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The Voluntary Maternity Hospital:
a social history of provincial institutions,
with special reference to maternal mortality, 1860-1930

Two Volumes

Volume One

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A thesis submitted in fulfilment of the
requirements for the Degree of Doctor of Philosophy

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"How can the dangers of child bearing, which have been attributed to various causes, be alleviated?" This question was asked over a century ago (and it is also asked now), and seeing how destitute of comforts, means, and medical assistance, and how abandoned and repudiated by society many of the married and single women about to be confined were, the thought occurred to some benevolent persons that they might be received and delivered in hospitals, and their answer to the above question was, "By the establishment of maternity hospitals", and what seemed more likely to be the means of saving these women in travail from peril than the maternity?

W. Williams, *Deaths in Childbed* (London, 1904), p.38.

Summary

From an historical perspective, the maternity hospital has borne criticism in two major respects. Firstly it has been argued that the voluntary maternity hospital played a negligible, even harmful role in delivering women in childbirth and therefore cannot be regarded as having a positive influence on maternal mortality. Secondly, but not unrelated, is the widely held assumption that the maternity hospital was little more than an instrument of male medicalisation responsible for subordinating midwives and their patients to medical authority.

Drawing evidence from hospital records (Board minutes, registers and annual reports) relating to Manchester, Liverpool, Sheffield, Birmingham and Newcastle, the thesis challenges both points of view. Using Manchester as a principal case study, it has been found that the city's two maternity hospitals, conducting both ward and home confinements, played a far more demographically significant role than previous estimates have allowed. By adopting those factors considered crucial determinants of low maternal mortality, 'free', 'accessible' care of 'a high standard', administered by a 'careful midwife' and a 'skilled doctor', the hospital's potential to influence local maternal mortality rates was formidable.

The Manchester material is again used in the medicalisation debates, but much more relevant to this discussion are the findings at the Liverpool Maternity Hospital. Managed by the Ladies Committee, practices at the hospital refute the opinion that, women managing women's affairs, was to the greater good of their gender simply because they shared 'the same biological experience of femaleness...'. Class interest also accounted for the women's involvement and the way they exercised their influence. The Liverpool material also provides, along with material from other provincial maternity hospitals, a detailed explanation of the medicalisation process so far as it effected maternity hospitals. It is only from the 1920s that the medicalisation of the institutions begin to have a detrimental effect on the confinement of women, but as the conclusions indicate, there was more to the maternity hospital by this date than forceps and sutures.

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Abbreviations

BMA	British Medical Association
BMJ	British Medical Journal
CA	Central Archive
CL	Central Library
CMB	Central Midwives Board
DPS	District Provident Society
JHA	Jessop Hospital Archive
JRUL	John Ryland University Library
LCRO	Liverpool Central Record Office
LGB	Local Government Board
MHA	St. Mary's Hospital Archive, Manchester

Introduction

The Maternity Hospital:

A Variable Worthy of Analysis

Childbirth - The Trauma

A deep, dark and continuous stream of mortality.¹

This extensively quoted, but nonetheless poignant, reference to 'the heavy loss of mothers in childbirth' was just as relevant to the maternal mortality returns of the late 1920s as it was when it was written, half a century earlier.² 'A dangerous and wasteful process', accounting for 3,000 lives a year, it was estimated, in the 1920s, that amongst women of reproductive age, the risk of dying in childbed was three times greater than dying from cancer and two-and-a half times greater than dying from tuberculosis, then the greatest, single cause of female mortality.³ Yet, even when lives were not immediately at risk, 'a vastly greater number', as many as 5,000 each year, were said to have died from the delayed results of childbearing and a further 60,000 were believed to have been left seriously ill or crippled as a result of a difficult or instrumental birth.⁴

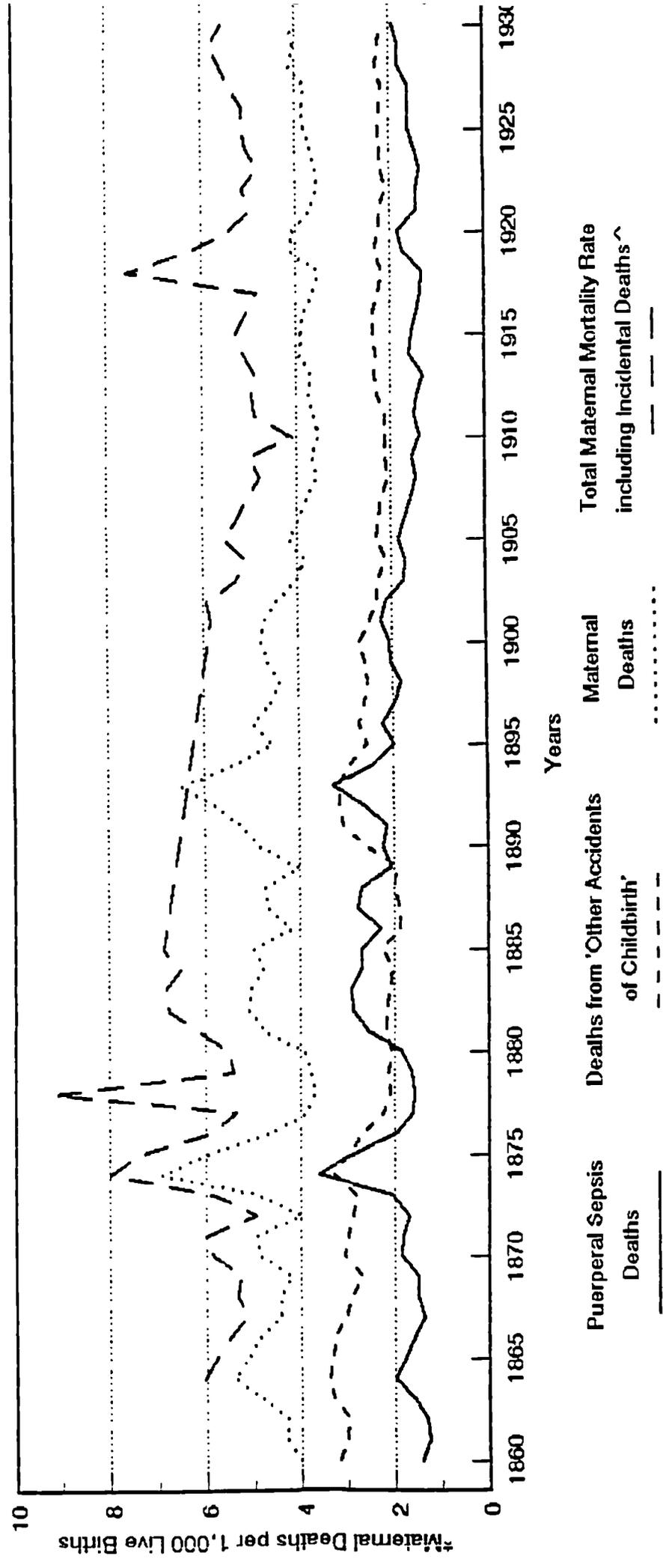
When are added to this the personal accounts of mothers, the reports of government officials, leading obstetricians and celebrated feminists, and the fictitious but credible commentaries of Victorian and Edwardian novelists, it is clear that childbearing, for most women was 'a time of travail, of true labour and considerable pain'.⁵ One mother of three, for instance, whose childbirth recollections are transcribed in Maternity, a collection of letters from members of the

