, having a suitable personality and a good general education. The visitors were expected to impart advice which was in accord with middle-class life styles rather than that of working-class homes. The nineteenth-century belief that working-class people benefited from association with their social superiors remained in evidence amongst some of those promoting the employment of health visitors.⁷⁴ In 1928, Lady Sprigge, of the London and National Society for Women's Service, called for better conditions of service, because fathers were reluctant to allow their daughters to enter the profession, and hence the profession was failing to attract 'the best type of young woman'.⁷⁵ In 1923, a representative of the College of Nursing told the Minister of Health that there was a shortage of probationers, because school teachers did not recommend the work because of the low pay.⁷⁶ Miss H.S. Cooper Hodgson, a superintendent health visitor in County Durham, who later became the chairman of the WPHOA, remarked

it is important that health visiting should be looked on as a profession for educated women. The social work that is required of a Health Visitor demands nothing less than the best.

We don't want people to continue to recommend really clever girls to go in for other professions. It is just as important to have a brilliant girl to teach the grown ups in their homes as it is to have a brilliant girl to teach children in school.⁷⁷ (italics in original)

Amy Sayle pointed out that more health visitors were required urgently, and she argued that women would be attracted to the occupation only if uniformity of pay, holidays and sick leave was established. She also advocated opportunities for promotion, by appointing superintendents in all large public health areas, and suggested a superannuation scheme.⁷⁸

Amy Sayle reiterated these arguments in a letter to The Times, pointing out that in many areas there was an inadequate number of health visitors, and arguing that conditions of service needed to be improved to encourage women to undertake the lengthy training and to remain in the occupation.⁷⁹

National Health pointed out that sanitary inspectors received better rates of pay, so educated women, needing to earn their living did not consider health visiting.⁸⁰

An anonymous article by a health visitor appeared in Time and Tide calling for improved pay and opportunities for promotion to attract more able women.⁸¹

It is, however, interesting to note that, when the WSI formulated its recommendations for a minimum salary, it was presumed that health visitors would continue to receive less than sanitary inspectors.⁸²

To provide opportunities for promotion, supervision by senior health visitors, rather than medical officers or another public health official, was advocated.⁸³

The Medical Officer pointed out that, as health visiting was poorly paid, one of the few inducements was the possibility of becoming a superintendent.⁸⁴

In 1920, the Ministry of Health discussed rates of pay, and upheld the principle of differentiation between men and women, but agreed that an attempt should be made to

establish a minimum salary for all new appointments. It was decided, however, that no recommendations should be issued.⁸⁵

Meanwhile, the WSI, with the support of the College of Nursing, exerted pressure on the Ministry to establish a minimum salary. In 1922, the Ministry of Health agreed to meet a deputation, headed by Gertrude Tuckwell. The Minister, however, informed the deputation that the time was inopportune and no action could be taken, although he assured the deputation that the Ministry appreciated the valuable work of the health visitors.⁸⁶ Subsequently, the Ministry was bombarded with letters of complaint about low pay from women's groups and voluntary societies.⁸⁷ The Ministry, nevertheless, remained steadfast. In March 1922, when the NLH asked for guidance on a minimum salary and annual holiday entitlement for health visitors, it refused to express an opinion.⁸⁸ The following month, Sir Alfred Mond, the Minister of Health, in reply to a question in the House of Commons, declared that, if the service was adequate, the Ministry could not interfere with local authorities.⁸⁹

In 1922, however, the Ministry discussed the possibility of fixing a minimum salary, and the sum proposed was £160 per annum. Local authorities could not be forced but they could be reminded that it might not be a true economy to employ a health visitor at the lowest rate. The Ministry did not want market forces to determine rates of pay, as it did not want recruits only from amongst those who had failed as private nurses, neither did it want to encourage health visitors to combine for collective bargaining.⁹⁰ Upon further consideration, however, the Ministry decided no

precise statement on policy should be made, and there should be no mention of the £160 minimum salary recommendation. The Ministry feared that, if an attempt was made to coerce local authorities, by a threat to withhold grants, they might refuse to appoint health visitors. Also, as local authorities could still get satisfactory health visitors at lower salaries, action could be postponed.⁹¹ When a circular was issued, informing local authorities of the new regulations regarding qualifications for health visitors, to come into force in 1928, the authorities were asked to remember the three and a half to four year training period when fixing their salaries. The Minister hoped

the salaries offered will be sufficient to attract and retain qualified women who can reasonably be expected to render efficient service.⁹²

The chairman of the WSI, Amy Sayle, however, thought the Minister's faith in the local authorities' willingness to follow this advice was misplaced. She demanded the introduction of a scale of salaries, which took into account the length and cost of training and the responsibility of the work.⁹³

In 1923, discussions were held between the Ministry of Health and the London District Council on uniform salaries for both sanitary inspectors and health visitors who worked in London.⁹⁴ The two sides, however, failed to agree on the minimum for the health visitors, with the Ministry advocating £120 and the Council £150. The Ministry subsequently justified its refusal to adopt the Council's recommendations by pointing out that not all borough councils

were represented on the London District Council.⁹⁵

From 1924, the WSI began to notify the Ministry whenever a post was advertised with an unacceptably low salary.⁹⁶ In the same year, another deputation, this time led by Mrs. Wintringham, and including a representative from the College of Nursing, was received by the Minister of Health. The Minister declared he was making 'unceasing efforts' to ensure that local authorities paid a minimum salary in London, and promised to take up the question of health visitors once conferences on salaries for MOSh were completed.⁹⁷ Other MPs, Lt.-Col. Fremantle and Mrs. Philipson, however, who proposed government inquiries, were instructed by the Ministry to drop their demands.⁹⁸

Meanwhile, demands for improved conditions for health visitors were increasing. In 1926, the TUC sent a deputation to the Ministry.⁹⁹ The SJC took up the health visitors' case. In 1928, a resolution was adopted calling on the Minister of Health to formulate a pay scale and conditions of service for health visitors.

Between the young mothers and the Health Visitor there should be a common interest. They are both engaged in promoting the welfare of children of the nation. What service organised mothers can do to help Health Visitors to a reasonable standard of life will be amply repaid by the improvement in the standard of public care for the children and the invalids.¹⁰⁰

Many MOSh argued that the pay of health visitors should be raised. Following the announcement of the demand for a minimum salary, made by the WSI in 1920, the Medical Officer stated that standards had declined in recent years,

owing to low pay,¹⁰¹ and this demand was reiterated later in the same year.¹⁰² Dr. F.A. Sharpe, the MOH for Preston, argued that higher pay would help to attract women of a better educational standard.¹⁰³ In 1925, an editorial in the Medical Officer argued that health visitors had to work largely on their own initiative, which required the right type of person, who would be attracted only if local authorities offered a realistic salary.¹⁰⁴ By the end of the decade, the Soc.MOSH had given its support to the health visitors' demands.¹⁰⁵

In 1928, at the annual conference of the WSI, a new initiative was launched. A salary of £250 per annum was recommended.¹⁰⁶ A resolution was passed unanimously:

That this conference considers that the time has arrived for the improvement and standardisation of conditions of service of Health Visitors, and requests the Minister of Health to appoint a committee consisting of representatives of Local Authorities and of Health Visitors to formulate suitable scales of salary, holi-¹⁰⁷days, and other conditions of service.

Following the 1928 conference, a deputation, led by Lt.-Col. Fremantle, an MP and a county medical officer, was received by the Minister of Health. This deputation, which included representatives of local government, the Soc.MOSH, health visitors and women's organisations, demanded standardisation of conditions of employment. The Minister expressed sympathy for their case, but he pointed out that he was not a 'Mussolini', and argued that it would be useless to appoint a committee, as it would not have the support of the majority of the councils.¹⁰⁸

In 1930, however, the Ministry of Health produced a circular which was issued to all maternity and child welfare authorities. This circular defined pay, superannuation and annual leave for certain public health officers, including health visitors.¹⁰⁹ The WSI had secured a considerable success.

Problems still occurred, as the Ministry lacked mandatory power. Some local authorities made no immediate response. In 1931, at the WPHOA conference, Amy Sayle read a paper on salaries, in which she claimed 267 local authorities offered a salary of less than £200, with fifteen offering less than £150.¹¹⁰ The economic crisis no doubt inhibited some authorities. In 1932, Amy Sayle complained that many local authorities reduced their expenditure by reducing the number of health visitors and by employing less qualified personnel at lower rates of pay.¹¹¹ The Woman Health Officer reported that, during the economic crisis, 470 local authorities reduced salaries, although, by the end of July, 1933, 129 had withdrawn these cuts, and a further 118 had modified them.¹¹² The economic crisis also curtailed the expansion of services, and some health visitors found it difficult to obtain work. In 1932, there were jobs for only one third of those qualifying. Amy Sayle, speaking at the WPHOA conference, recommended that the Ministry of Health should not recognise any more training institutions, and suggested that there should be some preliminary selection of candidates, while the number gaining certificates should be limited, by raising the examination standard.¹¹³ At a meeting of the National Baby Week Council in 1932, she anticipated that local authorities might reduce

their number of health visitors,¹¹⁴ an opinion reiterated the following year by the WPHOA.¹¹⁵

The Association had some success putting pressure on individual local authorities, and the situation became easier when the unemployment rate began to fall. In a review, published in 1935, the Woman Health Officer reported that some local authorities had been persuaded to raise their salaries.¹¹⁶ Standardisation, however, was never complete. In 1939, the committee responsible for co-ordinating the work of the training institutions, published a pamphlet on health visiting as a career, which noted that salaries varied widely, although it should not be necessary to accept a salary of less than £200. The attraction of the profession, however, was not material, and would be chosen out of interest and human affection.¹¹⁷

Conflict with Fellow Professionals and the Clients

The desire of the WSI to raise the status of health visiting was further hampered by the difficulties some health visitors experienced in their endeavours to establish their place in the public health service and to develop good relationships with their clients. Health visitors, in order to do their job well, needed to gain the confidence of the women whose homes they visited, and to be in a position to co-operate with the other professionals involved in welfare work and preventive medicine. Owing to the links with charitable organisations and the plethora of individuals and official bodies with which the health visitor had to deal, this proved to be difficult.

Health visitors needed to co-ordinate their activities with the local general practitioners, the midwives and the district nurses. Phyllis Armitage catalogued a lengthy list of official personnel with whom the health visitor should co-operate.¹¹⁸ The difficulties were exacerbated by the fact that several ministries were involved plus, until 1929, the Board of Guardians which administered the Poor Law; while, at the municipal level, the supervising authority for midwives was not necessarily the same as that responsible for the administration of the Maternity and Child Welfare Act and the employment of health visitors.

Health visitors realised that their presence was often resented by midwives and doctors. Phyllis Armitage, for example, complained that many doctors continued to favour the employment of handywomen, who often gave mothers the wrong advice and prejudiced them against the health visitor.¹¹⁹ She remarked that many doctors were prejudiced against health visitors, because they regarded them as amateur doctors.¹²⁰ Armitage confessed that, throughout her book, there had been occasion to refer to difficulties with doctors.¹²¹ In 1926, an unsigned article appeared in the columns of National Health, complaining that doctors were hostile to health visitors. It suggested that this occurred because doctors believed that health visitors would interfere and would take work away from the doctor.¹²² One area of conflict concerned the need for women to attend ante-natal clinics. Health visitors saw it as one of their duties to encourage women to attend a clinic.¹²³ The BMA, on the other hand, opposed ante-natal clinics, arguing that ante-natal examinations

should be undertaken by the general practitioner, either in his or her surgery, or in the woman's home.¹²⁴ The failure to define the precise scope of the health visitor's work probably made relations with some general practitioners more strained, as the health visitor would have been regarded as an inspector from the town hall, rather than as a person educating mothers in the care of their babies.

Difficulties with midwives were exacerbated by the fact that both groups were fighting for their place in the maternity service. Consequently, both groups were anxious to demarcate their spheres of responsibility, often to the detriment of co-ordination. Moreover, relations were not enhanced by the fact that, in some areas, health visitors received higher rates of pay, whilst some MOsH employed the health visitor as the inspector of midwives under the Midwives Act. Health visitors were aware of the disadvantages of inspecting midwives, and deplored the practice,¹²⁵ but the Ministry of Health did nothing to alter the situation until the late 1930s (see p. 282).

Disagreements with midwives arose over the question of when the health visitor should visit the home. Health visitors were expected to visit the mother during the ante-natal period, to prepare her for the arrival of the baby, to develop a relationship with the mother, to encourage her to undergo ante-natal examinations, and to determine whether she was entitled to local-authority aid. Health visitors wanted to extend these visits, arguing that many women did not know that certain ailments were curable, while the ante-natal period was valuable for getting to know the mother.¹²⁶

Midwives, however, resented the presence of health visitors in the home until the midwife had ceased to visit during the puerperium. Midwives argued that health visitors, unless they restricted themselves to advice on sewing, might give mothers advice on the care of the infant and of themselves during pregnancy and the puerperium which would contradict that given by the midwife.¹²⁷ No doubt many midwives felt that the health visitor fulfilled the role of inspector rather than educator. Indeed, an editorial in Nursing Notes suggested that the midwife should decide whether the mother needed to be visited after the midwife had terminated her supervision of the case, and that it should be up to the midwife to summon the health visitor.¹²⁸

In common with the general practitioners, some midwives did not want the women who had booked them for the birth to attend ante-natal clinics, as it was feared that the clinics would advise a hospital birth, and the midwife would lose her fee. Health visitors, on the other hand, were enthusiastic advocates of the ante-natal clinic.¹²⁹ Moreover, midwives were aware that health visitors often advised women to go into an institution for childbirth. Phyllis Armitage, for instance, advocated that primiparae should go to hospital, in case of any complications, whilst multiparae were advised to go into an institution so they could have a rest.¹³⁰

Consequently, many general practitioners and midwives did little to encourage women to consult a health visitor. Indeed, although working women's organisations welcomed the employment of municipal health visitors,¹³¹ individual women were often less enthusiastic. Jane Lewis found that

the women she interviewed preferred the welfare centres to the health visitor, as they could choose whether to attend, whereas the health visitor came uninvited, and was often authoritarian and unmarried.¹³² Women were accustomed to seek advice from others who had borne children, and were suspicious of young women without such experience. Midwives did little to dispel this attitude. For example, Nursing Notes, commenting on a government White Paper on the training of health visitors, remarked that eighteen-year-old girls would not be able to absorb all the information on maternity and child welfare, and anticipated that mothers would not take advice from such young girls.¹³³

Many working class households resented home visits, having experienced the patronising attitude of the early voluntary visitors, whilst other households had been inundated by numerous visitors. Nevertheless, voluntary organisations continued to send visitors out, while a large proportion of the health visitors were employed by voluntary associations rather than the local authority.¹³⁴ Indeed, Janet Campbell, in her first report on maternal mortality, published in 1924, advocated that women's groups should participate in the education of mothers.¹³⁵ Health visitors found that young mothers were discouraged from admitting the health visitor by their mothers, husbands, handywomen or well-meaning neighbours.¹³⁶

Margaret Hamilton, writing in the New Witness in 1919, suggested a women's party should be formed, pledged to fight for the liberation of the home and the abolition of state intervention. She wanted mothers to have the right to

keep their daughters at home during domestic crises, and described the inspection of babies and homes as the spectre of 'Prussianism'.¹³⁷ The Mothers' Defence League also urged mothers to refuse entry to health visitors, who were described as 'cranks'.¹³⁸ Mothers were told that they had a sacred right of possession over their children, and were encouraged to resist 'state regulation'.¹³⁹ The League received little national recognition, but the Honorary Secretary, Agnes Mott, claimed that nine-tenths of the membership was working class, and that its leaflets always met with approval when read at public meetings.¹⁴⁰ It was chaired by G.K. Chesterton, an outspoken critic of the old feminists' desire to persuade married women to treat motherhood as a part-time, temporary occupation and to seek employment outside the home.¹⁴¹

Health visitors tried to overcome this opposition from mothers. Although maternity and child welfare workers disagreed with the aims of the Mothers' Defence League, they recognised that some homes had been invaded by a plethora of visitors. An editorial in Maternity and Child Welfare acknowledged that there was a risk of damaging parental responsibility, but considered the risk worth taking because of the valuable work done by health visitors.¹⁴² In 1922, Maternity and Child Welfare published a letter from the district secretary of the Charity Organisation Society, who acknowledged that visitors should be kept to a minimum, and suggested that only the health visitor and a Charity Organisation Society representative should visit.¹⁴³ A superintendent health visitor, Miss H. Weir, in a paper read at the 1921 Royal Sanitary Institute Congress, argued that a health

visitor should be able to combine a number of functions, as the usefulness of her work would be impaired by having a number of officials visiting the home to advise different members of the family.