Women's Cooperative Guild, 'telling of childbirth and death, exhaustion and self-sacrifice', described her pregnancies as periods of 'Extreme sickness from first to last, and during last months [sic] much pain and much discomfort'. Likewise, a woman who underwent ten pregnancies, including two miscarriages, explained, 'I never felt a woman during pregnancy; as I got nearer I felt worse'. The same woman also related how, at her first confinement, 'the baby was hung with navel cord twice round the neck and once round the shoulder ... which caused me hours of suffering and it caused my womb to come down'. Another primipara 'was in labour thirty-six hours, and after all that suffering had to be delivered by instruments ... I am suffering from the ill effects today. This is thirty-one years ago'.⁶

Similarly, from a sample of 17 letters selected from Mother England, a collection of correspondence from working-class women to Marie Stopes, the birth-control pioneer, the overwhelming majority of women requested her help because they were either too ill to tolerate another pregnancy or because their last confinement had proved too painful and distressful to repeat. One letter in particular typifies the experience of her fellow correspondents:

I am a married woman with a family of small children, I was very ill over my last baby. I was under the Doctor all the time I was pregnant with my heart, and not only that I started with haemorrhage from the mouth, the consequence was I had not strength to bring the baby, my life was despaired of for quite a

**FIGURE 0.1: ANNUAL MATERNAL MORTALITY RATES PER 1,000 LIVE BIRTHS
ENGLAND AND WALES 1860-1930**



* Rates based on pre-1911 Classification ~ 1885-1900 Incidental Deaths (no figs)
Source: Annual Reports of the Registrar General 1860-1930

while but, thank God I came through after a struggle.⁷

Many women, however, did not live to recollect the trauma of childbirth and it is on these women that our attention is primarily focused. According to the Registrar General, those women who died as a direct result of childbirth, either in pregnancy, labour or the subsequent one month lying-in period, to which the maternal mortality rate refers, died from puerperal fever (after 1906, puerperal septicaemia) or from the accidents of childbirth. The former, a somewhat confusing, generic term, referring to a diversity of postpartum infections, symptoms and manifestations, was primarily associated with streptococcal infections of the uterus surface and genital tract.⁸ The accidents of childbirth referred to all other puerperal causes of death, of which the most significant were miscarriages and abortion, puerperal convulsions, puerperal mania, placenta praevia and postpartum haemorrhaging. Those who died *in* childbirth and not *from* childbirth, as a result of a pre-existing illness, such as a pulmonary disease, a heart complaint or a chronic renal disorder, were not included in the Registrar General's maternal mortality figures, but were, between 1864 and 1885 and from 1901, listed separately as indirect deaths of childbirth. Had they been included in the overall figure, as in Scotland, they would have increased the maternal mortality rate by approximately 30 per cent (Figure 0.1 and Table 0.1).

As it was, the maternal mortality rate was still relatively high and its pervasiveness, throughout the

**TABLE 0.1: MATERNAL MORTALITY (QUINQUENNIAL) RATES
FOR ENGLAND AND WALES 1861-1930**

	A: Puerperal Sepsis Rate	B: Other Accidents of Childbirth	C: Total Maternal Mortality Rate: A+B	D: Deaths Incidental To Childbirth	E: Total Death Rate A+B+D
(Mortality Rates: Per 1,000 Live Births)					
1861-1865	1.59	3.23	4.82		
1866-1870	1.58	3.00	4.58	0.84	5.42
1871-1875	2.44	3.03	5.47	1.10	6.57
1876-1880	1.75	2.25	4.00	1.47	5.47
1881-1885	2.77	2.17	4.94		
1886-1890	2.45	2.10	4.55		
1891-1895	2.50	2.99	5.49		
1896-1900	2.04	2.65	4.69		
1901-1905	1.95	2.32	4.27	1.29	5.56
1906-1910	1.56	2.17	3.73	1.26	4.99
1911-1915	1.50	2.31	3.81	1.21	5.02
*	1.42	2.61	4.03	0.99	5.02
1916-1920	1.57	2.30	3.87	1.98	5.85
*	1.49	2.61	4.10	1.75	5.85
1921-1925	1.48	2.21	3.69	1.35	5.04
*	1.40	2.50	3.90	1.14	5.04
1926-1930	1.78	2.23	4.01	1.50	5.51
*	1.73	2.54	4.27	1.24	5.51

* Figures refer to the new, official rates following re-classification in 1911

Source: Annual Reports of the Registrar General 1861-1930

period, most striking. The Registrar General, William Farr, one of the first leading figures to bring the problem of maternal mortality to the public eye was initially confident that as it was finally being understood how puerperal fever was transmitted and the need for competent birth attendants appreciated, there would be a great diminution in the risks of childbirth'.⁹ This was in 1867, when the maternal mortality rate was 4.44 per 1,000 live births and averaged 4.58 for the quinquennium 1866 to 1870 (Figure 0.1 and Table 0.1). In 1930, 63 years later, the maternal mortality rate was 4.16 per 1,000 live births and averaged 4.01 for the quinquennium, 1926 to 1930 (Figure 0.1 and Table 0.1).¹⁰ Thus, at the end of the period, childbirth was still accounting for over 4 maternal deaths for every 1,000 children born alive and registered, and had the number of still births and miscarriages also been included and the maternal deaths with which they were closely associated more thoroughly recorded, the maternal mortality rate might have been far higher.¹¹

Whatever the true figure, which also has to take account of under-registration and faulty reporting, the persistency of the maternal mortality rate drew comment from more than just the Registrar General. Papers on the subject were also filed by Medical Officers of Health, such as William Williams in Cardiff, Andrew Topping in Rochdale, Veitch Clark in Manchester and H. E. Collier in Redditch.¹² These were complemented by analysis from distinguished obstetricians such as Robert Boxall,

midwifery lecturer at the Middlesex and then the General Lying-in Hospital, London, and C. J. Cullingworth, a former physician at St. Mary's Maternity Hospital, Manchester and later President of the London Obstetrical Society.¹³ From the First World War period, they were joined by reports from government officials, such as those presented by Arthur Newsholme and Janet Campbell, and by the campaign literature of women's groups, including the Women's Co-operative Guild and the Women's Labour League and their representatives, including Margaret Llewelyn Davies, Sylvia Pankhurst and Gertrude Tuckwell.¹⁴ By the mid-1920s, the lay as well as the medical press were also drawn into the debates, giving maternal mortality 'a prominence never before accorded to any medical question'.¹⁵

Yet, what Janet Campbell was writing about in the 1920s and Sylvia Pankhurst a decade later, namely, death in childbed, Elizabeth Gaskell, Charles Dickens and other literary figures, often with a personal perspective of childbirth, were alluding to a century before. Whilst the realities of a difficult birth or the effect of repeated pregnancies were never really detailed, lest it offended Victorian sensibilities, few novelists were ever deterred from describing the deaths in childbirth of their female characters.¹⁶ Thus, Dickens, who fathered ten children, began Oliver Twist (1837) with the death of Oliver's mother only moments after his birth, and Elizabeth Gaskell, whose own mother died a month after she was born, referred in the opening chapters of Mary

Barton (1848) to the death of Mary's mother and her new born, after a 'prolonged, agonising labour'.¹⁷ William Thackeray, whose wife suffered postpartum depression after the birth of their third child, detailed in The Newcomers (1855) the deterioration and eventual death of one of his principal characters, Rosey, after a constant series of pregnancies and confinements.¹⁸ Likewise, the novelist Mrs Humphrey Ward, who had been 'profoundly stirred and disturbed by the pain of her own three pregnancies and deliveries', clearly reflected this in the passages of her most famous novel, Robert Elsmere, published in 1888. Here, the heroine, Catherine Elsmere, questions her very role as a wife and mother, in the light of her traumatic experiences at birth, which 'brought her so abruptly to a confrontation with mortality'.¹⁹