Her work depends on gaining the confidence of the mother, who values and respects a woman who is thoroughly capable and can give advice on various subjects that might arise, The nurse is more likely to obtain the best results if she can arrest the attention of the mother as a friend while performing the work of an official. She cannot do this if several health officials visit the same house, as the harassed mother has neither the time nor the inclination to answer the door to them all.¹⁴⁴

Health visitors were urged to ensure that their visits fitted in with the mother's schedule.¹⁴⁵ Nevertheless, it proved difficult to limit the number of visitors to people's homes owing to the number of agencies involved and the reluctance to allow health visitors to act as nurses.

Health visitors were encouraged to establish themselves as the friend of the mother. In 1926, an editorial in National Health criticised health visitors for being too brusque and for not respecting people's privacy. They were reminded that they had to counter the poor impression created by previous visitors.¹⁴⁶ Health visitors were advised to communicate with fathers, so that they would refrain from discouraging their wives from consulting health visitors.¹⁴⁷ Amy Sayle recommended that the public be educated as to the value of the work of the health visitor.¹⁴⁸

Nothing, however, was done to dispel the image that health visitors attended only those who could not afford to pay a doctor's fees. The circular, issued in 1918, out-

lining the duties of a health visitor, stated that visitors would go to selected homes.¹⁴⁹ Officials of the WSI assumed the health visitor's job was to educate the working class.¹⁵⁰ Phyllis Armitage, in a discussion of visits to new-born babies, remarked

Birth visits, both in kind and quantity, vary according to the area served. In a good standard - generally known as 'superior standard' - area it is obviously rarely necessary to see the baby undressed. One can judge by the clothing and care during general conversation, and the mothers, on being asked, will give trustworthy information as to the physical condition of the baby, and will probably be only too ready to point out any defects. It will also generally be found that she has been attended by a competent person who has shown her how to bath the baby. The mother of poorer classes, on the other hand, might be inclined to hide any defects, which she would be treating according to the advice of any old-fashioned handy-woman, or kindly but ignorant neighbour. Similarly, she may have had no good advice on the subject of bathing and the necessity of good hygiene. The question of practical help is far less likely to crop up in the one area than the other, and whereas in the poorer area it is essential to find out the family income, it is not only often unnecessary, but in many cases impossible to ask questions relating to this point in the better-class area. Visits to better-class mothers may take a much longer time in many cases, as the mothers are sufficiently well-educated to be intelligently interested in the questions relating to infant care, and to public health matters in general; they also generally have more time to spare, and they are not so bothered with the children who are ever present in the poorer homes during the interview.¹⁵¹

The Health Visitor in the 1930s

The apathy of many mothers, antagonism from professional colleagues and the controversy over the scope of the health visitor's work placed the health visitor in a difficult position. Much attention was directed towards ensuring

that visitors had a suitable personality for the task, and this was sometimes stressed above the need for training.¹⁵² Emphasis was placed on the need to be tactful, sympathetic and cheerful. Health visitors were expected to be good judges of character, to have a knowledge of elementary psychology, and to be sensitive and patient, and they were expected to be neat and to possess good manners.¹⁵³

At the same time, health visitors were encouraged to avoid controversial issues, such as birth control. The Woman Health Officer never discussed birth control, which would seem to imply that the inability to give this information was not a matter of concern to the leadership.¹⁵⁴ Ethel Cassie advised health visitors on attitudes to birth control in her textbook for public health workers, as she found it was a subject that was often raised.

It is essential to remember that it is no concern of hers. Whatever views she may hold in regard to birth control, the spacing of families, over-population, etc, in her work she must forget them all. Maternity and Child Welfare work is only concerned with the child from conception to the age of five, and with the mother only in her relation to that particular child. Birth control is not within its scope.¹⁵⁵

In 1932, the annual conference of the WPHOA voted against birth control information being given at maternity and child welfare centres, although it was accepted to be a vital public health service.¹⁵⁶

Nevertheless, health visitors were becoming more confident. Conditions of employment were improving, and some of the confusion relating to training had been removed. In 1932, Amy Sayle told a public health conference that health

visitors were welcomed into people's homes.¹⁵⁷ During the 1930s, conferences for health visitors were no longer concerned entirely with the status and working conditions of members. At the third annual conference of the WPHOA, held in 1933, a resolution was passed calling for a national maternity service.¹⁵⁸

The Association welcomed the Midwives Bill. It anticipated that the employment of midwives by maternity and child welfare authorities would facilitate co-operation between health visitors and midwives. Employment by a municipality would lead to higher standards of work and greater permanence of personnel. It pointed out that health visitors would be a vital element in the midwifery service. The WPHOA argued that the health visitor gained the confidence of the mother, and, therefore, was often the first to hear of a pregnancy. As she was a trained midwife, she would know the importance of clinical advice and supervision, and, through her, the mother would engage the municipal midwife. Although the midwife would then assume responsibility, it presumed the health visitor would continue to render help and advice on social and environmental matters. Her position would enable her, through the MOH, to secure the help of the sanitary inspector and the co-operation of officials and voluntary agencies. It hoped that, to aid co-operation, midwives and health visitors would be equal colleagues in the service.¹⁵⁹

The health visitors, comparing themselves to midwives in the mid 1930s, considered their situation to be preferable. Certainly their earnings were generally greater. Moreover,

they had never had the same aspirations as midwives regarding their professional status within the public health service. Leaders of the WSI referred to the establishment of a profession, but they did not envisage independence from the MOH.¹⁶⁰ The WSI wanted health visitors to be supervised by senior members of the occupation, but there was never a suggestion that overall control should be wrested from the MOH. Miss Cooper Hodgson declared that a health visitor's position under the MOH was one of the attractions of the occupation.¹⁶¹ It was voluntary involvement which the WSI wished to eliminate. For instance, the Association published a memorandum in 1926 demanding that administration of the Maternity and Child Welfare Act be retained by local authorities, and not delegated to district nursing associations or voluntary committees. Voluntary associations did not offer such good salaries, and, therefore, did not attract the more able women. Furthermore, the views of the wealthy members of these committees might be paramount and might outweigh those of the MOH.¹⁶² Dr. Eustace Hill told a conference, organised by the WSI in 1928, that the employment of health visitors by voluntary bodies was undesirable, because they might be influenced by the organisation's political or religious beliefs.¹⁶³ In 1934, a resolution was put before the annual general meeting of the WPHOA which demanded that grants to county nursing associations should be only for district nurses and midwives. Health visitors should be appointed and directly responsible to the local authority.¹⁶⁴

Health visitors, unlike midwives, did not seek to compare themselves with doctors, but rather with sanitary in-

spectors, although the relations between men and women sanitary inspectors were not always harmonious and the men did little to encourage women to become sanitary inspectors.¹⁶⁵ Hence the decision, taken in 1918, to affiliate to the TUC was not at variance with the health visitors' objectives, as the male sanitary inspectors were already unionised. It is evident, however, that the WSI, and later the WPHOA, delegates to the TUC did not feel entirely comfortable at the Congress.¹⁶⁶ This could indicate that the health visitors regarded themselves as a class apart from working women, or it could merely reflect the prevalent male hostility to the presence of women in the trade union movement.

By the outbreak of the Second World War, health visiting had developed into a recognised occupation for women within the public health service. MOSH were pleased with the way the work had evolved. McCleary, writing in 1935, declared

Health visiting, which began as a spare-time occupation for a few public spirited ladies in Manchester and Salford, has during the last forty years developed into a new profession for educated women The work is varied and full of human and scientific interest. There are few ways of earning a living that offer wider opportunities for enlargement of experience, for expression of personality and for work of high social utility. The health visitor fulfils important functions in the community, and the prospects of the profession, which is now well established in public estimation, appear to be growing brighter.¹⁶⁷

The work had been classified as women's work, requiring womanly qualities of tact and sympathy. Although great store was placed on the need for qualifications, these other attributes continued to be regarded as important by

both employers and the health visitors themselves. The health visitors regarded the educational work as important, and did not seek to extend their role in the health service. They expressed no desire to become involved in the diagnosis or treatment of ill-health, and, therefore, posed no threat to the medical profession. Health visiting was a new occupation, so the Ministry of Health and the MOsH were able to mould the job according to their requirements, unlike midwifery. There was no question of health visitors gaining further autonomy. Their field of work was clearly demarcated by the MOsH, who had overall control over them. Health visitors were established, but as subordinates to the medical profession, concerned primarily with the education of mothers in the care of their infants. A health visitor worked in women's homes, and her skill was in communicating technical information amassed by others. The leaders of the health visitors had strenuously fought in favour of municipal control rather than the continued involvement of the charitable organisations, but at the same time their readiness to subordinate themselves to medical practitioners and their acceptance of the need to focus attention on child welfare and to maintain a traditional view of women's role in the home ensured that the ideals and motivation of the nineteenth-century voluntary workers remained intact within the municipal framework.

NOTES AND REFERENCES

- 1 see Lewis (1980) op. cit., pp. 61-77
- 2 McCleary (1935) op. cit., p. 17
- 3 Davies (1984) op. cit., p. 5
- 4 ibid., p. 6
- 5 Lewis (1980) op. cit., p. 105
- 6 McCleary, an MOH who published widely on the maternity and child welfare services, always included a discussion on health visiting, and linked it with the decline in the infant mortality rate, e.g. McCleary (1935) op. cit., pp. 25-26
- 7 Article in the Medical Officer (1921) 26, pp. 127-128
- 8 Article on the role of district nurses and health visitors, ibid. (1922) 28, pp. 45-46
- 9 Editorial on women's place in the health service, ibid. (1921) 25, p. 131
- 10 ibid.
- 11 Public Health and Health Visiting (1928) Report of a conference held at Caxton Hall, London, published by the WSI, Tuckwell Collection, File 619, p. 39
- 12 The health visitors' duties were outlined in LGB Circular Maternity and Child Welfare 4 (1918) Maternity and Child Welfare, issued to county councils (other than the LCC) and sanitary authorities, pp. 6-8
- 13 e.g. Ethel Cassie's specimen scheme for a health visitor's visits to a mother after the birth of a child expected the health visitor to inquire after the mother's health only once during the first visit, Ethel Cassie (1929) Maternity and Child Welfare: a Text-book for Public Health Workers (London: H.K. Lewis) pp. 14-16
- 14 e.g. Nurse Daniels was dismissed from her post as a health visitor in Edmonton for giving a woman addresses where she could obtain birth-control information, Sheila Rowbotham (1977b) A New World for Women: Stella Browne - Socialist Feminist (London: Pluto Press) pp. 49-50
- 15 e.g. Phyllis Armitage, a former health visitor, asserted that health visitors would never have occasion to deal with the illness of men, C. Phyllis Armitage (1927) Health Visiting, the New Profession (London: John Bale, Sons and Danielson) p. 5
- 16 McCleary (1935) op. cit., pp. 29-31
- 17 Board of Education (1919) Board of Education (Health

- Visitors' Training) Regulations (London: HMSO)
- 18 e.g. Battersea Polytechnic course approved in 1919, PRO MH53/60; Leeds University course approved in 1922, PRO MH53/58
 - 19 e.g. there are reports of Dorothy W. Taylor visiting Leeds, PRO MH53/86, and Battersea, PRO MH53/87
 - 20 Ministry of Health (1926) The Training and Appointment of Health Visitors, Circular 680. The Ministry of Health, however, was able to influence the formation of this Board, which was dominated by MOsH. At the Ministry's request one health visitor, Miss O. Baggallay, was included on the Board. Subsequently, twelve health visitors or supervisor health visitors were on the fifty-five member Board, and it became common practice to have two MOsH and one health visitor on each examination board, PRO MH53/85
 - 21 Ministry of Health (1925) Circular 557, issued to all maternity and child welfare authorities.
 - 22 Local Government (Qualifications of Medical Officers and Health Visitors) Regulations (1930) under Section 59 of the Local Government Act, Statutory Rules and Orders No. 69, MH53/17
 - 23 Numerous letters and the Ministry's response, PRO MH53/59
 - 24 Report of Dr. E.C. Creaser, 9 November, 1926, PRO MH53/120
 - 25 The sum they were to receive was £50. The scheme was agreed on 15 May, 1925, MH53/59
 - 26 A letter from Battersea Polytechnic reported that the best posts never went to those with the two-year training, 16 October, 1920; and the Principal of Bedford College made the same statement, 15 October, 1920, PRO MH53/101
 - 27 Reported in the Woman Health Officer (August, 1936) 9, p.1
 - 28 The Joint Consultative Committee of Training Institutions recognised by the Ministry of Health estimated the cost of training for those doing a two-year public health course, plus the CMB course and six months in a hospital, would be £231. For those qualifying via nursing, the cost would be £152. Some of those doing the latter course were able to obtain assistance from the local authorities during the last six months of training, Joint Consultative Committee (1936) The Work of the Health Visitor, Children's Health and Welfare, Fawcett Library
 - 29 Letter and memorandum to the Ministry of Health from the Dean of the Household and Social Science Department of King's College for Women, University of London, Dr. Janet Lane-Clayton, 13 May, 1920, PRO MH53/101
 - 30 Quoted in the Woman Health Officer (1934) 7, p. 1

- 31 Minute signed by Miss Z.L. Puxley, 15 March, 1938, PRO MH53/83
- 32 Dr. Turnbull wanted the public health part of the training to be extended to nine months, report dated April, 1936. No action was taken because of the impending changes in the midwifery service. The content of the course was also criticised: Miss Puxley argued that too much attention was paid to anatomy and physiology, to the detriment of social work, minute dated 9 May, 1938, PRO MH53/83
- 33 Miss Baggallay's report, 1 December, 1938, PRO MH53/83
- 34 Minute signed by Miss Puxley, 19 December, 1938, PRO MH53/83
- 35 Ministry of Health (1938) Circular 1694, Health Visitors: Training
- 36 Editorial in the Medical Officer (1922) 28, pp. 246-247
- 37 Article in Public Health (1927) 40, p. 326
- 38 Public Health and Health Visiting (1928) pp. 5-6
- 39 BMJ (1920) ii, p. 648
- 40 PP (1930) 237, col. 1021
- 41 Public Health and Health Visiting (1928) pp. 36-37
- 42 Lancet (1926) i, pp. 147-148
- 43 Article in Public Health (1939) 52, pp. 161-163
- 44 e.g. the Ministry of Health's two-year training courses were welcomed, editorial in National Health (1919) 12, pp. 49-51
- 45 Editorial, ibid. (1922) 15, pp. 1-2
- 46 Davies (1984) op. cit., pp. 6-7
- 47 Personal communication, Margaret Stacey, September, 1985
- 48 Quoted by McCleary (1935) op. cit., p. 27
- 49 Article on the essential qualities of the health visitor, Maternity and Child Welfare (1922) 6, p. 242
- 50 WSI (1926) Memorandum on Matters connected with the Administration of the Maternity and Child Welfare and other Acts directly related to Health Visitors (London: WSI) pp. 4-5
- 51 ibid., pp. 5-10
- 52 Miss Cooper Hodgson, superintendent health visitor for

- Durham County Council, Maternity and Child Welfare (1920) 4, pp. 271-272
- 53 e.g. Miss M. Lowe, superintendent health visitor for Warwickshire, wanted girls to be taken directly from school and trained for five years, Public Health and Health Visiting (1928) p. 35
- 54 Paper read at the Royal Sanitary Institute Congress by Miss H. Weir, quoted in Maternity and Child Welfare (1921) 5, p. 197
- 55 Armitage (1927) op. cit., pp. 3-5
- 56 ibid., p. 11
- 57 Maternity and Child Welfare (1925) 9, pp. 27-28, 65-66
- 58 ibid., pp. 85-86
- 59 Time and Tide (1923) 4, pp. 1079-1080
- 60 Reported in the Woman Health Officer (January, 1932) 6, p. 4
- 61 Davies (1984) op. cit., pp. 13-18
- 62 The change of name was announced in the Woman Health Officer (July, 1930) 5, p. 1
- 63 Reported in the Medical Officer (1920) 23, p. 199
- 64 In 1933, the membership was in excess of 1,100, only a small proportion of the total number of health visitors employed by local authorities and voluntary associations, figures quoted in the Medical Officer (1933) 49, p. 84
- 65 Reported in the Labour Woman (1923) 11; p. 88
- 66 e.g. Hester Viney, article in Maternity and Child Welfare (1922) 6, p. 241
- 67 Armitage (1927) op. cit., pp. 312-313
- 68 Quoted in The Times 25 February, 1935
- 69 Armitage (1927) op. cit., p. 1
- 70 Phyllis Armitage stated that salaries ranged from £160 to £350 per annum, ibid., p. 6. Amy Sayle, at the WSI conference the following year, complained that twenty-eight local authorities, including five county councils, paid salaries of only £150 per annum, Public Health and Health Visiting (1928) p. 41
- 71 Figures were compiled by the Ministry of Health in March, 1922. In the county districts, for example, Waltham Holy Cross paid £120, while in Chiswick the salary was £292-305,
PRO MH53/61

- 72 WSI (1926) op. cit., p. 7
- 73 Quoted in Armitage (1927) op. cit., pp. 6-7
- 74 e.g. Hester Viney presumed that health visitors would be middle class and that mothers would be influenced by their example, Maternity and Child Welfare (1922) 6, p. 241
- 75 Public Health and Health Visiting (1928) p. 39
- 76 Remarks made by Miss Musson, the matron of a training school in Birmingham, during a visit to the Ministry of Health as a member of a College of Nursing deputation, 17 May, 1923, PRO MH53/61
- 77 Public Health and Health Visiting (1928) p. 35
- 78 Article in the Medical Officer (1928) 39, pp. 96-97
- 79 The Times 5 November, 1927
- 80 Editorial in National Health (1919) 12, pp. 49-51
- 81 Time and Tide (1923) 4, pp. 1175-1176
- 82 The WSI wanted a starting salary of £250 for health visitors, rising by £10 annual increments to £350. For a woman sanitary inspector a salary of £350 was suggested, with annual increments of £15 to a maximum of £500, memorandum on minimum scales of salaries sent to the Ministry of Health, May, 1920, PRO MH53/61
- 83 e.g. article in Time and Tide (1922) 3, p. 792
- 84 Editorial in the Medical Officer (1923) 29, p. 110
- 85 Internal discussion between Janet Campbell, H.O. Stutchbury, E. Strohmer, Mr. Coutts and A.B. Maclachlan, 10 July, 1920, PRO MH53/61
- 86 Deputation received 17 February, 1922, PRO MH53/61
- 87 e.g. the WSI, 24 February, 1922, the National Council of Women, 23 March, 1922, the Consultative Committee of Women's Organisations, 23 March, 1922, the National Baby Week Council, 16 May, 1922, while the NLH requested an investigation into the cost of living of health visitors, 30 May, 1922, PRO MH53/61
- 88 Letter from the NLH, 24 March, 1922, and the Ministry's reply, 10 April, 1922, PRO MH53/61
- 89 PP (1922) 152, col. 1865; 153, col. 6166
- 90 Minute signed by H.O. Stutchbury, 28 April, 1923, PRO MH53/61
- 91 Further minute signed by Stutchbury, 11 May, 1923, PRO MH53/61

- 92 Circular 557, Training of Health Visitors, 9 February, 1925, p. 3
- 93 Article in the Women's Leader (1925) 17, p. 142
- 94 The London District Council was a Whitley Council intended to determine salaries in the public sector.
- 95 It noted that seven or eight boroughs were unrepresented on the Council, reports of discussions, PRO MH53/12 and MH53/13
- 96 Numerous letters were sent during 1924, 1925, 1926 and 1927, PRO MH53/61
- 97 The deputation was received on 27 May, 1924, PRO MH53/61
- 98 Letter to Lt.-Col. Fremantle from George Newman, 9 April, 1925; and letter to Mrs. Philipson from Kingsley Wood, 24 April, 1925, PRO MH53/61
- 99 The deputation was received on 9 March, 1926, PRO MH53/61
- 100 Quoted in the Labour Woman (1928) 16, p. 151
- 101 Medical Officer (1920) 23, p. 199
- 102 ibid., 24, p. 260
- 103 Article on health visitors' training in Public Health (1927) 40, pp. 390-394
- 104 Medical Officer (1925) 33, p. 105
- 105 Editorial calling for better conditions of work for health visitors in Public Health (1929) 42, p. 281
- 106 Public Health and Health Visiting (1928) p. 36
- 107 ibid., p. 52
- 108 Representatives attended from the county councils, county boroughs, metropolitan boroughs, urban district councils, Soc.MOSH, National Association of Local Government Officers, the College of Nursing, the London and National Society of Women's Service, the NUSEC (Mrs. Adrian Corbett), the WCG (Councillor Mrs. Moore, Willesden) and sixteen members of the WSI, including the president, Gertrude Tuckwell, and the chairman, Amy Sayle, PRO MH53/61
- 109 Ministry of Health (1930) Circular 1117
- 110 This paper was published as a pamphlet, Amy Sayle (1931) The Present Position with regard to Salaries, Holidays, and Conditions of Service of the WPHOA (London: WPHOA)
- 111 Article in the Labour Woman (1932) 20, p. 98

- 112 Reported in the Woman Health Officer (September, 1933) 6, p. 1
- 113 Reported in Mother and Child (1933) 4, p. 106
- 114 Reported, ibid. (1932) 3, p. 324
- 115 ibid. (1933) 4, p. 150. In March, 1933, the Ministry of Health issued a circular (No. 1311) suggesting that one million pounds could be saved per annum. Cuts were supposed to be made on the administrative side, but the WPHOA feared that some local authorities might reduce health visiting staff instead.
- 116 Woman Health Officer (May, 1935) 8, p. 1; (November, 1935) 8, p. 1. The journal, however, admitted that most of the work of the Association involved individual cases related to pay, ibid. (December, 1934) 7, p. 1
- 117 Joint Consultative Committee of Institutions approved by the Ministry of Health (1939) Health Visiting as a Career, Fawcett Library.
- 118 Armitage recommended that health visitors should co-operate with doctors, midwives, hospitals, tuberculosis dispensaries and visitors, day nurseries, infant life protection officers, relieving officers and schools, Armitage (1927) op. cit., pp. 299-301
- 119 ibid., pp. 77-79
- 120 ibid., pp. 298-299
- 121 ibid., p. 299
- 122 National Health (1926) 19, pp. 174-176
- 123 e.g. Amy Sayle, article in the Medical Officer (1928) 39, p. 97
- 124 e.g. Sir Ewen Maclean, speaking at the BMA annual conference, reported in the Lancet (1927) ii, p. 228
- 125 Armitage (1927) op. cit., pp. 17-18
- 126 ibid., p. 31
- 127 Nursing Notes (1919) 32, pp. 22-23 and 100
- 128 ibid., p. 23
- 129 e.g. Amy Sayle recorded a success in Tottenham, where 50% of the mothers had been persuaded to visit the ante-natal clinic, remarks made at a Public Health Congress at the Agricultural Hall in November, 1932, reported in Mother and Child (1933) 3, pp. 364-365

- 130 Armitage (1927) op. cit., pp. 73-75
- 131 e.g. see Wilkin et al. (1917) op. cit., p. 4
- 132 Lewis (1980) op. cit., pp. 106-107
- 133 Nursing Notes (1919) 32, p. 66
- 134 see Women's Leader (1923) 14, p. 395. In 1930, at the annual congress of the Royal Institute of Public Health, Lady Keyes, who presided over the Women, Children and Public Health Section, revealed that 3,108 women doing health work for voluntary organisations were employed part time as health visitors, reported in The Times 6 June, 1930
- 135 This inspired Mary Stocks to suggest that the NUSEC could participate, Women's Leader (1924) 16, p. 95
- 136 e.g. article in National Health (1926) 19, pp. 174-176; Armitage (1927) op. cit., pp. 24-25
- 137 New Witness, 10 January, 1919, Tuckwell Collection, File 23
- 138 Mothers' Defence League leaflet, reproduced in Maternity and Child Welfare (1919) 3, p. 431
- 139 Letter from the Honorary Secretary, Agnes Mott, ibid. (1920) 4, p. 29
- 140 ibid.
- 141 see Lady Rhondda's articles in Time and Tide on women of the leisured classes, and the ensuing debate between Lady Rhondda and G.K. Chesterton, organised by the journal, on 'the menace of the leisured woman', Time and Tide (1926) 7, p. 979; (1927) 8, pp. 108-109
- 142 Maternity and Child Welfare (1919) 3, pp. 415-417
- 143 ibid. (1922) 6, pp. 131-132. The Charity Organisation Society was founded in 1869 with the object of avoiding the overlapping of charitable work and halting the indiscriminate distribution of alms, see Charles Loch Mowat (1961) The Charity Organisation Society 1869-1913: Its Ideas and Work (London: Methuen); and Stedman Jones (1976) op. cit., pp. 256-259
- 144 quoted, ibid. (1921) 5, p. 198
- 145 e.g. article by Dr. Sidney Davies, National Health (1920) 12, pp. 208-209
- 146 ibid. (1926) 18, pp. 336-338
- 147 Armitage (1927) op. cit., p. 306

- 148 Article in the Medical Officer (1928) 39, p. 97
- 149 This circular was discussed in McCleary (1935) op. cit., pp. 20-23
- 150 e.g. Amy Sayle, in an article published in 1928, assumed that health visitors would be visiting working-class women, Medical Officer (1928) 39, p. 97
- 151 Armitage (1927) op. cit., p. 27
- 152 e.g, ibid., pp. 11-12
- 153 ibid.; Cassie (1929) op. cit., Chapter Two
- 154 In 1935, when the Ministry of Health relaxed its regulations on giving birth control information, Dorothy Thurtle wrote to the journal appealing to health visitors to tell their clients about the service, Woman Health Officer (August, 1935) 8, p. 5
- 155 Cassie (1929) op. cit., p. 54
- 156 Reported in The Times 17 May, 1932
- 157 Reported, ibid., 21 November, 1932
- 158 Reported, ibid., 19 April, 1933
- 159 Reported in the Woman Health Officer (June, 1936) 9, pp. 6-7
- 160 Amy Sayle wanted health visitors to be registered workers, possessing prescribed qualifications, article in the Women's Leader (1920) 12, p. 821
- 161 Maternity and Child Welfare (1920) 4, pp. 271-272
- 162 WSI (1926) op. cit., p. 2
- 163 Public Health and Health Visiting (1928) p. 5
- 164 reported in the Woman Health Officer (June, 1934) 7, p. 12
- 165 Davies (1984) op. cit., pp. 10-11
- 166 see reports of attendance at the annual Trades Union Congress in the Woman Health Officer
- 167 McCleary (1935) op. cit., pp. 36-37

C H A P T E R T E N

WOMEN DOCTORS, HEALTH VISITORS
AND MIDWIVES; AN ASSESSMENT

After 1918, an important goal for the women's movement was to gain entry to some of the occupations closed to women, and to be treated in the same manner as their male colleagues. When women were permitted to enter an occupation, they often found they were not automatically accorded parity with their male colleagues. From the data presented in the preceding three chapters, it is evident that women workers in the health services benefited from the expansion of the maternity and child welfare service. At the same time, however, they were faced with the problem of low pay experienced by other women workers, which was exacerbated by the financial stringency enforced during the economic depression of the 1920s and the 1930s.