Current Interpretations, Omissions and Assumptions

This 'confrontation with mortality' practically every time a woman became pregnant, regardless of her social class or wealth, and the pervasiveness of the maternal mortality rate, in spite of medical advances, such as the use of anaesthesia to ease labour pains and antiseptics to arrest puerperal fever, has prompted many, from William Farr to Irvine Loudon, to inquire into the reasons why. These reasons, though hailed as 'obscure and perplexing', 'numerous and complex', 'indefinite and non-specific', considering everything from the employment

of women to local variations in the rate of illegitimacy, have ultimately focused on the failings of obstetric care.²⁰ 'Skill', concluded Farr, with reference to childbirth, 'can do more here in averting danger and death than in other operations'. He identified, at a very early date, that 'educated nurses as well as physicians are required to secure the best chances of life to mother and child'.²¹

Whilst Farr's comments were subsequently tailored as new evidence was brought to the fore, his arguments provided the premise for all major maternal mortality studies thereafter. His ideas were incorporated, for example, in the work of Edis (1878), Boxall (1893), Williams (1896), Cullingworth (1897), Edgar (1898), Smyly (1900), Byers and Murray (1901), to name but the earliest.²² 'I feel sure', contemplated Milne Murray in 1901,

that an explanation of much of the increase of maternal mortality from 1847 onwards will be found in, first, the misuse of anaesthesia [promoting unnecessary interference], and second, in the ridiculous parody which in many practitioners' hands, stands for the use of antiseptics. In a word, the use which has been made by many of two of the greatest blessings of humanity has converted them into little else than a curse.²³

The blame for this lay firmly, in Murray's opinion, with the medical profession. For Cullingworth and Williams the blame lay with the midwife, but for Arthur Newsholme, author of the first government report on maternal mortality, both were to blame. There can, he argued,

be no substantial doubt that a chief factor concerned in causing the excessive mortality in childbearing and ...serious chronic debility or invalidism ...is lack of skilled medical and midwifery assistance before and during the childbirth.²⁴

Whoever the principal instigator, the cause of maternal mortality, 'was primarily a clinical problem', for, as Eardley Holland explained in 1935, 'There is no lack of [obstetric] knowledge, only an obstinate neglect of the application of known facts'.²⁵

Considered 'an eminent example of preventable deaths', historians who have studied the maternal mortality problem in any detail have tended to agree with the contemporary explanation, that maternal mortality was '*remarkably resistant to the ill-effects of social and economic deprivation, but remarkably sensitive to the good and bad effects of medical intervention*'. 'Not all the evidence points this way', Loudon adds cautiously, 'but most of it does'.²⁶ An historical authority on maternal mortality, Loudon argues that one of the reasons for believing that socio-economic factors played a relatively small role in influencing maternal mortality rates was because of their immunity to rising standards of living which played a very important role in the decline of the general mortality rate from 1838 and infant mortality from 1900. Another important reason was the reverse relationship found (1930-32) between social class and maternal mortality. Wives of husbands of classes I and II, 'professional and managerial', frequently experienced higher maternal mortality rates than wives of men from social classes IV and V, 'the

semi-skilled and unskilled'. This relationship was also reflected, Loudon argues, between one district of a city and another, as in London, where the poor areas of the City such as Bermondsey, Shoreditch, Lambeth and Whitechapel, had lower rates than Hampstead, Islington, Kensington and Chelsea. In Loudon's opinion it was all to do with the distribution of competent medical care

Where a high standard of care, free of charge or at minimum cost was made available to the poor [as in the case of these poorer London boroughs], childbirth with low mortality was usually the result, regardless of social and economic conditions.²⁷

Once Loudon is fairly comfortable with this clinical interpretation of events, he becomes more specific about the interpretation itself, calling into question firstly, the care and skill of the birth attendant and then, the place of delivery. As a starting point he refers to the reverse relationship between social class and maternal mortality. The explanation, he argues, lies with the greater use amongst the professional and managerial classes of medical practitioners who were less patient in their attendance and more prone to intervene in the natural delivery of a child than midwives, and therefore more likely to cause an infection or an abnormality.²⁸ The stream of accusations by leading members of the medical profession in the 1920s to the effect that their more junior colleagues were potential carriers of infection, incompetent in the labour room and unnecessarily interventionist, and the verification they received from comparative studies of midwives and

practitioners, supports, Loudon argues, his belief that domiciliary attendance by a midwife, who took reasonable precautions against infection and interfered as little as possible, was the safer option. 'The stronger the tradition of home deliveries by well-trained midwives', Loudon concluded, 'the more likely that the maternal deaths in a country would be kept to a minimum'.²⁹

In his second major paper on maternal mortality, published two years after the first, in 1988, Loudon began to pay more attention to the place of delivery as well as the quality and type of attendance parturient women received. In fact, the two were inextricably related, for he readily equated a home birth with a midwife and a hospitalized delivery with a doctor:

The evidence suggests that between 1870 and 1935 it was usually safest to be delivered at home by a well-trained midwife rather than in a hospital by a doctor.³⁰

Whilst he admits that 'the apparently greater safety of home', may well have been 'due to off-loading of high risk cases and emergencies on to the hospitals, especially cases of septic abortion', this was only part of the explanation. A much more important reason, Loudon argues, was the inadequate hygiene procedures and unnecessary acts of intervention in normal labours, which he readily associated with the maternity hospital, the very epitome of mal-medical practice. 'Infection and excessive obstetric intervention were prominent features of many hospitals', he concluded, 'and a major factor in high mortality rates'.³¹

Accepting for a moment that clinical factors were the most important influence on maternal mortality rates, then, with the notable exception of Edward Shorter, whose views will be considered shortly, most historians have agreed with Loudon, particularly his opinions about the role of the maternity hospital. Indeed, Thomas McKeown, who held little faith in the hospital system in general, maintained as early as 1955 and re-iterated in 1976, that 'there can be little doubt that the effect of the institutional confinement on maternal mortality was wholly bad...'.³² Whilst not necessarily agreeing with McKeown's overall analysis of hospital care, 'staffed by "raw country boys" and "uncouth apothecaries"', and periodically swept by outbreaks of sepsis, F. B. Smith nevertheless felt that the maternity hospital was a dangerous place to be and that 'a woman and her infant did best if the birth was managed outside a hospital'.³³ Carter and Duriez are of the same opinion, that prior to 1940 and the introduction of sulphonamides, the maternity hospital had neither the equipment nor the expertise 'to make for noticeably greater safety in birth; indeed the often overcrowded and unhygienic condition of older hospitals made them decidedly more dangerous'.³⁴ For such feminist historians as Ann Oakley, Margaret Versluisen, Patricia Branca, Marjorie Tew and Mary Chamberlain, it was not just a question of poor training and limited facilities that hindered institutional maternity care, but also the hospital's close association with the male medical profession. Characterised as misogynous,

domineering, incompetent and insensitive, hospital doctors were seen as a poor alternative to the domiciliary midwife.³⁵ 'The mortality rates [of local midwives]', Chamberlain claimed, 'were considerably lower than those of hospitals and the lying-in wards and infinitely lower than those of the Poor-Law', the presumption being, of course, that hospital cases were invariably attended by doctors.³⁶