In common with other women working outside the home, the representative bodies of these women workers were forced to devote much of their time and resources to a campaign to raise wages, and to dispel the belief that women did not need to

receive comparable salaries to men, even if they were performing identical tasks. Women doctors felt especially aggrieved as a direct comparison could be made with male colleagues. Although women sanitary inspectors could make comparisons with their male counterparts, health visitors could not make similar comparisons. Nevertheless, low pay in certain districts was a matter which took up a considerable amount of time of the WSI and later the WPHOA. Likewise, midwives could not make direct comparisons, but their fees remained well below those of a doctor summoned to a confinement, while they did not receive the same guarantee from local authorities with regard to the payment of fees for necessitous women.¹

The other difficulty encountered by women workers was over the question of the right to work after marriage. It was only the midwives who avoided this difficulty. It was accepted that midwives could be married, as it was traditional that this work was undertaken by married or widowed women.² It seems probable, however, that the determining factor was the fear that it might be difficult to attract single women to remote areas.³ Some women doctors and health visitors were expected to resign on marriage. It was necessary for women to combat the marriage bar not only to give women freedom of choice, but also because it was used as a justification for pay differentials based on sex.

In addition to a shared need to campaign for higher remuneration, commensurate with that paid to men, and a desire to end the marriage bar, the midwives, health visitors and women doctors shared similar attitudes to women's role with regard to domestic responsibilities and childbearing. Women

who entered a branch of the health services during and immediately after the First World War were encouraged to believe that they were fulfilling a woman's role, in the same way as those who stayed at home to bear children and run a household. As discussed in Chapter Four, those who, for whatever reason, could not bear children were encouraged to believe that they could make their contribution by 'mothering the race' and helping those women with children to produce healthy citizens (see pp. 119-120). A justification for women's entry into the medical profession was that they had special knowledge of children and home life. Women were employed as health visitors because it was considered appropriate for the education of mothers in their own homes to be undertaken by another woman, who would appreciate domestic difficulties. They were there to serve mothers and children. Midwives, health visitors and women doctors were united in their desire to reduce infant mortality and debility, and the majority were wary of any association with those wishing to enable women to exercise control over their bodies, by deciding whether they wished to have children.

Those working in maternity and child welfare tended to accept George Newman's dictum that the service existed to save life and not to prevent it.⁴ Some MOsH readily endorsed this view. For example, in 1925, Duncan Forbes, the MOH for Brighton, wrote to Public Health condemning the use of birth control by any means other than abstinence. He acknowledged that an exception could be made for sick women, but argued that the teaching of birth control methods should be done by voluntary associations, without the aid of public money, and

asserted that no suggestion be given that the practice was right.⁵ Health visitors were primarily concerned with the welfare of infants, with only passing interest in the well-being of mothers (see p. 302). The leaders of the occupation discouraged visitors from giving birth control advice (see p. 331). Indeed, the WPHOA, at its annual conference in 1932, decided that education would overcome the need to provide birth control information, except on medical grounds when it should be given at a special clinic and not at a child welfare centre.⁶ Midwives, aware of prior association with disreputable practices, including infanticide and abortion, gave no indication that they wished to participate in anything other than the delivery of babies.⁷

Many of the leading women doctors expressed the opinion that women should bear children. In the 1920s, some doctors still opposed the use of birth control, arguing that it could lead to sterility or cause psychological problems.⁸ An MOH, writing in 1924, favoured birth control, to space families, but warned against its use until after the birth of two children, in case it resulted in sterility.⁹ Similarly, Kathleen Gamgee, the assistant medical officer for maternity and child welfare in Hull, referred to the possibility of sterility, and argued that women with large families were generally more healthy than those with small families.¹⁰ Moreover, it was not uncommon for women doctors to declare that all women had a maternal instinct, and to suggest that it might be damaging to deny this instinct. For instance, in 1927, the London Association of the MWF held a meeting to discuss maternal instinct at which Elizabeth Casson read a

paper advising doctors to be aware of the strength of maternal instinct in most women. She urged them to be on the look out for its repression or wrong expression. She claimed that many female mental patients benefited if they had a doll or a pet to care for. Casson went on to argue that some women did not realise that they needed

the natural outlet of devoted service They were the kind who kept well by doing war work and collapsed when they were left without it. For them a cure must be found; they must be persuaded to adopt a child, or guided into teaching, nursing, police, infant welfare work, management of working-class housing, or even into politics. By this means a selfish, self-centred, miserable woman might sometimes be transformed into a happy, useful citizen.¹¹

This opinion was shared by Alice Hutchinson, of Great Ormond Street Hospital and the Tavistock Clinic, who told a meeting of the WSI that birth control wrecked many marriages. She declared that some women did not realise the strength of maternal instinct, and claimed that an acceptance of birth control often meant that women built up animosity towards their husbands.¹² Other women doctors opposed birth control on religious and moral grounds, one of the most notable being Dame Louise McIlroy, although she eventually changed her opinion.¹³ Dr. Letitia Fairfield, a medical officer for the LCC, opposed birth control on the grounds that contraceptives were 'a frustration of God's design in nature'.¹⁴ Likewise, some women doctors spoke out forcefully against abortion.¹⁵

Nevertheless, despite similar aims and outlook, members of the three occupations under review did not acknowledge a common interest, enabling them to recognise a common identity. Social-class divisions were evident between the doctors, who

were generally recruited from the middle and upper classes, and the midwives and health visitors who were more likely to come from the lower middle class and the upwardly-mobile working class. The organisation of the health service, with doctors assuming ascendancy over these other workers, tended to reinforce this segregation. Moreover, when recruits to the different occupations came from the same social class it is possible that their outlook would have been different. Those middle-class women entering health visiting, for example, could have been inspired by the tradition of charitable work established in the nineteenth century, whereas many of those fighting for the right to practise medicine were likely to be inspired by the equal-rights feminists anxious to prove that women could compete on equal terms with men.

There is, however, much scope for further research into the class origins of the rank-and-file members of all three occupations. In addition to social differences, all were fighting for their place in the medical service, and hence there was a tendency to view those in other occupations as rivals. Throughout the period, there were appeals for more co-operation. Those involved, however, felt unable to comply. Although prominent persons in both midwifery and health visiting wanted midwives and health visitors to co-operate and reinforce one another,¹⁶ in practice the absence of clearly-defined spheres of responsibility and differences of opinion over the need for ante-natal clinics and the use of institutional accommodation for normal childbirth hindered this development. Similarly, conflicts over the responsibilities of doctors and midwives caused friction, a matter which was discussed at length in

Chapter Eight. Differences of opinion between doctors and health visitors were less marked. Health visitors and public health doctors could work well together, as health visitors were committed to the need for clinics, and did not want to act as surrogate doctors, accepting the authority of the MOH. Relations, however, with the general practitioners were not always so harmonious, as general practitioners were fighting for their right to do midwifery work and were resisting any suggestion that a state health service should be based on a salaried service of doctors.¹⁷ Consequently, they were wary of any interference from the town hall, and relations between doctors in the public health service and in private practice were not always good.

It was concluded in Chapter Four that the principle changes in the maternity and child welfare services resulted from the intervention of the state in the provision of services, and the growing interest of the medical profession in obstetrics and child health. The nature of the services changed, and at the same time professionals began to replace voluntary and often untrained workers. From the data presented in the preceding three chapters, it is apparent that the evolution of these services gave rise to uncertainty over the place of the various professionals in the services. It is argued that health visitors and women doctors were largely a product of these changes, albeit a constrained one, whilst midwives became the victims.

The Effects of State Intervention

Health visiting was clearly affected markedly by the intervention of the state. Visiting, as discussed in Chapter

Two had its origins in the nineteenth century. It was organised, however, on a small scale, reliant upon voluntary workers. Some of these visitors had little knowledge of working-class life, while others sought to deliver a particular religious message. In some areas, one family would be visited by several competing organisations. Consequently, they became unpopular with many of their clients (see pp. 326-328). The LGB, and later the Ministry of Health, encouraged local authorities to appoint health visitors (see pp. 298-300). Once the health visitors were employed by local authorities, their status changed: they moved from the private domain to the public.¹⁸ When their charitable status was removed, they became acceptable to the working women's organisations.

Although the objective of befriending the mother and offering advice remained unaltered, the local authorities required a different type of woman. Whereas the voluntary societies sought a 'motherly type' to live in the community, the local authorities wanted the health visitor to be a 'lady', who set herself apart from her clients. Once the Ministry of Health was created, it set about regulating the training of health visitors. It did not abandon the notion of the 'mother's friend', but it wished to ensure that health visitors were imparting technical information gleaned from the public domain. Health visitors were often told by the MOsH that they were vital to the maternity and child welfare service, providing a link between the local authority institutions and the mothers in the home. They were able to perpetuate the British nineteenth-century practice of charity which aimed to

keep families together, to maintain parental responsibility, and to encourage families to be self-supporting. The concept of health visiting remained unaltered, but its control was taken from women. In so doing, the female health visitor was invariably subordinate to a male MOH. A women's initiative, which not only could have led to the development of an important independent profession but also could have helped to raise women's self-esteem and faith in their inherited knowledge and skills, was usurped by the male-dominated medical profession.

The gradual introduction of training schemes, and the increase in work occasioned by the state's diversification into the provision of welfare centres and ante-natal clinics, provided health visitors with more work. As their responsibilities increased, they were able to demand higher pay. The fact that they were responsible to the MOH was regarded as a sign of status (see p. 333). It seemed to health visitors that the state provided them with more work, offered better security of employment, and made them more popular with their clients. There were problems, notably over pay and the length and content of training, but health visitors were generally optimistic about the future. Their role was circumscribed, but the boundaries were clearly defined, and many health visitors evidently welcomed this precise definition of their role and felt that within the existing boundaries there was sufficient scope to develop a satisfactory career structure.

The position of the woman doctor was not so clearcut as that of the health visitors, as women entering medicine did not necessarily all share the same opinion about their role

within the profession. Nevertheless, a significant number accepted the view that women were needed in medicine because of the unique contribution they could make in the field of preventive medicine, particularly with regard to women and children (see pp. 198-201).

The state's intervention into maternity and child welfare was based on the assumption that a solution would be found through the education of mothers, and through medical advances and the extension of medical services (see pp. 98-99). The medical profession, therefore, was closely associated with the work, and the Ministry of Health's reliance on the support of the medical profession has been discussed. As with other matters, like birth control, which were linked with medicine but did not fall within a definition of curative medicine, the profession was reluctant to lose control of the work. At the same time, with the notable exception of some MOsH, there was little enthusiasm amongst the men established in the profession to undertake routine inspection of pregnant women, infants and school children.

It did seem, however, with the perceptions of the day about sex role divisions, to be work well-suited to the women who were beginning to enter the profession in increasing numbers. The staffing of local-authority clinics seemed suitable for women, because women were supposed to be more able than men to deal with the more minor complaints, and it was argued that mothers would be more likely to confide in a woman doctor. As women were expected to retire on marriage, the fact that they were in a branch of medicine in which the opportunity for promotion was limited was not cited as a

problem by those anxious to categorise women's role in medicine. Consequently, women doctors found a place in the profession which was not challenged by their male colleagues, a fact which was probably an advantage during the 1920s when the surplus of doctors was encouraging the medical schools to close their doors to women. The reliance of women on this branch of work is indicated by the support the MWF gave to municipal ante-natal clinics. As mentioned in Chapter Four (see p. 108), the BMA opposed these clinics, arguing that the work could be done more efficiently by the general practitioner, working either in the patient's home or in the surgery. The MWF's maternity scheme was identical to that proposed by the BMA with the one exception being that ante-natal clinics were not condemned.¹⁹ Sylvia Pankhurst commented

The women doctors do not echo the men in urging the abolition of the ante-natal clinics which have provided too valuable a field for women practitioners to be lightly discarded.²⁰

The women doctors found, however, that although their role in the ante-natal clinics, the welfare centres and the school medical service was applauded and their aptitude for the work with women and children acknowledged, there was little enthusiasm either among women patients or the male establishment within the medical profession for women doctors to extend their competence to include paediatrics, gynaecology and obstetrics. Women in effect were expected to deal with the minor and the mundane aspects of medical work, leaving men to dominate the more lucrative and technically-demanding aspects of the work. The status of the women doctors, therefore, with a few notable exceptions, remained

low.

State intervention also brought the midwives under the public gaze. The need to have a register of midwives was finally acknowledged (see pp. 243-245). The registration granted to midwives, however, was quite different from that granted to the medical practitioners in 1858. Under the terms of the midwives' registration, control of the profession rested in the hands of the CMB, which was dominated by the medical profession, while responsibility for the inspection of the midwives was given to the local authorities. The manner in which the midwives were inspected often proved to be purely disciplinary. Midwives felt their autonomy and professional integrity was being undermined, particularly when some MOsH delegated their duties to members of staff with little experience of practical midwifery. Indeed, some MOsH gave this task to the health visitors, perhaps giving an indication of their opinion of the standing of health visitors with regard to midwives.²¹ Furthermore, midwives found that municipal ante-natal clinics often advised women to go into an institution for the confinement, resulting in a loss of cases. Whilst midwives were independent practitioners there was little co-operation and co-ordination between midwives and the staff of the clinics. Some midwives, therefore, were reluctant to advise their clients to attend a clinic, resulting in conflict with the local health visitor.

Health visitors were of the opinion that midwives should become public health employees, accorded a similar status to themselves. The 1936 Midwives' Act was welcomed in principle by the WPHOA, as the Association anticipated that it would

facilitate co-ordination (see p. 332). Some MOsH were anxious that midwives be brought under closer control, a sentiment shared by the Ministry of Health. The Bolam Committee recommended that the Ministry of Health should take over some of the responsibilities of the CMB.²² The Ministry rarely consulted the professional opinion of midwives, preferring to rely on the advice of the medical profession (see pp. 251-253).

The Medicalisation of Childbirth

It was, however, the medical profession's determination to establish control of childbirth which had the most profound effect upon midwives, making it impossible for them to combat the incursions of the Ministry of Health and the MOsH into the management and control of the profession. Oakley, in an essay on the demise of women healers and the emergence of contemporary maternity care, postulates that there has been a shift from female to male control, epitomised by the medicalisation of childbirth and the loss of women's traditional healing skills.²³ The data collected on midwives during the inter-war period substantiate this assertion.

The campaign by the BMA to restrict the role of the midwives has been discussed above. At the same time, obstetricians were extolling the advantages of hospital confinements for many categories of patient; while some hospitals, in order to obtain sufficient patients for their students, offered to accept maternity cases for very modest fees. The growing popularity of hospital confinements amongst childbearing women has been discussed in Chapter Four (see pp. 109-116). Consequently, midwives were faced with reduced case loads, which imposed

financial hardship upon them, making a salaried service seem the only solution. The difficulties of the midwives were exacerbated by failure to improve training, to enable them satisfactorily to undertake responsibility for normal confinements. For example, the BMA sought to prevent the midwives from learning techniques designed to relieve discomfort during labour (see pp. 265-271). Although training was extended, there was no attempt to restrict the number of institutions offering courses, so standards varied widely.

The Lancet, in a review of the Bolam Committee's report, noted that the Committee devoted only one quarter of its report to a consideration of training. The journal noted that an improvement in standards of training was essential if midwives were to be able to offer an adequate service for those women having their babies at home, as envisaged under the maternity scheme outlined in the Report.²⁴ The Lancet, however, was perhaps critical of the Report because the proposed administrative changes placed control in the hands of nominees of the Ministry of Health, to the virtual exclusion not only of midwives but also of the teachers of obstetrics.²⁵ The recommendations relating to training were not implemented until after the Midwives Act of 1936, and even these modifications did not increase the length of training for those entering the profession directly to that required of nurses.²⁶

Conversely, the medicalisation of childbirth had only a small effect upon health visitors. Regardless of the place of confinement, health visitors retained their educational role. Indeed, as hospital-based nursing training was the main component of the training programme of most health

visitors, it is perhaps not surprising that they exhibited no dislike of changing midwifery practices. Unlike midwives, who often came from the same background as their patients, and traditionally were often married women who had born several children themselves, health visitors were generally unmarried. Moreover, the Ministry of Health encouraged health visitors to keep their distance from their generally working-class clients.

Further research would be needed to determine the social class position of entrants to the occupation. The upwardly socially mobile would perhaps have been attracted to health visiting, rather than midwifery, as health visiting had its origins in middle-class charitable work, although some of the visiting had initially been done by working-class women, whereas midwifery, because of its links with illegal practices, which the obstetricians had been eager to draw out, had become unfashionable in Victorian England. The cost of training and its length, however, would presumably have debarred girls from the poorer working-class homes from entering the occupation, and the tone and content of the WPHOA's journal suggests a fairly affluent readership.²⁷ Moreover, the greater independence enjoyed by health visitors, in contrast with the rigid discipline of general nursing, might have attracted some middle-class women, with an interest in nursing, who would not have wished to be subjected to the strict regime of a nurses' home. The health visitors, therefore, would have been more ready to adopt current ideas propounded by the obstetricians and the Ministry of Health, as they would have been isolated from working-class patterns of

maternity care. Perhaps their peers were choosing to have their babies in a hospital or nursing home, following the example of middle-class women.

Health visitors had no wish to usurp the role of the doctor, so there was no conflict between the health visitors and the clinic doctors. Moreover, any withdrawal of midwifery work on the part of general practitioners might have increased reliance on the health visitor. The general practitioner would conceivably have been asked for advice on the care of the infant during his visits. It seems unlikely that a hospital-based obstetrician, whom the mother did not know, would have been consulted in the same way. The mother who used the clinic and the hospital would thus be more dependent upon the health visitor. Furthermore, the hospitals might have helped to break down traditional patterns of community help, making first-time mothers more reliant on the advice given by the professional health visitor. It is, however, not possible to substantiate this point, without knowledge of individual cases, as it could have been those without the support of the community and their family who elected to have a hospital birth.

Women doctors were not encouraged to become obstetricians or gynaecologists. Few hospitals appointed women to senior posts, and the British College of Obstetricians and Gynaecologists was dominated by men. Consequently, it was state intervention rather than the medicalisation of childbirth per se which was largely responsible for providing jobs for women doctors. Middle-class women, however, were beginning to demand a woman doctor for their confinements, and this led some

to seek a female general practitioner (see pp. 202-204 and 221). Some leading obstetricians, who wanted general practitioners to be excluded from midwifery, anticipated that normal cases would be supervised by women doctors, but any suggestion that general practitioners should be denied the right to do midwifery work was resisted by the BMA (see pp. 197-198).

Moreover, women doctors would have been unlikely to develop their own ideas on the conduct of maternity work. Women medical students, including those trained in the women-only school, were educated according to the male model. Furthermore, women doctors were generally unmarried women from middle-class backgrounds, who would have had little direct knowledge of working-class traditions, while it was becoming common practice amongst middle-class women to enter an institution for the confinement. Indeed, as women doctors formed such a small minority, and were accepted only on sufferance by some of their male colleagues, they would have been in a weak position to campaign for any alternative strategy, or to support the aspirations of any organisation outside the profession.

The Relations between Doctors, Midwives and Health Visitors

By the outbreak of the Second World War, with the benefit of hindsight, it is possible to distinguish the beginnings of contemporary midwifery practice. Although workers in the three occupations considered above suffered the problems encountered by all women workers, with this qualification, it was the doctors and the health visitors who had benefited by the changes, while midwives had undergone a fundamental change of status.

When war was declared in 1939, women doctors had secured a place for themselves in the profession, albeit a restricted place, and one that did not satisfy all the women medical practitioners. Similarly, health visitors had achieved considerable advances, although problems over training and pay remained unresolved. Midwives, on the other hand, had failed to maintain their independent status and to establish themselves as the professional colleagues of medical practitioners.

During the inter-war period, midwives were engaged in a battle to maintain their independence and to secure recognition as professionals with an expertise entitling them to be considered the equal of general practitioners. As a result they rejected trade-union affiliation, as this was seen as incompatible with professional status, and they worried about whether the wearing of uniforms was compatible with this status. Conversely, health visitors had no such worries. They did not envisage comparability with the medical profession. Historically they had allied more with sanitary inspectors. Unlike the midwives, therefore, affiliation to the TUC did not present a problem. The fact that they were employed by the local authorities was considered to be an advantage, whereas midwives viewed the prospect with apprehension. The health visitors did not have to suffer the unsatisfactory inspection meted out to some midwives, as they were generally directly responsible to the MOH. The patriarchal arrangement was not questioned. Indeed, the fact that some health visitors carried out the inspection of midwives must have affected their perception of the relative status of health visiting and midwifery.

The pay of health visitors tended to improve during the

period, whilst, until they became municipal employees, the remuneration of midwives was declining. Health visitors were becoming an integral part of the maternity and child welfare service, but midwives in independent practice were finding it increasingly difficult to secure sufficient work. The WPHOA was anxious that midwives should become municipal employees, as it argued this would lead to better co-operation. The health visitors envisaged a maternity service staffed by municipal health visitors and midwives with ante-natal clinics and hospitals. Moreover, the health visitors wanted to limit the work of voluntary organisations, considering efficiency would be improved if the health visitor and the midwife had the same employer. The WPHOA was opposed to the employment of health visitors by county nursing associations,²⁸ and, during the debate on the Midwives Bill, it sought to insert a clause limiting voluntary involvement to those associations already providing a service deemed to be adequate by the local authority.²⁹

By the time the salaried service for midwives was debated, health visitors were clearly in a superior financial position, and believed their position to be more satisfactory than that of the midwives. The WPHOA drafted an amendment to the Midwives Bill, which stipulated that the midwives' salaries should not be lower than those given to the health visitors in the locality. This amendment was defeated, but the Minister did agree that a circular, recommending equal pay, should be issued to local authorities.³⁰ The WPHOA resolution to the TUC in 1936, which was adopted by the Congress, called on local authorities to give midwives the same salary as the health

visitors in the area.³¹

In 1939, midwives, in terms of status, levels of remuneration and working conditions, had much more in common with health visitors than with doctors. As the maternity service became more hospital based, so midwives became more dependent upon doctors. Independent midwives, who considered that they had a particular skill and expertise, which enabled them to be regarded as the professional equals of the general practitioners, had become the victims of the state's desire to be seen to take an interest in maternity and child welfare, and the medical profession's desire to secure complete control of work which had previously seemed peripheral to curative medicine. The disreputable elements within the profession had been used to devalue the contribution made by those who drew on experience gleaned over the centuries. Skill was judged in terms of criteria formulated by the medical profession.

Health visitors and women doctors were not subject to these attacks, because they had not developed an independent tradition and could be moulded to fit in with the changing maternity and child welfare service. Health visiting was an entirely new occupation, created to comply with the needs of the new services. As public health officials, they were seen to be more reliable than independent midwives. For example, in 1919, a leading article in Public Health suggested that midwifery regulations be modified, arguing that health visitors should visit mothers as soon after a birth as possible, rather than waiting until after the midwife had relinquished her responsibilities, so that the health visitor could check the work of the midwife.³² It is evident that the medical profession

was able to exert influence on the development of the health services. The women who entered the elite of the profession, however, tended to be those willing to accept that their skills would lie in the spheres of preventive medicine, midwifery and maternity and child welfare. Women could not expect to become innovators in the profession until they had established their right to be there and had infiltrated the governing bodies of the profession. In the inter-war period, women had won the right to be in the profession, but largely on the understanding that they had attributes enabling them to work with mothers and babies, attributes which apparently did not extend to obstetrics and gynaecology.

Furthermore, these women health professionals were frequently working in services which were catering primarily for the working class. The municipal maternity and child welfare services were intended only for those unable to pay for medical services (see pp. 71-72), while the school medical service covered the state schools. Midwives and health visitors were offering a similar service to that which had been organised in the private domain by women themselves, but, as paid employees, they had lost their autonomy. Women doctors had fewer opportunities than their male colleagues to make contact with wealthy fee-paying patients, and thus to reap the benefits of lucrative practices and important social contacts.

The maternity service which was emerging at the end of the 1930s was based upon the medical profession's definition of appropriate care, coupled with the maintenance of the belief in the need to educate mothers. Control was in the

hands of the male elite of the medical profession and the Ministry of Health, while the work was given to health visitors, women doctors, and midwives, who were being transformed into subordinates of the doctor, performing a limited technical task. It is only in recent years that some midwives have begun to reassert their right to supervise normal labour in women's homes. By 1939, although the number of women working in the health services had increased, control was largely in the hands of their male colleagues.

NOTES AND REFERENCES

- 1 e.g. arrangements for the payment of midwives varied from place to place, while there was no system for the reimbursement of midwives whose cases were transferred to hospital because of an unforeseen complication.
- 2 In 1921, of the 5,507 midwives listed in the census, 3,398 were married or widowed, Census of England and Wales 1921 (1924) Occupation Tables, Table 4, p. 101 (London: HMSO). In 1931, 3,458 were married or widowed and 3,089 were single, Census of England and Wales 1931 (1934) Occupation Tables, Table 5, p. 58
- 3 Kingsley Wood, the Minister of Health, told a conference of the Royal Sanitary Institute in 1936, that there was nothing in the Midwives Act to prevent local authorities from employing married women, reported in the BMJ (1936) ii, pp. 871-872
- 4 Although local authorities were allowed to give birth control advice from 1930, this was strictly limited and local authorities received scant encouragement from the Ministry to provide this service. Lewis notes that birth control did not achieve official sanction until 1949, Lewis (1980) op. cit., p. 214
- 5 Public Health (1925) 38, pp. 162-163
- 6 Reported in Mother and Child (1932) 3, p. 100
- 7 Madeleine Simms has discussed the contribution the Midwives' Institute made to the deliberations of the Birkett Committee, set up to investigate abortion in 1933. The memorandum submitted by the Institute was based on a questionnaire sent out to all members of the Institute, but of the 7,500 members only 1,200 replied, the Midwife and Health Visitor (1974) 10, p. 114. Nursing Notes devoted little space to a discussion of either birth control or abortion in the 1930s.
- 8 e.g. anonymous letter from two gynaecologists, Public Health (1923) 36, pp. 291-292
- 9 C. Killick Millard, the MOH for Coventry, ibid. (1924) 37, pp. 129-133
- 10 Article, ibid. (1925) 39, pp. 9-14
- 11 Quoted in the BMJ (1927) i, p. 620
- 12 Reported in The Times 29 December, 1927
- 13 Marie Stopes proved that McIlroy had changed her views by dressing up as a poor woman and attending McIlroy's clinic to be fitted with a cap, quoted in Lewis (1980) op. cit., pp. 203-204

- 14 Letitia Fairfield made these remarks when she was a member of a committee set up by the National Council of Public Morals, reported in Public Health (1925) 38, pp. 327-328
- 15 e.g. during a discussion organised by the BMA on abortion, Louise McIlroy opposed abortion as it would increase sexual slavery, as did Letitia Fairfield, reported in the BMJ (1932) ii, pp. 968-969
- 16 e.g. article in National Health (1919) 12, pp. 102-103
- 17 see Honigsbaum (1979) op. cit., pp. 45-89
- 18 Davies (1984) op. cit., pp. 1-2
- 19 see BMJ (1930) i, Supplement, pp. 5-7
- 20 Pankhurst (1930) op. cit., p. 140
- 21 e.g. Dr. W.A. Bullough, the County Medical Officer for Essex, in a paper given at a national maternity and child welfare conference, argued that health visitors were more highly trained than midwives and hence would be the most suitable people to supervise midwives, quoted in Mother and Child (1933) 4, p. 186
- 22 Ministry of Health (1929) op. cit., p. 63
- 23 Ann Oakley (1976) Wise women and medical man: changes in the management of childbirth, in Juliet Mitchell and Ann Oakley, eds., The Rights and Wrongs of Women (Harmondsworth: Penguin) pp. 17-58
- 24 Lancet (1929) ii, pp. 669-670
- 25 see Ministry of Health (1929) op. cit., p. 63
- 26 Nurses had been required to undergo a three-year course of training since 1919. Midwives, although training had been gradually extended from an initial three months in 1905, were expected in 1937 to be able to complete their entire training in two years, while trained nurses were expected to take a one-year course.
- 27 The fact that the WPHOA's journal ran regular articles on foreign travel would suggest that health visitors were generally more affluent than their colleagues in midwifery, see the Woman Health Officer 1928-1938
- 28 ibid. (January, 1934) 7, p. 12
- 29 ibid. (June, 1936) 9, p. 6
- 30 ibid.
- 31 ibid. (November, 1936) 9, p. 1
- 32 Public Health (1919) 32, pp. 133-134

S E C T I O N F O U R

INTRODUCTION

This thesis set out to analyse the aspirations and the role of women working in the health services in the inter-war period, and to relate their experience to the conduct of the lay women active in the campaign to extend maternity and child welfare services.

It is evident from the manner in which women entered the public domain that the women's movement did not seek to break down social-class divisions. At the same time, attempts by the equal-rights feminists to alter the gender division within the family were largely unsuccessful, while the manner in which women entered the public domain did little to challenge the prevailing perceptions of women's particular aptitudes and skills or their primary role in society. The aim is to assess the lay women's health campaign and the endeavours of women to obtain paid employment in the health services in the light of these observations. Meanwhile, the thesis seeks to relate the achievements of these women to the restrictions which continued to be placed on women looking for a role outside the home, to place the achievements in the context of the divisions within the women's movement, and the continuing middle-class tradition of voluntary social service under the guidance of generally male technical experts. It is hoped that this approach will shed further light on the lay woman's health campaign and will assist in the understanding of the aspirations of women health workers and offer an explanation to account

for the hostility of many male members of the health services to any attempts by women workers to achieve autonomy and to raise the status of their occupation.