Whilst this may not have been the case, there is no denying that Loudon and Chamberlain's historical preference for the midwife is one shared by many, contemporaries and historians alike. Whilst William Williams, for instance, was most scathing of the 'unskilled and ignorant midwife', he could not deny her importance to the overwhelming majority of working-class mothers. 'There is', he remarked, with special reference to Wales, 'scarcely a person whose life or whose mother's life, might not at one time have depended upon the skill of the midwife'.³⁷ According to one survey, conducted by the London Obstetrical Society in 1870, between 30 and 90 per cent of women among the poorer populations of villages and large manufacturing towns in England and Wales were attended by midwives, while at Glasgow and Coventry, for instance, it was 75 and 90 per cent respectively.³⁸ However, on average, a Select Committee on Midwifery in 1892 found that three-quarters of births were attended by midwives, 'a large and important body', whose numbers were in excess of 15,000.³⁹ By the early 1920s, with the advent of registration and training of

midwives and outlawing of handy-women, the proportion of midwife attended cases was about 55 per cent, but again the figure varied considerably from as high as 90 per cent in parts of Wales, to less than 30 per cent in Newcastle-upon-Tyne.⁴⁰

Once amongst the labouring masses, the midwife served two important roles. Firstly, from a clinical perspective, she adopted almost a contraposition to that of the doctor, for,

She was more patient in her attendance ...less likely to interfere ...did not use instruments and rarely inserted a hand in a labouring woman ...The 'naturalness' of her technique often meant fewer complications and unlike some of the doctors she did not inspire fear.⁴¹

'The provision of a trained midwife in every childbirth whether a doctor is in attendance or not...' was indeed something that government officials and leading obstetricians strove for in the 1920s because of these very qualities. There was a strong belief amongst such critics as Lea, Jellett, Kerr and Campbell, that 'under favourable conditions and effective supervision', well-trained midwives were 'capable of conducting deliveries even in the homes of the poor, with a very low morbidity and mortality'. The success of midwives employed by the outdoor charities and the extensive use of well-trained and regulated midwives in Holland, Denmark, Italy and Scandanavia bore witness to this.⁴² Secondly, offering her services for as little as 2s 6d compared to a doctor's fee of between 7s 6d and a guinea, she was cheap, but more importantly supportive, helping with the

household chores and child care, and providing, where possible, advice, information, emotional support and friendship.⁴³ As one woman explained from Worcestershire, in 1892, she

always had the 'woman who goes about nursing' [as midwives were called in the West Country and elsewhere] [because] she did not see the good of paying a doctor a guinea fee just for the time, and looking after her and the baby for a few days afterwards, when she could get a woman who would do all that was needful at the time, and wash the child when it was born, and then attend her and the child for nine or ten days all for 5/-.⁴⁴

Whilst not denying that there were real 'Sairey Gamps', most historians, with the exception of Shorter, have agreed with Loudon that 'sections of the medical profession' were even less suitable, because they 'did not take the contagious theory seriously enough to apply strict antiseptic precautions' and 'often embarrassed, confused and frightened', they 'tended to intervene more and more'.⁴⁵ This had a detrimental if not fatal impact on the lives of many women, as Victoria Wignall, born in Wigan in 1900, testifies. At the age of 20 and attended by a doctor, she gave birth for the first time and left the labour room 'tired, weak and in constant pain', only to be told it was nerves and that she would soon recuperate. 'I was ashamed of what I thought was my lack of character', she recalled, 'and tried to do all in my power to overcome my pain and weakness. I struggled for many months as do many mothers, washing, scrubbing, cooking and nursing with too many trials and disappointments to describe'. Following the birth of her

second child, again delivered by a doctor, the pain became acute, but another seven years lapsed before she was referred to a specialist who discovered extensive internal injuries caused by instruments used in her first labour, 'and all for the want of proper means of training'.⁴⁶

Snubbed by the most esteemed members of the medical profession and treated 'as the handmaid of medicine and surgery', midwifery for many years was regarded amongst medical students and tutors as a 'Cinderella subject', a neglected, haphazard discipline of medicine, to be looked upon as a 'nuisance' and 'completed in the shortest possible time'.⁴⁷ It was not until 1886, for example, 28 years after the mandatory registration and instruction of all practising doctors, that midwifery was made a compulsory element of the medical examination. Even then, still lacking in prestige and status, it was squeezed into a short summer course of lectures and observations of a dozen confinements, 'in favour [for example] of an exhaustive study of obscure nervous diseases or prolonged attendance at major surgical operations'.⁴⁸ As a result, there was a striking imbalance in the syllabus to the extent that a newly qualified doctor equipped only with his 'little Red Herman' would find that he had been 'taught surgery which he never practised and that he practised midwifery that he had never been taught'.⁴⁹ Yet, 'as soon as the student was qualified the public trusted him to perform the more difficult operations which he had rarely seen and almost

certainly never performed'.⁵⁰ It was, as one distinguished obstetrician, Dr. W. S. Playfair, noted, 'a manifest and ridiculous absurdity, leaving health blighted and homes rendered desolate by the lamentable ignorance of a large and important part of practice'.⁵¹

Yet it was not only doctors who engendered puerperal fever, Shorter wishes to remind us, but also midwives, who in many instances examined and attended women before the doctor was called in. The midwife, Shorter claimed, was just as likely to be a cause of septic deaths as the doctor, because of the internal examinations she performed. 'The problem', he explained, 'was the exploring hand not the gender of the attendant'.⁵² This is undeniable for amongst working-class mothers doctors tended to come to a labour only after the mother had been examined and attended unsuccessfully by the midwife or when a complication arose, which customarily and after 1902, by law, had to be attended by a doctor.⁵³

These claims, however, are academic, for Shorter subsequently denies that there was any significant degree of incompetence in the labour room anyway, suggesting 'that British Statistics were at fault, rather than British birth attendants'.⁵⁴ Using what he referred to as 'checkback studies' conducted in the 1920s and 1930s, which re-evaluated the information recorded by general practitioners on death certificates when a maternal death occurred, and exposed many sepsis deaths that had been mis-reported or omitted, Shorter claimed that full-term maternal mortality, especially death from infection, fell

sharply after the 1880s. What kept the maternal mortality rate high, he argued, was an increase in deaths from septic abortion rather than childbirth itself. The checkback studies revealed that full term and abortion-related sepsis deaths were being assigned by doctors 'anxious...to avoid the odium of malpractice' to 'every [other] reporting category imaginable', in particular deaths from puerperal sepsis, the returns for which were inflated by as much as 50 per cent. Eliminate this discrepancy, Shorter argued, and we are left with a declining death rate in full term mothers, thus fully vindicating the British birth attendant, both midwife and doctor.⁵⁵

Shorter's hypothesis, hardly surprisingly, has been received by an international symposium of historians and demographers with a certain degree of caution and scepticism.⁵⁶ His data were contradictory, for on the one hand he claimed puerperal fever deaths were highly under-reported, but on the other that they were in decline. His data also had very limited application, for his 'checkback studies' were largely restricted to post-World War I maternal deaths, invalidating his claims for the late-Victorian and early-Edwardian era. What does warrant further consideration, however, in the light of Loudon's use of North American sources to discredit the maternity hospital and the failure of McKeown, Tew, Chamberlain and others, to consult hospital sources, is Shorter's reference to the sharp decline in hospital maternity deaths from the 1880s, the validity, relevance

and implications of which, will be considered in the remainder of this introductory chapter.

The Maternity Hospital - A Variable Worthy of Analysis ?

The major objective of this enquiry is to re-introduce the voluntary maternity hospital into the maternal mortality debates, not simply to challenge its popular 'gateway to death' image, but to revise it, by claiming that the very presence of the maternity hospital moderated, if not actively reduced, the maternal mortality levels of its host community.