In this final section, these strands are drawn together. It is hoped that the analysis will complement the work already done on the women's health campaign and the history of women workers in the health services, and will indicate the gains and pitfalls encountered by the women's movement in the continuing struggle for women's emancipation.

C H A P T E R E L E V E N

CONCLUSION

A re-organisation of the women's movement after 1918 was inevitable, as women had had a variety of reasons for wanting the vote. Some saw the granting of the franchise as an end in itself; others regarded it as merely an, albeit vital, step towards the achievement of legal equality with men; while a third group hoped to use the vote as a means to further other goals relating to social and welfare issues, and were less concerned with establishing complete equality between the sexes.

Those who wished to pursue the social and welfare reforms tended to justify their involvement in terms of their special knowledge of domestic matters and their particular commitment to child welfare. Moreover, they were ready to argue that women had characteristics of sympathy, tact, an ability to deal with minutiae and a liking for communication on a one-to-one basis which made them especially able to tackle social and welfare issues. For them there would always be differences between the sexes, making some occupations

sexually specific, but they did hope that women's work would not be regarded as inferior to work done by men.

The outlook of these women was markedly different from many of those seeking to extend legal equality as the first priority. These equal-rights feminists sought to deny that innate differences between the sexes precluded women from some occupations and made them the natural child carers and housekeepers. They asserted that, with a 'fair field and no favour', women could compete on equal terms with men. Some challenged the idea that all normal women would want to bear and rear children, and argued that men should take an equal share in household duties.

In the 1920s, these conflicting views effectively split the middle-class suffrage movement into two factions. There were those who sought to justify women's entry into the previously male domains because of their role as mothers and housewives, claiming that the sexes were different but equal, and there were those who sought to minimise the differences between the sexes, refuting the opinion that all women should be regarded first as wives and mothers, and seeking equality on the same terms as men. It was perhaps inevitable that the maternity and child welfare campaign should alienate the equal-rights campaigners, as the maternity and child welfare workers wished to help women to remain in the home and to regard child rearing as an important and time-consuming task for which they were, with education and help from professionals, particularly fitted to undertake.

This separation between the equal-rights feminists and the maternity and child welfare campaign, however, had an

important effect upon the conduct of the campaign. The lay women's maternity and child welfare campaign, for example, endorsed the need for health visitors and maternity and child welfare centres where women could obtain advice on the care of their infants. Conversely, there was less enthusiasm for obtaining crèches at places of employment. At the same time, middle-class women, who had been brought up to regard voluntary work as a duty, found a place in the campaign and a continuing demand for their services despite the advent of local-authority involvement. These voluntary workers had set out to educate working-class women in the management of their households and the care of their children, and had been ready to work under the direction of male philanthropists, clergymen and MOsH. They found little difficulty in adapting to the post-1919 maternity and child welfare campaign. The voluntary workers were ready to agree that they should defer to the professionals and should not seek to give mothers technical advice. Nevertheless, there remained ample scope for voluntary organisations to augment municipal services and to provide services outside the scope of the 1918 Maternity and Child Welfare Act. In this they were encouraged by the Ministry of Health which saw the voluntary contribution as a means of keeping costs down and of introducing new ideas, while voluntary workers were expected to provide the sympathy and help to those with particular difficulties, which, it was believed, could not be provided by the state machinery.

Many working-class women, however, objected to the continuing participation of voluntary workers, demanding a full municipal service. Working-class women wanted services to

be available to all women. Also, they wanted services to be run by experts working full-time and with a professional status. Successive Ministers of Health, however, adhered to the principal that municipal services should cater for those unable to pay for services, while the need for financial stringency led both Conservative and Labour ministers to uphold the need for a contribution from the voluntary sector. The charitable organisations, for their part, were happy to continue the nineteenth-century tradition of providing for the deserving poor, and justified their presence alongside the municipal services on the grounds that they could give personal attention and adapt to individual needs, could be innovative and experimental and could act more quickly than the state bureaucracy.

Furthermore, there was a readiness to follow the lead of the predominantly male medical elite. Women active in the maternity and child welfare campaign advocated the medical supervision of childbirth, and found many women were willing to abandon traditional practices in favour of hospital births. An important part of the maternity and child welfare campaign was to educate women to follow the advice of doctors and to submit themselves to regular ante-natal examinations. Both the voluntary workers and leaders of the Labour and Co-operative women who took an interest in child welfare pinned great hopes on scientific advances as a means of reducing maternal and infant mortality. There was little criticism of the medical profession. Perhaps the maintenance of the relations within the family which placed the husband/father as the head of the household and the one responsible for major

decisions made it more likely that women would follow the lead given by male technical experts. Campaigns were directed towards husbands to encourage them to advise their wives to seek medical aid.

There were women in the maternity and child welfare movement who regarded poverty and bad housing as relevant to maternity and child welfare work. Some middle-class women, especially those involved in the Labour and Co-operative movements, recognised the problems associated with poverty and bad housing, and made this a central part of their campaign, but many others focused only on the medical aspects of maternal health, arguing that education would enable women from the poorest backgrounds to cope. The conduct of the maternal mortality campaign illustrates how the influence of housing, diet and heavy manual work remained controversial issues, whereas the need for medical services and the advice of technical experts was accepted by all those active in the campaign. The Maternal Mortality Committee achieved its greatest impact in the early years, when the focus was on this one issue. Divisions appeared when the question of morbidity was raised, leading to discussions of diet and the ability to purchase the appropriate food and on women's home circumstances, notably the need to do heavy manual work and the opportunity to rest after childbirth. Labour and Co-operative women wanted to broaden the campaign, while the voluntary organisations wanted to co-operate with the Ministry of Health and to work for the extension of medical services and the education of women.

This view of women as being first homemakers and child

carers affected attitudes to women working in the health services. There was considerable enthusiasm for women doctors to work in maternity and child welfare centres and an assumption that all health visitors would be women. These jobs were regarded as particularly suited to women because of the need to attend to detail and to discuss household management. Likewise, it was presumed that a midwife should be a woman, but there was little support from lay women for the midwives' desire to remain independent from supervision by the largely male medical profession. Demands for women obstetricians and gynaecologists were less common, perhaps reflecting a belief that work requiring considerable technical knowledge was more likely to be mastered by a man. There were, of course, exceptions, the popularity of the hospitals staffed entirely by women providing an example.

In the middle-class organisations, both the equal-rights campaigners and the welfare reformers accepted the class structure of society. Both groups retained the widely-held belief that social-class differences were inevitable. Thus the equal-rights campaigners found no difficulty in employing domestic servants to enable them to pursue a career outside the home. Similarly, many welfare reformers regarded it as inevitable that different services would be required for middle-class and working-class women.

It was assumed by many of the middle-class campaigners that midwives would attend working-class women in their homes, while their middle-class counterparts would be attended by a doctor probably in a private nursing home. The municipal maternity and child welfare centres were located in working-

class areas, on the assumption that middle-class women would obtain advice from a trained nanny or their family doctor. Many middle-class women equated municipal services with charity and presumed that any service they paid for directly was inherently superior. While health visitors were expected to visit middle-class homes, it was anticipated that few problems would be found in these homes and that the bulk of their work would be directed towards working-class women. It seems likely that this definition of midwives, health visitors and workers in welfare centres as attendants to the working class must have had an effect upon the status of those employed in these occupations. It hindered contact with wealthy patients who would have raised the incomes of these workers. Perhaps the middle class's lack of involvement with midwives meant that they took less interest in the midwives' campaign for better training, pay and working conditions and the retention of their independence than would have been the case if they were cared for by these midwives in their own homes. The Co-operative women had, from the early years of the twentieth century, been actively involved in raising midwifery standards, and had supported the campaign for the registration of midwives and sought to improve midwifery training. Even working-class women, however, were impressed by the value of the presence of a doctor, and did not always give the midwives wholehearted support.

Moreover, the lay campaigners' definition of women as wives and mothers, and their ready acceptance of the medicalisation of childbirth had an impact on the medical profession's attitude to maternity work and its treatment of

women entering the profession, while it also influenced the tactics and aspirations of the women who entered the health services as paid workers.

Previously, the male medical profession had taken little interest in maternity work or the special needs of infants. During the early years of this century, attitudes to obstetrics and gynaecology changed dramatically while paediatrics emerged as a new discipline. Increased knowledge showed that the work could be interesting and demanding, while women's enthusiasm for specialist services and the Ministry of Health's preoccupation with medical solutions to the problems of maternal mortality and morbidity and a desire to improve child health ensured that work with women and children would be lucrative. By the 1920s, it was evident that the pioneers in this work did not regard it as an appropriate sphere for the growing number of women entering the medical profession. The membership of the new British College of Obstetricians and Gynaecologists illustrates the male dominance of the work, while a similar situation occurred in paediatrics.

Conversely, the medical profession was ready to acknowledge that women were particularly suited to maternity and child welfare work. The growth in popularity of these welfare services ensured that new jobs in this area were created, providing an avenue for the medical women graduates. This work, however, unlike other public health work, was not regarded as a likely route to promotion to medical officer of health, a fact which was not regarded as a problem because women were expected to marry and cease paid work. At the

same time, the medical profession was at pains to ensure that midwifery and health visiting remained low status jobs, requiring the supervision and direction of the medical profession. The medical profession did not advocate that these occupations should be open to men, regarding it as routine work based largely in the women's homes. With a few exceptions, the medical establishment argued against the extension of training for midwives, which would enable them to deal competently with all home deliveries, and disputed a midwife's ability to determine whether a patient should be sent to hospital or whether an obstetrician should be summoned. Similarly, health visitors were regarded as educators and monitors of mothers in the home, following the dictates of the MOH and reporting back to their medical superiors. The medical profession was able to gain control of the maternity and child welfare services, and to give the low-status and less lucrative positions to women workers.

It is perhaps not surprising that women seeking entry into the medical profession should proclaim their right to be there in terms of the distinctive contribution they could make. Many were willing to accept that their skills would lie in the treatment of the diseases of women and children. Unfortunately, this approach made it easy for them to be segregated from their male colleagues. It provided justification for the separate education of men and women and the virtual exclusion of women students from the London teaching hospitals. Women found they were excluded from hospital appointments, and were thus barred from pursuing their studies to become specialists, and hence few became obstetricians, gynaecologists or

paediatricians. Moreover, as their work was regarded as different from that done by men, they found it difficult to argue for equal pay. Many of the able women were encouraged to advocate separatism and to favour the expansion of women-only hospitals. Others, finding employment opportunities at home were limited, were forced to seek employment abroad. These women achieved renown in the profession and accomplished excellent work, but their isolation from the London teaching hospitals meant they had little impact on the controlling elite of the profession which remained predominantly male. They were regarded as exceptional and it was assumed that the majority of women would be most suited to midwifery, health visiting and the more mundane aspects of medical practice. The medical elite continued to argue that it would be inappropriate for a male junior doctor to be under the supervision of a woman.

Meanwhile, the fight for a place in the health services meant that women doctors, midwives and health visitors often saw one another as rivals in their endeavours to secure a place for themselves and to raise the status of their occupation, thus precluding any sense of solidarity to combat low pay, poor working conditions and control by the male medical elite. Independent midwives found the struggle for status as an independent profession was thwarted to opposition from the Ministry of Health and the medical profession and by the lack of support from women, who were demanding hospital births with the benefit of all the available medical expertise. Relations between midwives and health visitors were often strained by disputes over when the

health visitor should visit the mother and over the type of advice the health visitor should impart, while in some areas co-operation was further undermined by the MOH's decision to employ a health visitor as the supervisor of midwives. Health visitors never sought to become independent, expecting supervision by the MOH. Much of their energy was devoted to campaigns for improved pay and working conditions and to achieve standardisation of training. Following in the tradition of the nineteenth-century voluntary workers, they saw their role as educators of working-class women, to persuade them to adopt standards and practices based on middle-class habits and the recommendations of the medical profession. As public health employees, they had little in common with other workers, notably the midwives, seeking autonomy. Health visitors welcomed the advent of the municipal midwife who came under the direction of the medical profession. Meanwhile, women doctors, excluded from so many branches of medicine, were reliant upon maternity and child welfare work in the public health service, and, therefore, were unlikely to support the midwives' campaign for autonomy and were happy for health visitors to be under the jurisdiction of a medical officer.

Furthermore, the women doctors, midwives and health visitors were divided by social class. Entrants to the medical profession were more likely to be middle class, while health visitors and midwives were more likely to be recruited from the lower middle class and the upwardly-mobile working class. There is, however, need for more research into the family background of the rank-and-file members of these occupations to substantiate this point.

By 1939, considering the constraints that remained on women seeking a public voice, both lay women and those seeking paid employment in the health services had achieved successes. The lay women had, for a few years, mounted a powerful campaign against the lack of action to combat maternal mortality, and had kept the issue of maternity and child welfare before the public during the 1930s when world events and government policy were likely to eclipse it from the nation's attention. Meanwhile, women were entering the health services in increasing numbers, and were proving to be the academic equals of the male students in terms of examination passes. Their acceptance of their role as wives and mothers, their failure to challenge relations within the family and their inability to abandon class and sectional differences to fight as women for a right to an equal place with men in the public domain, however, meant that their achievements were generally peripheral. Women politicians were generally restricted to domestic issues and found it difficult to influence policy or raise issues for debate, while women achieved only a statutory presence on official committees and public bodies. Women were recognised as wives and mothers, but their transmitted knowledge was dismissed in favour of the opinions of the technical experts. Women in the health professions, although becoming more numerous, remained segregated from their male colleagues, generally with lower status and remuneration. Class differences remained fairly rigid. Women were still expected to take full responsibility for the daily running of the household, while relations between the sexes were largely unchanged.

Despite these restrictions, women's lives had changed dramatically since Victorian times, when their presence in the public domain was exceptional. Nevertheless, by the outbreak of the Second World War, much remained to be achieved by the women's movement. The manner in which women can achieve an equal place in the public domain without following the pattern laid down by men and colluding with the male elite remains an issue central to the contemporary women's movement.