The principal flaw with current perceptions about the maternity hospital is their tendency to project, consciously or otherwise, the disparaging accounts of maternity hospitals of the 1860s and 1870s into the 1880s and beyond. During this earlier period, when a hospital confinement was estimated to be ten times more fatal than a home delivery, contemporary observers, including Florence Nightingale, William Farr, Evory Kennedy, A. B. Steele and J. E. Erichsen, were indeed highly critical.⁵⁷ 'The fact is', concluded Erichsen of University College London (1874), 'a woman had a better chance of recovery after delivery in the meanest, poorest home than in the best conducted hospital'.⁵⁸ Such an institution, it was argued, was little more than 'a propagating house for every form of puerperal fever', 'an evil of enormous magnitude', whose 'excessive', 'horrible and appalling'

mortality figures, were 'far, far greater ...than among women lying-in at home'.⁵⁹ None was more cutting, however, than the Lancet, which dismissed the work of the maternity hospital as a 'catastrophe' and a 'disaster'. It would not be satisfied until these 'charnel houses for parturient women' were abandoned 'at once and forever'.⁶⁰

Whilst the anti-maternity hospital lobby had gained much support and ran an effective campaign, forcing, for example, the closure of the Birmingham Lying-in Hospital in 1867, it was essentially a mid-Victorian phenomenon whose vitality and fervour waned in the late 1870s, following the dissemination of the 'doctrine of septic poison' and the introduction of antiseptic-aseptic techniques. Thus, by the end of the nineteenth century, the Lancet was one of the maternity hospital's staunchest supporters and amongst the first to confess that,

Whereas formerly the mortality of private practice was greatly less than that of lying-in hospitals, of late years, the tendency is in the other direction.⁶¹

Seeking 'to preserve the sweetness of the atmosphere and the purity of the hands, instruments and co.[sic]', maternity hospitals, by the mid-1880s, became far more aware of the contagiousness of puerperal fever and the need for 'good air, good food and perfect cleanliness'. As one Lancet editorial observed, 'The days are passed [sic] when any worker can venture to be seen with soiled hands or nails that do not seem to be on friendly terms with the nail-brush'.⁶²

The Edinburgh Royal Maternity Hospital epitomised the new institutional practices by systematically applying antiseptic and aseptic techniques, including the disinfecting of hands, instruments and appliances, and the use of disposable sponges and linen fabrics. The immediate result was a reduction in the death rate from one in 27, to one in 75 (1879-82). One in 75 deaths was still relatively high, but the Lancet felt this was only to be expected, because of the hospital's proportionally higher intake of complicated cases. 'A hospital exists', the Lancet proclaimed, 'not for a show of tables of mortality but for the accommodation of the afflicted'.⁶³

Ironically, the maternity hospitals which had so inflated puerperal fever deaths during the 1860s were, two decades later, highly acclaimed for their effectiveness against puerperal mortality and their ability to demonstrate that it could be avoided. Although it had been realized for some time that puerperal fever was 'a markedly preventable disease' the supporting evidence was not widely available until maternity hospitals began to apply antiseptic-aseptic methods and 'substantially' reduce puerperal fever deaths to 'a point even less than that of obstetrical practice generally' if not 'almost to vanishing point...'.⁶⁴ Thus, from the mid-1880s maternity hospitals were regarded by both the medical press and health officials as models to be applauded and emulated, since 'medical man [now] had the high standard of lying-in hospitals by which to judge his own success'.⁶⁵

As expectations of what constituted cleanliness rose and the measures expected to achieve it multiplied, the chasm between institutional and domiciliary practice became even more distinct. Writing in the early 1920s, Janet Campbell, for example, found the home birth 'in striking contrast to the methods recommended', for

Gloves are rarely worn. A gown or coat is the exception. Sterile pads and towels are not at hand, and the bed may or may not be covered with clean sheets...If forceps are used they are frequently imperfectly sterilized. There is often insufficient light for a satisfactory examination of the perineum and vagina for lacerations.⁶⁶

Looking forward 'to a steady and substantial increase in the number of maternity homes and hospitals...', for Campbell, the hospital birth was literally the healthier competitor. She still found, sixty years after the introduction of antiseptics, which had 'led to the practical disappearance of puerperal fever from lying-in hospitals', that 'similar success, has not, as already indicated, followed in the private practice of midwifery'.⁶⁷

In addition to prophylactic methods to counter puerperal fever there was a series of improvements in obstetric technique, often the fruit of hospital activity, to deal with other major problems of childbirth. There was, for example, a marked reduction in the use of embryotic instruments such as perforators, crotchets and craniotomy forceps, which were used largely in cases of contracted pelvis to crush and extract the skull of the foetus, alive or dead, with crippling, if

not fatal consequences to the mother. 'The whole tendency of modern midwifery-practice', explained Alfred Meadows amidst cries (at the B.M.A. summer conference, 1886) of 'child-murder by craniotomy', 'a revolting' and 'abhorrent custom', 'is setting very decidedly in the direction of absolutely and entirely abolishing this most abominable and brutal proceeding...'.⁶⁸ There was, Thomas Moore Madden concluded at the same time, but quite independently of Meadows, such a rapid decline in the use of embryotic instruments 'as to lead to a confident expectation that all such implements...will be regulated from the obstetric armamentarium to the Chamber of Horrors of some future museum'.⁶⁹

Whilst those expectations were not fulfilled as quickly as perhaps Meadows and Madden would have hoped, with craniotomy still featuring amongst the 'obstetric armamentarium' of the 1920s, the fact that there was detailed and lengthy discussion on the subject suggests a change in attitude towards obstetric care and a genuine search for safer, less painful and more effective means of delivery. The concerted effort to secure new alternatives to deal with the problem of the contracted pelvis, including caesarian section which was performed with increasing success from the late 1880s and induced labour, whose maternal mortality and morbidity rate was 'practically nil', is evidence of this.⁷⁰

Simultaneously, there was growing caution displayed towards the use of forceps and condemnation of those who applied them with 'undue haste' and 'mischievous

recklessness'. As early as 1877, for example, the President of the London Obstetric Society made forceps abuse the subject of his inaugural address and called for the more 'timely' and 'appropriate' use of forceps as determined by experienced and skilled practitioners.⁷¹ Parallel to this were growing fears that obstetrics, as Japp Sinclair of the Southern hospital, Manchester, remarked, was 'largely surgical - too surgical', and accompanying pleas for giving the 'natural laws of labour' every opportunity of effective delivery.⁷²

These comments, which really repeat what was said at the Obstetrical Society in 1877, were made in 1897, showing little change in twenty years except in the hospital. Sinclair, who raised these concerns and avoided intervention, was a leading figure at the Southern Maternity Hospital, Manchester. Other innovative ideas and techniques were similarly pioneered in a hospital setting, such as the first successful series of caesarian cases which were carried out by Murdoch Cameron at The Glasgow Royal Maternity Hospital (1888-89) and the means of dealing with eclampsia, a problem never solved in this period, but which was most effectively treated by Ernest Tweedy at the Rotunda (1903-10).⁷³ Thus it was the hospital more than any other sector of medical practice which was at the hub of obstetric activity, devising pioneering methods and ideas as well as providing the most receptive audiences.⁷⁴

There is every reason therefore, to re-consider the maternity hospital as a variable of some importance,

particularly as Loudon's present explanatory model of local variations in maternal mortality rates remains responsive to further analysis, revision and causal interpretation. Loudon's work has, for example, been recently criticized by Enid Fox, for failing to consider with any academic rigour the effects of socio-economic factors, in particular malnutrition, on maternal mortality.⁷⁵ By Loudon's own admission this influenced deaths from haemorrhaging and, in the form of an improved wartime diet, contributed to the sustained decline in maternal mortality, but not before 1941, by which time poverty and malnutrition played only a minor role.⁷⁶ Whilst an important factor, deserving more analysis, there is currently insufficient evidence concerning the role of diet to challenge Loudon's clinical interpretation of what influenced maternal health and mortality profiles. Of more immediate concern is Loudon's claim that 'the presence, or absence of well-trained midwives' was the chief determinant of maternal mortality variations between different localities.⁷⁷

Whilst the midwives' presence in the labour room, as has been suggested, was undeniably important, there are nonetheless certain limitations to the scope and validity of Loudon's claim. Firstly, it underestimates the importance of skilled medical assistance, particularly when there was a complication of labour which a midwife was not qualified to treat, and who was obliged by law, after 1902, to call a doctor. Secondly, Loudon fails to consider the origins of the 'well-trained midwives',

**TABLE 0.2: THE ADMINISTRATIVE COUNTY OF LANCASHIRE
MATERNAL MORTALITY RATES AND OTHER RELEVANT DATA
1919-1922**

	Maternal Mortality Rates (Per 1,000 Live Births)			No. of Midwives Births % By Trained		% of Women Working 1921 Single Married		Total Birth Rate	Infant Death Rate	General Death Rate
	Puerperal Fever	Other Accidents	Total Rates							
Blackpool	2.83	4.72	7.55	69%		64%	22%	14.3	73	
Rochdale	1.80	5.25	7.05	68%		82%	26%	18.0	98	14.2
Bury	2.83	3.60	6.43	80%	56%	78%	30%	16.9	90	14.8
Oldham	2.77	3.64	6.41	68%		61%	25%	19.5	105	15.2
Blackburn	2.13	4.06	6.19	80%	76%	82%	41%	18.1	104	13.9
Preston	2.32	3.28	5.60			79%	31%	21.6	105	13.8
St. Helens	2.02	3.11	5.13			50%	7%	28.3	112	13.5
Southport	1.87	3.04	4.91			59%	13%	14.9	66	
Burnley	1.79	3.11	4.90			82%	41%	19.8	121	14.4
Barrow	0.97	3.73	4.70			51%	7%	24.0	86	
Bolton	1.86	2.83	4.69	82%	74%	80%	17%	19.9	94	13.6
Salford	2.63	1.89	4.46			72%	18%	23.5	104	13.7
Wigan	1.90	2.53	4.43			71%	10%	26.0	117	15.0
Warrington	1.43	2.98	4.41			68%	9%	24.5	90	12.2
Manchester	2.16	1.72	3.88	61%		72%	19%	22.3	97	13.6
Liverpool	1.71	1.78	3.49	78%	100%	63%	12%	28.7	107	15.3
Bootle	1.20	2.05	3.25			60%	8%	26.7	93	13.0
Lancashire	1.84	3.16	5.00			70%	20%	19.5	90	
England/Wales	1.57	2.54	4.11							12.8

Source: J. Campbell, 'Maternal Mortality', Reports on Public Health and Medical Subjects, 25 (London, 1924), Appendix A

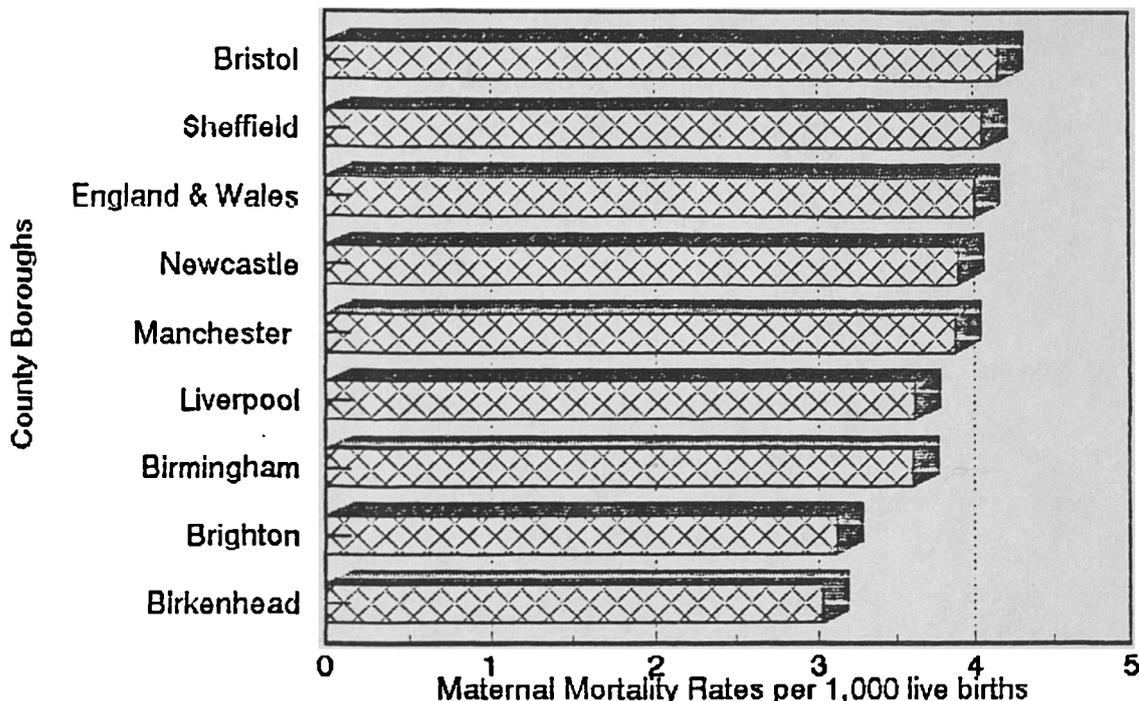
which raises questions about where midwives prior to 1902 were trained, and by whom, and once qualified, where and for whom they worked, for their fees would have been beyond the means of most working-class women. Thirdly, as the following reference to Lancashire illustrates, the presence of trained midwives alone cannot fully account for the disparity in regional maternal mortality rates.

By the 1920s, 80 per cent of practising midwives had received a formal training and, subject to routine inspection and classroom instruction, were far more closely supervised by local health officials.⁷⁸ Yet the communities of which they were an integral feature were still displaying excessive maternal mortality levels. In Bury, in the county of Lancashire, for example, where up to 80 per cent of births were conducted by midwives who provided a generally good service, the town had the seventh highest maternal mortality rate in England and Wales and the third highest in the county (1919-21) (Table 0.2).⁷⁹ Similarly, in neighbouring Blackburn, during the same period, more than 80 per cent of the town's annual birth total was attended by midwives, over 75 per cent of whom had received some form of training, yet Blackburn had the tenth highest maternal mortality rate in the country (1919-21) (Table 0.2).⁸⁰ Skilled midwives were available and from 1921 an ante-natal clinic was fully operational, but what Blackburn lacked and the local Medical Officer of Health, Allen Daly, demanded, was a small lying-in hospital, as 'absolutely necessary if our Maternity and Child Welfare scheme is to

be complete'.⁸¹ Indeed, most Lancashire boroughs were similar in character to Blackburn, where few handy-women practised because of the threat of prosecution by local police and where their registered midwives were regularly visited, monitored and tutored, yet in all but three of the county boroughs, their maternal mortality rate was above the national average (Table 0.2).