T A B L E O N E

Age Distribution of Infant Mortality, 1881-1939
Rates per 1000 live births (England and Wales)

Year	Under 4 weeks	1-3 months	3-6 months	6-9 months	9-12 months	Total
1881-85	67		28		44	139
1886-90	69		30		46	145
1891-95	74		31		46	151
1896-00	74		34		48	156
1901-05	70		28		40	138
1907	40.7	23.3	21.3	17.3	15.1	117.6
1908	40.3	24.2	23.6	17.7	14.6	120.4
1909	39.8	20.4	19.2	15.6	13.8	108.7
1910	38.5	20.0	18.8	15.0	13.2	105.4
1911	40.6	24.7	25.9	20.6	17.4	129.2
1912	38.4	17.7	14.9	12.5	11.4	94.7
1913	39.5	20.3	19.8	15.7	13.6	108.9
1914	38.5	19.3	18.7	15.0	13.0	104.4
1915	37.7	18.6	18.2	16.0	15.2	105.8
1916	36.9	16.9	15.2	11.7	10.3	91.1
1917	37.1	16.9	15.0	11.6	10.6	91.1
1918	36.6	17.1	16.1	14.4	13.7	97.9
1919	40.4	16.4	14.4	11.8	10.3	93.2
1920	35.0	15.5	13.0	11.0	10.0	84.5
1921	35.2	14.7	13.7	9.7	7.8	81.2
1922	33.9	12.4	10.6	9.2	8.6	74.7
1923	31.9	11.4	10.0	8.3	7.6	69.2
1924	33.0	12.4	10.8	9.3	8.8	74.2
1925	32.3	12.5	11.2	9.4	9.0	74.5
1926	31.9	11.6	10.4	8.6	7.7	70.2
1927	32.3	10.7	9.7	8.7	8.2	69.7
1928	31.1	10.7	9.2	7.4	6.8	65.1
1929	32.8	11.6	10.7	9.9	9.4	74.4
1930	30.9	9.6	7.8	6.1	5.5	60.0
1931	31.6	10.9	9.3	7.8	6.8	66.4

continued overleaf

T A B L E O N E C O N T.

Year	Under 4 weeks	1-3 months	3-6 months	6-9 months	9-12 months	Total
1932	31.6	10.8	9.1	7.2	6.3	65.0
1933	32.2	9.9	8.8	6.8	6.6	63.7
1934	31.3	8.8	7.5	5.8	5.1	58.6
1935	30.4	9.1	7.7	5.4	4.3	56.9
1936	30.2	9.3	8.3	6.0	4.9	58.5
1937	29.8	9.4	8.3	5.9	4.3	57.6
1938	28.3	8.2	7.2	5.0	4.0	52.7
1939	28.1	7.9	7.0	4.4	2.9	50.4

Source: Registrar-General's Statistical Review of England and Wales, 1938-1939 (London: HMSO)

T A B L E T W O

Birth Rate for England and Wales 1911-1938

Year	Live and still births registered	Live birth rate per 1000 population
1911	881,138	24.4
1912	872,737	24.0
1913	881,890	24.1
1914	879,096	23.8
1915	814,614	21.8
1916	785,520	21.0
1917	668,346	17.8
1918	662,661	17.7
1919	692,438	18.5
1920	957,782	25.5
1921	848,814	22.4
1922	780,124	20.4
1923	758,131	19.7
1924	729,933	18.8
1925	710,582	18.3
1926	694,563	17.8
1927	654,172	16.7
1928	660,267	16.7
1929	643,673	16.3
1930	648,811	16.3
1931	632,081	15.8
1932	613,972	15.3
1933	580,413	14.4
1934	597,642	14.8
1935	598,756	14.7
1936	605,292	14.8
1937	610,557	14.9
1938	621,204	15.1

Sources: On the State of Public Health (1939) p. 72;
Registrar-General's Statistical Review of England
and Wales for the Year 1938 (1940) p. 57

T A B L E T H R E E

Maternal Mortality Rates per 1000 live
births for England and Wales, 1911-1944

Deaths ascribed to pregnancy and childbearing and deaths not ascribed to but associated with pregnancy and childbirth

Year	Deaths of women classed to pregnancy and childbearing				Deaths not classed to pregnancy and childbearing, but associated therewith	
	No.	Rates per 1000 births registered			No.	Rate per 1000 births registered
		P.S. ^a	Other p ^b	Total P		
1911 ^c	3413	1.43	2.44	3.87	909	1.04
1912	3473	1.39	2.59	3.98	848	0.97
1913	3492	1.26	2.70	3.96	803	0.91
1914	3667	1.55	2.62	4.17	831	0.95
1915	3408	1.47	2.71	4.18	881	1.09
1916	3239	1.38	2.74	4.12	739	0.94
1917	2598	1.31	2.58	3.89	638	0.95
1918	2509	1.28	2.51	3.79	2529 ^d	3.81
1919	3028	1.67	2.70	4.37	1337 ^d	1.93
1920	4144	1.81	2.52	4.33	1086 ^d	1.13
1921	3322	1.38	2.53	3.91	925 ^d	1.09
1922	2971	1.38	2.43	3.81	1051 ^d	1.35
1923	2892	1.30	2.51	3.81	764	1.01
1924	2847	1.39	2.51	3.90	849	1.16
1925	2900	1.56	2.52	4.08	759	1.07
1926	2860	1.60	2.52	4.12	709	1.02
1927	2690	1.57	2.54	4.11	861	1.32

^a P.S. - puerperal Sepsis

^b P - puerperal

^c Deaths before 1911 are not directly comparable because of changes in classification

^d Deaths in this group were particularly high because of the influenza epidemic

Continued overleaf

Year	No.	Rates per 1000 births registered			No.	Rate per 1000 births registered
		P.S. ^a	Other p ^b	Total P		
1928	2920	1.79	2.63	4.42	790	1.20
1929	2787	1.80	2.53	4.33	960	1.49
1930	2854	1.92	2.48	4.40	774	1.19
1931	2601	1.66	2.45	4.11	911	1.44
1932	2587	1.61	2.60	4.21	713	1.16
1933	2618	1.83	2.68	4.51	828	1.43
1934	2748	2.03	2.57	4.60	747	1.25
1935	2457	1.68	2.42	4.11	712	1.19
1936	2301	1.39	2.41	3.80	668	1.10
1937	1988	0.98	2.28	3.26	759	1.24
1938	1917	0.89	2.19	3.08	629	1.01

Source: On the State of Public Health (1939) p. 72

In the next report, published after the war, a new classification was employed, so the figures are not directly comparable

Year	Pregnancy and child-bearing (Nos. 142-150 International list, 1938)				Abortion (Nos. 140-141 on International list, 1938)			
	No. of deaths	Rate per 1000 births			No. of deaths	Rate per 1000 births	Rate per million women aged 15-44	
		Infectious	Other	Total			Septic	Other
1931	2258	1.41	2.02	3.43	448	0.68	29	17
1932	2213	1.33	2.13	3.46	470	0.73	31	17
1933	2251	1.49	2.23	3.72	486	0.80	32	18
1934	2367	1.59	2.21	3.80	513	0.82	37	16
1935	2126	1.34	2.07	3.41	464	0.74	33	14
1936	2011	1.18	2.01	3.19	420	0.67	29	13
1937	1773	0.79	2.00	2.79	369	0.58	23	14
1938	1742	0.70	2.00	2.70	354	0.55	23	13
1939	1643	0.62	1.93	2.55	354	0.55	25	11
1940	1372	0.54	1.64	2.18	268	0.44	16	11
1941	1352	0.48	1.77	2.25	325	0.54	21	12
1942	1360	0.42	1.60	2.02	313	0.46	24	7
1943	1296	0.39	1.45	1.84	322	0.46	24	8
1944	1174	0.28	1.24	1.52	312	0.40	24	7

Source: On the State of Public Health during the Six Years of War (1946) p. 264

A P P E N D I X O N E

THE 1918 MATERNITY AND CHILD WELFARE ACT

In 1914, the Local Government Board had outlined its definition of a complete maternity and child welfare service, and had undertaken to provide a grant to assist local authorities and voluntary agencies.¹ The service incorporated the supervision of midwives, the provision of ante-natal clinics, home visiting for expectant mothers, hospital beds for the complicated cases of pregnancy, adequate assistance to ensure that mothers had skilled and prompt attendance during home confinements, provision for sick women to be confined in a hospital, the treatment of any condition arising from parturition, whether in the mother or the infant, the provision of systematic advice and treatment of infants and children up to school age, and the systematic visiting of infants and children not on the school register.

This concept of a maternity service was incorporated in the Maternity and Child Welfare Act. The Act had two elements. First, it required councils to appoint a maternity and child welfare committee, with two-thirds of the membership elected council members and at least two women. Secondly, the services for which a Local Government Board grant could be claimed were extended. The Act, however, did not compel councils to provide any of the recommended services, did not stipulate whether the services should be provided at the county or district level, and presumed that some services would continue to be provided by charitable organisations, which were also entitled to apply for grants.

A circular, issued by the Local Government Board, drew the attention of all county councils and sanitary authorities to the tenets of the Act.² The councils were informed that a grant not exceeding one half of the approved net expenditure would be payable by the Local Government Board to local authorities and voluntary organisations in respect of arrangements for attending to the health of expectant and nursing mothers and children up to the age of five years. The following services were itemised:

- 1 the salary and expenses of an inspector of midwives
- 2 the salary and expenses of health visitors and nurses engaged in maternity and child welfare work
- 3 the provision of a midwife for necessitous women and for areas insufficiently supplied with midwives
- 4 the provision of a doctor to attend necessitous women during pregnancy or a confinement
- 5 the expenses of a maternity and child welfare centre
- 6 arrangements for instruction in general hygiene
- 7 hospital treatment for complicated maternity cases and children under five years
- 8 the cost of food for expectant and nursing mothers and children under five years supplied under the direction of the MOH or a medical officer at a maternity and child welfare centre
- 9 the expenses of crèches and day nurseries
- 10 the provision of convalescent homes for mothers and children under five years
- 11 the provision of homes and other arrangements to safeguard the health of children of widowed, deserted and unmarried mothers

12 experimental work carried out with the approval of the
Local Government Board

13 the contributions of local authorities to voluntary in-
stitutes and agencies approved under the scheme

The Local Government Board emphasised the need to ensure that competent midwives were available to all women needing the service. The importance of the health visitors and the maternity and child welfare centres was stressed. The attention of local authorities was drawn to the need to increase the lying-in accommodation. Local authorities were told they could provide home helps or arrange for children to be boarded out during a confinement. A scale of charges for food and milk provided for expectant and nursing mothers and children under five years was advocated, which could be remitted or reduced if necessary. Local authorities were requested to keep capital expenditure to a minimum by adapting existing accommodation.

REFERENCES

- 1 The memorandum, outlining a complete maternity scheme, was published on 30 July, 1914. See also, Local Government Board (1916) Maternity and Child Welfare (London: HMSO) and (1915) Regulations under which Grants will be paid by the Local Government Board to Maternity Centres during the year ending 31 March, 1916 (London: HMSO)
- 2 Local Government Board (1918) Maternity and Child Welfare (London: HMSO) issued to all county councils (other than the London County Council) and sanitary authorities

A P P E N D I X T W O

A NOTE ON SOURCES

This project evolved out of work for a dissertation on the Ministry of Health's policy to tackle the high rate of maternal mortality. My findings were based on a study of the Ministry's files held at the Public Records Office, augmented by material obtained from The Times, the BMJ and the Lancet. Women's part in the health campaign was not investigated at that point, but the sources seemed to indicate that women had little influence on the Ministry's policy. A desire to assess the validity of this impression provided the stimulus for the present study. The problem was thus to select a range of sources which placed the women's health campaign in the context of the prevailing attitudes to women's role in society, and of the changing social divisions in society. Moreover, in order to obtain a better understanding of women's place in the health campaign, I decided to investigate not only lay campaigners but also those who sought a career in the health service.

Having read the previous work on women's health in the inter-war period, it was apparent other authors had not addressed the matter in this way. Histories of the maternity and child welfare movement written at the time tended to focus on the extension of medical and allied services, a notable example being the work of G.C. McCleary (1933, 1935). Women campaigners discussed the medical and economic needs of women, but tended not to relate the health campaign to the wider issues of women's emancipation (e.g. Pankhurst, 1930, Pember.

Reeves, 1913, Spring Rice, 1939). Contemporary authors have centred their research around specific campaigns. Jane Lewis, for example, discusses why the maternity and child welfare services took the form they did, and has concentrated attention on the infant welfare movement, hospitalisation of childbirth, birth control and family allowances (Lewis, 1980). Other authors have tackled one issue: notably work by Peter Fryer and Linda Ward on birth control (Fryer, 1965, Ward, 1981), Audrey Leathard's history of the Family Planning Association (Leathard, 1980), John Macnicol's investigation of the controversy surrounding the introduction of a system of family allowances (Macnicol, 1980), Madeleine Simms work on abortion law reform (Simms, 1974, 1975), while Diana Gittins' research has been on working-class women's knowledge of birth control, their relations with their husbands, and the factors determining family size (Gittins, 1982). Although local studies would be illuminating, I felt that the picture at the national level was still unclear, making it difficult to select appropriate areas for investigation. I decided, therefore, to embark upon a national study. This study, however, covers only England and Wales and not the whole of Britain, as legislation for Scotland and Ireland does not always correspond to that for England and Wales.

Rather than selecting particular events or campaigns I began by analysing a range of journals. First, I consulted journals representing the interests of lay and professional health workers. National Health, which changed its name in 1930 to Mother and Child, and Maternity and Child Welfare were used to obtain information on lay workers. Maternity and Child Welfare was particularly valuable, providing evidence of the shift in priorities amongst middle-class people from a

desire to help the disadvantaged to a desire to obtain advice on child care and child psychology for themselves. Public Health, the official journal of the Society of Medical Officers of Health, and the Medical Officer provided data on professional public health workers. Careful reading of Public Health provided a useful insight into the Society's attitude to women doctors in the public health service as well as its stance on the role of the health visitor. The Lancet and the BMJ were consulted to obtain information on the general practitioners and the hospital-based doctors. The BMJ's reports on the meetings of the British Medical Association and the Medical Women's Federation were useful. Information on women doctors, midwives and health visitors was obtained from their respective journals, the Medical Women's Federation News-Letter, Nursing Notes and the Midwives Chronicle and the Woman Health Officer.

Secondly, I perused the journals of the suffrage societies, namely the Women's Leader, formerly the Common Cause, and the Vote, as well as Time and Tide, a journal established after the First World War to provide women with a forum to discuss theories on the role of women in society and to articulate their views on matters of national interest. These journals provided ample evidence to show that the women's movement, although it underwent a change following the franchise victory, did not stagnate. The information gleaned from the suffrage literature was augmented by data obtained from the journals published by the women's sections of the major political parties, the Labour Woman and Home and Politics, the Conservative Party publication.

The next step was to analyse the published work of individual women and women's organisations who participated in the

health campaign. I consulted the work of women working in the health service, notably Ethel Cassie (Cassie, 1929), Phyllis Armitage (Armitage, 1927) and Janet Campbell both when she was working in the Ministry of Health (Campbell, 1924, 1927, 1932) and after she had retired from the Ministry (Campbell, 1935). Also, I found two books written by medical women which were intended to give women advice on marriage, motherhood and maternal instinct (Hutton, 1935; Hutton, 1938). Particular attention was given to the literature of the Fabian Women's Group and the Women's Co-operative Guild. Both these organisations took an active interest in health and welfare issues. The former was principally a middle-class, London-based society, while the latter represented the interests of married working-class women, and had many branches in the North of England.