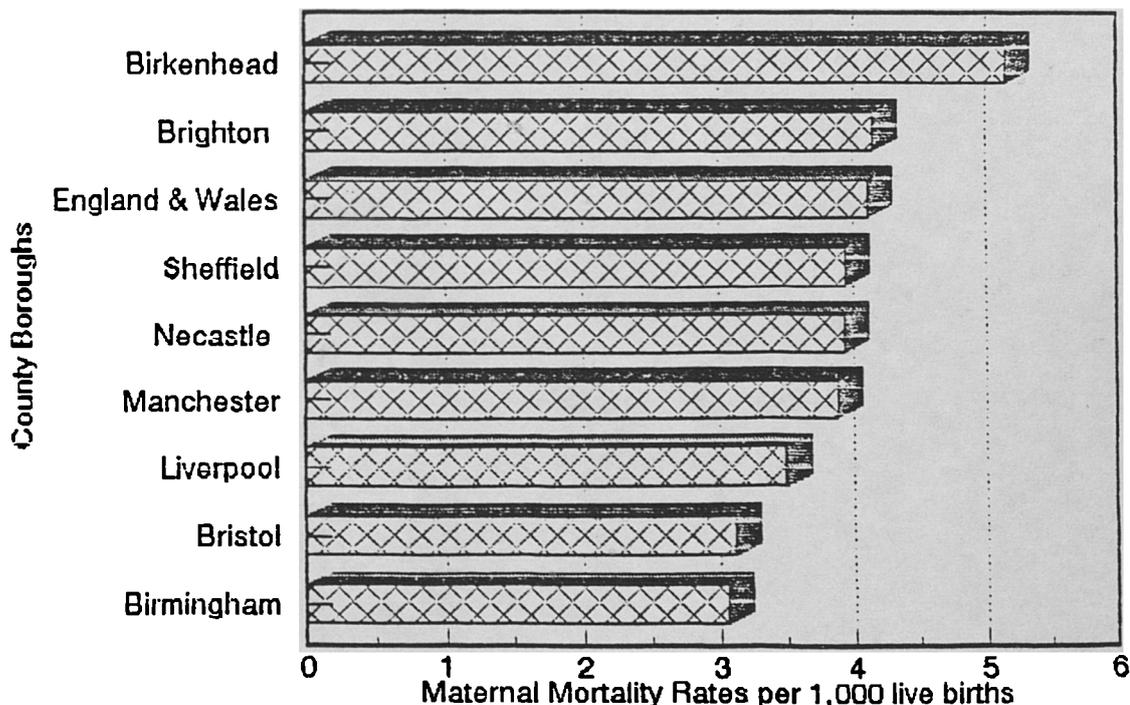
Trying to account for the high maternal mortality rate, Daly felt that it was 'not unlikely that [it was] ...associated with the employment of so many married women in industrial occupations'.⁸² This, and the fact that most of these Lancashire towns, which displayed equally high infant mortality rates, were with the notable exception of Blackpool, industrial centred, with poor housing stock and deficient sanitary facilities, may well have been an explanation. Yet in this sense, they were no different from the much larger urban centres of Manchester and Liverpool, the latter of which had a higher infant mortality rate, 'the poverty barometer', than Blackburn and Bury, but a much lower maternal mortality figure. When the maternal mortality rate for Lancashire was, on average, 5.00 deaths per 1,000 live births and for England and Wales 4.11 deaths per 1,000 live births (1919-21), the maternal mortality rates for Manchester and Liverpool were 3.88 and 3.49 respectively. This gave them the sixty-ninth and sixty-third lowest maternal mortality positions amongst the eighty-two provincial boroughs in England and Wales and two of the

FIGURE 0.2: COUNTY BOROUGHs WITH MATERNITY HOSPITALS AND THEIR RESPECTIVE MATERNAL MORTALITY RATES 1911-14



Source: J. Campbell, 'Maternal Mortality', Reports on Public Health and Medical Subjects, 25 (London, 1924) Appendix

FIGURE 0.3: COUNTY BOROUGHs WITH MATERNITY HOSPITALS AND THEIR RESPECTIVE MATERNAL MORTALITY RATES 1919-22



 Mortality Rate: Puerperal Sepsis and Other Accidents of Childbirth

Source: Arthur Newsholme, A Report on Maternal Mortality in Connection with Childbearing, 44th Annual Report of the Local Government Board 1914-1915 (London, 1915)

lowest rates in the County (Table 0.2).⁸³ Indeed, it was cause for comment by maternal mortality analysts, Janet Campbell, Arthur Newsholme and Isabella Cameron, that it was

much more hazardous for a woman to give birth to a child in say Halifax, Blackpool or Rochdale, than in Manchester, Newcastle-upon-Tyne or Birmingham.⁸⁴

Whilst certainly not the only answer and one that has to be more thoroughly researched, it is tempting to argue at this stage that the one of the principal variables distinguishing Manchester, Birmingham and Newcastle, less than 30 per cent of whose births were attended by midwives (1911-14), from Blackpool, Halifax and Rochdale, was the presence, in the former, of established maternity hospitals. In these county boroughs with the highest maternal mortality there were either very few or no institutional maternity facilities. In contrast, in the eight provincial towns with established maternity hospitals, the maternal mortality rate was generally below the national average, despite high poverty levels, poor sanitation and substandard housing (Figures 0.2 and 0.3). By 1922, all but one of these towns, Birkenhead, was in the top 40 per cent of boroughs displaying the lowest maternal mortality levels.⁸⁵

Issues and Objectives

Regarded as a crusading force against puerperal fever and as a local, but nonetheless important determinant of maternal mortality rates, there is little justification to argue, as Loudon and most other historians do, that the maternity hospitals until the 1930s were 'a major factor in high mortality rates'. On the contrary, there is every reason to believe that if the maternity hospital delivered a sufficient number of parturient women, either in their own home or in hospital, it could have acted as a moderating influence upon local maternal mortality levels. Loudon himself has unveiled an 'impressive' list of international examples of maternity hospitals, including the Rotunda Hospital in Dublin and the York Road Lying-in Hospital in London, which introduced antiseptic and aseptic methods with 'remarkable results', reducing sepsis deaths to insignificance. What Loudon fails to do, however, is reflect on this, assess their representativeness and explore the implications. Nonetheless, his work provides a useful starting point for subsequent research and discussion on the role of the maternity hospital.⁸⁶

Before outlining the research proposal, several issues and points of definition need to be clarified. Firstly, whilst childbirth involved two lives, mother and child, and entailed a 'four fold evil' (a high maternal mortality rate, subsequent invalidity of the mother, a relatively large number of still-births and an excessive

mortality and morbidity rate amongst young infants), this research is primarily concerned with the mother's life and the first of these 'four evils', namely maternal deaths.⁸⁷ Secondly, with the exception of Chapter 1, which will provide an overview of institutional midwifery, the discussion will concentrate on the voluntary maternity hospital and in the case of the Jessop, Sheffield, and St. Mary's, Manchester, women's hospitals with substantial maternity departments. This is because this type of hospital bore the brunt of the criticism and for which, unlike the Poor Law sector, the relevant information is readily available. Thirdly, the focus will be on the relatively unknown English provincial maternity hospitals and their host communities.⁸⁸ This will allow us to escape from Loudon's impressive but not necessarily representative list of internationally reputed hospitals and to present more 'typical' examples of institutional midwifery.

This has been achieved by responding to a series of key issues:

I Establishing for whom the maternity hospital was intended

Governed by admission criteria, restricted catchment areas and recommendation procedures, it is important to establish which women were accepted with regard to: their age, marital status, health condition, past obstetric history, home circumstances and,

where possible, their ethnic origins and economic and social circumstances.

II Quantifying in what numbers women were attended

Once the category of women accepted, as ward or home cases, is not only identified, but also quantified, then the hospital's demographic relevance to the annual total of local births, an important means of assessment, can be ascertained and comparisons can be drawn with other maternity institutions, including the local workhouse and general hospital.

III Determining by whom the women were confined

As so much emphasis is placed on the quality of obstetric care, in particular the calibre and gender of the birth attendant, it is important to assess whether hospital cases were attended by midwives or doctors. If the former, then questions have to be asked as to whether they were trained, experienced and properly supervised, or little better than the local handy-women, ignorant and unrestrained. If the latter, then similar questions have to be asked of the medical staff, for on the one hand they may have been qualified, experienced and leading figures of their profession, which brought advantages for the women under their care, or on the other hand, junior members of their profession, perhaps even students, ill prepared to deal with childbirth, natural or otherwise.