Less obvious perhaps was the decision to explore the published work of women active in the women's movement who did not play a prominent part in the health campaign. An assessment of the strength and weaknesses of the campaign cannot be complete without some knowledge of the aspirations and fears of women with alternative perspectives and goals. Vera Brittain and Winifred Holtby, who published both fiction and non-fiction, provide a valuable insight into the life of women of that time as well as giving their interpretation of the goals of the women's movement (Brittain, 1936, 1941, 1953, 1968, 1979; Holtby, 1934, 1947, 1981). Virginia Woolf's books Three Guineas and A Room of One's Own (Woolf, 1935, 1943) helped me to understand the conditions under which women had to work. These authors, plus the published work of Dora Russell (Russell, 1925, 1977, 1981), Lady Rhondda, a co-founder and

editor of Time and Tide (Rhondda, 1933), and Eleanor Rathbone, the president of the National Union of Societies for Equal Citizenship during the 1920s (Rathbone, 1948), have provided information on the aspirations of feminists between the wars. Their writings not only helped me to understand the distinct strands within the women's movement but also to place the health campaign in a broader context.

Published material, however, has limitations, as by its nature it contains only matters which the authors wish to make public, and which have been prepared for a particular audience. Wherever possible, therefore, I have sought to use unpublished material. I am grateful to have been permitted to examine the minute books of the Central Committee of the Women's Co-operative Guild and the Executive Committee of the Fabian Women's Group, the Medical Women's Federation archive, and the papers left by Violet Markham. I have also been able to consult the unpublished autobiography of Gertrude Tuckwell, and her collection of press cuttings has contributed to my understanding of the way in which the issues were covered in the national and local press. The Women's Co-operative Guild material was particularly rich, as fairly detailed minutes were taken. The Fabian Women's Group records were less comprehensive, and often little information was given to indicate the content of meetings. I was particularly pleased to be able to consult the Markham papers as these have only recently been made available for scrutiny. The Fawcett Library has been a rich source of data relevant to all three sections of the thesis, as it holds press cuttings, feminist journals and unpublished accounts of meetings and reports from women's groups, voluntary organisations and hospitals and welfare groups. Delving into the Fawcett Library's

section on maternity provided information on such groups as the National Baby Week Council, the National Birthday Trust Fund and several of the maternity and child welfare charities. The Library also contains data on many of the women's organisations including the old-established suffrage societies and the Six Point Group and the National Council of Women of Great Britain.

In the light of the knowledge obtained from these sources, I re-examined the files of the Ministry of Health. I was not only able to look at files which had been outside the scope of the previous study, but I was also able to re-assess some of the data used in my previous research which provided evidence of the Ministry's treatment of women, both employees in the health service and in the Ministry, and lay campaigners.

All these sources have been used throughout the thesis, but within each section the balance between secondary and primary material and between the medical and lay literature varies. For Section One, which is intended to provide the background for the substantive study, considerable reliance has been placed on secondary sources. Knowledge of nineteenth-century philanthropy has been gleaned from the detailed work of F.K. Prochaska (Prochaska, 1980) and Anne Summers (Summers, 1979). Similarly, Catherine Hall's work on evangelicalism in nineteenth-century England (Hall, 1979), Sally Alexander's study of women workers in London during the same period (Alexander, 1976) and Leonore Davidoff's analysis of the workings of English 'society' (Davidoff, 1973) provide useful insights into the women's movement in the nineteenth century, which complement the studies of philanthropy. These data helped me to place my work on the inter-war period in a

wider context.

Women politicians have been investigated not only because they provide an example of women's entry into a well-established male institution, but also because they saw themselves as representing women and had the opportunity to publicise their views. Research by Melville Currell (Currell, 1974), Pamela Brookes (Brookes, 1967) and Elizabeth Vallance (Vallance, 1979), has provided background data. The autobiographies of several of the women MPs have been consulted: Margaret Bondfield (1948), Katharine, Duchess of Atholl (1958), Leah Manning (1970), Edith Pickton Turbervill (1939), Edith Summerskill (1967), as well as the biographies of Nancy Astor (Grigg, 1980), Eleanor Rathbone (Stocks, 1949) and Ellen Wilkinson (Vernon, 1982). These data have been augmented by a perusal of Gertrude Tuckwell's press cuttings.

The policies of the major political parties both on the role of women in the public domain and on health issues are clearly relevant. The Labour Party archive revealed the discrepancy between the Party policy when in opposition and that adopted during periods of Labour government. The library of the Conservative Party contains a collection of pamphlets which illustrate the messages the Party wished to give to the electorate, and provide a valuable insight into the Party's attitude not only to health issues but also to women and their role in politics. The journals of the women's sections of the Labour and Conservative Parties have been perused. Home and Politics, the Women Unionist Association publication, devoted considerable space to the discussion of women's role in national politics. The Labour Woman provides useful information on the conflicts between the National Conference of Labour Women and the National

Executive of the Labour Party. Unfortunately I did not find similar data on the Liberal women.

The principal suffrage journals, the Women's Leader and the Vote, have been studied to obtain knowledge of the development of the women's movement in the inter-war period. These data have been incorporated with data obtained from the records of the Women's Co-operative Guild, held at the University of Hull Library and at the London School of Economics. The records of the Fabian Women's Group, held by Nuffield College, Oxford, were also consulted. The Minute Books of the Executive Committee contain interesting data on the Group's relations with other women's societies as well as its attitude to the Ministry of Health's initiative to combat maternal mortality. Unfortunately the Minute Books for the 1930s have not survived. This may be less of a problem than it initially appears, since from Margaret Cole's history of the Fabian Society (Cole, 1961), it would appear that Fabians were not very active during the 1930s. The papers of Violet Markham, kept at the London School of Economics, contain further data on the campaign for equal pay and on attitudes to the employment of women outside the home. Possibly more data could be obtained from this source, however, as recently more documents have been made available. These data on the development of the women's movement have been supplemented by a perusal of Time and Tide. The journal paid particular attention to women's role in society, and devoted special attention to the arguments presented by the equal-rights feminists. Vera Brittain, Winifred Holtby and Lady Rhondda were regular contributors. Time and Tide provides a good contrast to the Women's Leader, which supported the arguments of those seeking to promote the in-

terests of women in the home. Celia Davies drew my attention to Time and Tide for which I am grateful.

Jane Lewis's work on the development of the maternity and child welfare services (Lewis, 1980) has been an important pointer to the variety of sources available on the maternity and child welfare movement. Her sources have been supplemented to provide data on the development of the maternity and child welfare and the maternal mortality campaigns. The Ministry of Health files and reports, Hansard, the medical press, the national press and the journals and records of the women's groups have been consulted. Medical opinion has been assessed by a search of the BMJ and the Lancet. Public health officials played an important part in maternity and child welfare work, and the Medical Officer and Public Health have been consulted to obtain knowledge of their objectives. Maternity and Child Welfare, National Health and Mother and Child were particularly relevant, and gave a clear picture of the evolution of the voluntary organisations in the wake of the introduction of municipal services. The reports of the major voluntary societies and the Maternal Mortality Committee, held at the Fawcett Library, were of special value. Gertrude Tuckwell's autobiography and her collection of press cuttings were used, as were the Markham papers. Knowledge of lay involvement was obtained also from the Labour Woman, the Women's Leader, Time and Tide and the Townswoman, and the pamphlets and reports of the National Federation of Women's Institutes, the Women's Co-operative Guild and the Fabian Women's Group. Further information on medical, government and lay activity was obtained by reference to The Times. The Daily Herald and the Spectator were also consulted. These data enabled me

to develop the interpretation put forward in the text of the thesis.

The medical journals were valuable sources for the chapters on women health professionals. The BMJ, the Lancet, the Medical Officer and Public Health were consulted for all three chapters, supplemented by contributions in The Times from both lay commentators and medical personnel. The files of the Ministry of Health have been studied. For the chapter on women doctors, the New-Letter published by the Medical Women's Federation has been perused, but it gives no indication of internal conflicts. It gave little space to alternative opinions, perhaps because of the desire to attract women to medicine and to promote positive attitudes amongst the male members of the profession and the general public towards the presence of women in the profession. Fortunately, I was able also to consult the archive of the Federation, which was more revealing, the debate on the strategy to adopt to retain co-education in London in the 1920s being especially useful. For the chapter on midwives, Nursing Notes and the Midwives' Chronicle and the reports of the Central Midwives' Board were consulted. The plight of the independent midwife was discussed also in the women's journals and the national press. The Woman Health Officer was perused for the chapter on health visitors. Unfortunately, the British Library does not have a complete set of this journal, but there are sufficient issues to obtain an impression of the style of the publication and its objectives. I found this journal rather disappointing, as there was little space devoted to correspondence, while the editorials were consistently cheerful and bland, giving little indication of any problems experienced

by health visitors. Luckily I was able to augment this material with information gleaned from reports of meetings of the Women Sanitary Inspectors' and Health Visitors' Association and from Ministry of Health files and discussions in the medical press. Lay women's attitude to women working in the health services has been obtained from the columns of the Vote, the Women's Leader, the Labour Woman, and Time and Tide, augmented by data in the Women Co-operative Guild archive, the Markham papers and the Tuckwell collection.

Unfortunately, there has not been time to attempt any of the painstaking work which would be required in order to unearth biographical details of those women working in midwifery, health visiting and medicine who made up the rank and file of these occupations. Although some delving into the history of women doctors has been undertaken by Celia Davies (Davies, 1982) and May Ann Elston (Elston, 1984), no comparable work has been done on health visitors or midwives. Such investigations would necessitate different research methods to those employed here, and would constitute a research project in their own right. Further local studies would also be illuminating to complement the work done already (e.g. Lodge, 1983). Data from branches of the national lay women's organisations, professional and trade union groups, voluntary agencies and local authorities would lead to a fuller understanding of the needs and desires of recipients of the midwifery and welfare services, as well as drawing out the influence of social-class differences and provide further evidence of gender segregation. It is hoped that the data obtained from the sources consulted will provide a basis for such work and will help to place in context the local studies which have already been completed.

A P P E N D I X T H R E E

AN ANNOTATED LIST OF THE JOURNALS,
PUBLISHED DURING THE INTER-WAR PERIOD,
WHICH ARE REFERRED TO THROUGHOUT THE THESIS

- 1 British Medical Journal: The journal of the British Medical Association
- 2 Englishwoman: Published from 1908 until January, 1921, when it ceased publication because of financial difficulties. The Journal consistently campaigned for women's suffrage. Millicent Garrett Fawcett, Cicely Hamilton and Ray Strachey were among the contributors.
- 3 Home and Politics: Began in September, 1920, as a four-page journal for the Women's Unionist Association. In May, 1921, it was replaced by the Popular View, a journal for men and women, with Home and Politics as a four-page supplement. In 1923, Home and Politics was again printed separately, although some articles were common to both journals. In June, 1924, Home and Politics became totally separate.
- 4 Labour Woman: The journal for working women published by the Women's Labour League. When the League was amalgamated with the Labour Party in 1918, publication was taken over by the Labour Party. The Chief Woman Officer, Marion Phillips became the editor. When she died in 1932, Mrs. Barbara Ayrton Gould was made temporary editor. When Miss Mary Sutherland was appointed Chief Woman Officer later in 1932, she assumed the editorship.
- 5 Lancet: A journal of British and foreign medicine, surgery, obstetrics, physiology, chemistry, pharmacology, public health and news. It was always edited by leading members of the profession.
- 6 Maternity and Child Welfare: Founded in 1917 for workers among mothers and children. The editor was an anonymous member of the medical profession. In 1921, it became the official journal of the Central Council for Infant and Child Welfare, which incorporated thirteen infant welfare organisations. In 1930, it became an independent journal. It ceased publication in 1934, stating that it believed its task was complete as infant welfare was firmly established and welfare agencies had drawn together to coordinate their activities.

- 7 Mother and Child: First published in 1930, and was the official journal of the National Council for Maternity and Child Welfare. This journal replaced National Health. It was decided to change the name as, from the First World War, the emphasis had been on maternity and child welfare
- 8 Medical Officer: Founded by G.S. Elliston, the Executive Secretary of the Society of Medical Officers of Health, in 1908, for 'medical men in the government and municipal services'
- 9 Medical Women's Federation News-Letter: The journal of the Federation, edited by Violet Kelynack
- 10 National Health: Founded in 1908 as a journal for state, municipal and voluntary health administrators. It was officially recognised by the National League for Health, Maternity and Child Welfare, the National Association for the Prevention of Infant Mortality, the National Baby Week Council and the Women Sanitary Inspectors' and Health Visitors' Association, all of which published notes of their activities in the journal. It stated that it was widely used by maternity and child welfare centres, medical officers of health and teachers. The name of the editor was not revealed. In April, 1930 the journal became the official journal of the National Council for Maternity and Child Welfare, and its name changed to Mother and Child
- 11 Nursing Notes and the Midwives Chronicle: It was described as a practical journal for midwives and nurses, and was first published in the 1880s. It was the journal of the Incorporated Midwives' Institute, the Association for Promoting the Training and Supply of Midwives, the Association of Inspectors of Midwives, the Colonial Nursing Association and the Workhouse Nursing Association
- 12 Public Health: The official journal of the Society of Medical Officers of Health, founded in 1856. The honorary editor was R.A. Lyster, who resigned when he became president of the Society. He was replaced, in April, 1926, by Charles Porter
- 13 Time and Tide: Founded in 1920 by a group headed by Lady Rhondda, and including Mrs. Chalmers Watson, the founder of the Women's Auxiliary Army Corp, Mrs. Helen Archdale, the first editor, Miss Jean Lyon, employed on the magazine Punch, and three novelists, E.M. Delafield, Cicely Hamilton and Rebecca West. Lady Rhondda assumed the editorship in the mid-1920s. She intended it to be a platform for feminist discussion
- 14 Townswoman: The journal of the National Union of Townswomen's Guilds, which began as a section of the Women's Leader. The editor was Mrs. Blanco-White
- 15 Vote: The journal of the Women's Freedom League. It ceased publication abruptly in 1933 following the death of Elizabeth Knight, the honorary treasurer, who had put

up the money to keep the journal solvent

- 16 Woman Health Officer: The official journal of the Women Sanitary Inspectors' and Health Visitors' Association and, from 1930, the Women Public Health Officers' Association. It was first published in 1927

- 17 Women's Leader: It replaced the Common Cause, the journal of the National Union of Women's Suffrage Societies in 1920, when the Union was renamed the National Union of Societies for Equal Citizenship. The editors were Eva Hubback, Elizabeth Macadam and Mary Stocks. These editors retired in November, 1931, and were replaced by Mrs. Priestley, when the journal became a monthly rather than a weekly publication. The Chairman of the Board of the Women's Leader was Millicent Fawcett, who was replaced, in 1925, by Ray Strachey. The journal ceased publication in 1932.

B I B L I O G R A P H Y

Full references are given at the end of each chapter. Listed below are the principal sources, both published and unpublished.

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