IV Identifying by whom these services were provided

As the role of the maternity hospital was largely influenced by the ideas, aspirations and efforts of its sponsors and volunteers, it is necessary to consider the personal profiles of those who paid the midwives' salaries, underwrote the daily running costs and volunteered their time to appoint staff, balance the books and formulate policy. This will be achieved by reviewing the composition of the subscription lists and Boards of Management, paying particular attention to whether there was a lay or professional bias to this and the nature and extent to which women were involved. With respect to the latter, it would be rewarding to discover whether women played a significant, if not leading role in the development of an institution which ostensibly served their own gender, or as some historians currently believe, acted as mere amateurs, 'doll's house women', performing subservient and insignificant tasks.⁸⁹

V Assessing for what reasons:

(i) doctors, at the apex of their profession, devoted their time without pay, compromised their professional autonomy and dealt with the most impoverished.

(ii) the lay public not only donated their money, but also their time for a service from which they could not personally benefit.

In the doctors' case, it may have been for personal gain: to demonstrate their 'gentlemanly status', legitimize their specialty and enhance their professional careers, or it may have been a genuine response to a local need. In the case of the lay public, it too may have been for personal rather than humanitarian reasons: to gain social recognition and acceptance, to pacify the masses, to provide an insurance policy for employees, or quell a deep sense of guilt.

These issues are important when determining how those holding various ideologies, men and women, professional and lay, defined the hospital's role and how they influenced hospital policy, either through debate, negotiation and compromise, or domination and dogmatism.

VI Reviewing the expectations of provider and recipient

Once accepted by the hospital for a confinement, it is necessary to establish, what choices women could make for themselves, over whether, for example, they were delivered at home or in hospital, by a doctor or a midwife, in the company of family or strangers and by interventionist or natural means. It is also important to ask what women could expect in terms of standards of hygiene, the quality of birth attendant

and the degree of technical expertise in an emergency situation and whether they could expect on a personal level, financial help, assistance with domestic chores and an opportunity to recuperate fully during their confinement and lying-in period.

On the other hand, women's views may have been secondary to the ideologies and aims of the birth attendants and benefactors, so it is equally important to ask what medical staff, doctors and midwives, could expect from their hospital with regard to: a voice in its management, professional prospects and autonomy, the quality of training, the levels of supervision and support and the opportunity for lucrative introductions to private cases.

VII Analysing the Overall Effects of Maternity hospital Provision

Combining much of what has already been said, the ultimate aim is to determine whether or not women who entered hospital for a normal delivery left alive and well, whether those who endured a complication survived, and if there were any other advantages or indeed drawbacks to being confined in a maternity hospital as opposed to a home. In short, did the absence or presence of a maternity hospital make any real difference to the local mortality profiles or did it merely influence the lives of those who passed through it?

The Contribution To Current Literature

When answering these questions, the thesis will not only seek to revise current historical thought about the maternal mortality debate, it will also, in the process, respond to recent demands for 'new institutional histories of hospitals' and for 'total hospital histories'.⁹⁰ Perhaps a commemorative publication or a text compiled by a former employee, most hospital histories to date have been largely conducted on antiquarian lines, 'content to string together star names and momentous dates'.⁹¹ As a result, we are left with a 'chronological aide-mémoire', so steeped in parochialism and hampered by stories of famous doctors and celebrated philanthropists, that little is said about the patients, the support staff, the volunteers and sponsors, about what actually went on in hospital from day to day and about the hospital's relationship with its host community, of which it was an integral feature. The need, therefore, to redress these deficiencies and place the 'total hospital', patients as well as staff, firmly in its historical context, remains pressing.

Where historians such as Risse, Lane, O'Gràda and, to a lesser degree, Woodward and Cherry, have begun to respond to these problems and probe more deeply, the focus has tended to be on the eighteenth and early nineteenth centuries, or in the case of Rivett and Granshaw, nineteenth-century London.⁹² These studies say little about the late Victorian period, the urban setting

and the provincial hospital, and even less about specialist maternity provision.

This is not, however, through lack of interest. As early as 1976, one reviewer of John Woodward's book on the British voluntary hospital system and its contribution to mortality rates, felt the work would have been better served had he also considered the maternity hospital and its role in influencing nineteenth century mortality profiles, favourably or otherwise.⁹³ This suggestion was no doubt made because of the maternity hospital's particularly high profile in the mid-Victorian debates about mortality rates in hospitals generally and their questionable ability to do more good than harm, and perhaps because Thomas McKeown, who popularised the hospital's 'Gateways to Death' image, specifically cited the maternity hospital in his controversial review of institutional provision and its relationship to changing trends in health and mortality.⁹⁴ Whatever the reason though, neither Woodward nor anyone else has risen to meet the criticism. Yet, still maligned for no justifiable reason other than the short-lived puerperal fever scandals of the mid-Victorian period, and still in the midst of this long debated but inconclusive controversy about the hospital's contribution to communal health care and mortality levels, there is every reason to re-open the discussion and introduce the maternity hospital as a very relevant case example.⁹⁵

Another important discussion to which an intensive study of the maternity hospital would contribute,

concerns the relatively new field of study, of the history of childbirth. One widely held assumption of many scholars is, that the maternity hospital was little more than an instrument with which to secure male domination and professionalisation. For Margaret Versluysen the maternity hospital was part of a nascent process of professionalisation, aimed at subordinating female midwives and their patients to medical authority. 'It was the desire to establish male control', she claimed, 'rather than therapeutic advances in medicine that provided the impetus for the creation of maternity hospitals'.⁹⁶ Likewise, Patricia Branca has argued that obstetrics, of which the maternity hospital was invariably the flag-ship, was similarly a product of 'the professionalisation process...designed in the first instance, in the interest of doctors who needed new jobs and new claims to knowledge, and only somewhat later benefited the personal clientèle'.⁹⁷ These professional needs were, in Marjorie Tew's opinion, largely satisfied by the maternity hospital which served as 'a very effective means of gaining competitive advantage by reducing the power and status of midwives and confirming the doctors' ascendancy over their professional rivals'.⁹⁸ Women's exclusion from the management of childbirth, was, however, in Anne Oakley's opinion, not just a product of professionalisation, but also symptomatic 'of the male medical profession's misogyny ...facilitated by changing economic and social conditions'.⁹⁹

In stark contrast, Edward Shorter has argued that the medicalisation of childbirth, of which the hospitalisation of maternity cases was an integral feature, eliminated the pain and death associated with birth and made it spontaneous and joyful, as well as safe. It was also, he claims, a conscious decision on the part of women themselves to medicalise birth, to turn to doctors in preference to midwives and to choose a hospital bed not a home delivery, rather than any concerted act on the part of doctors to impose these conditions on women.¹⁰⁰

There is, as Wally Seacombe noted, a great deal of conflicting evidence and superficiality about current debates on the medical takeover of birth. On the one hand there are the 'radical feminists who...denounce the conversion tout court', and on the other, individuals like Shorter who can do nothing but praise the doctors for grasping the reins and moulding the hospital in the profession's own image.¹⁰¹ This controversy urgently needs a hospital perspective using hospital sources to the full. Such a study might help to explain the mechanics of and the reasons behind the hospital's transformation from a lay to a professionally led institution. It might also aid the evaluation of the impact of these changes upon the confinement and fate of hospital maternity cases, for they were amongst the first generation of women to experience the so-called medicalisation of childbirth on any great scale.

Sources

As six of the eight chapters focus very closely on the voluntary maternity hospital, the bulk of the evidence has been derived from institutional archives (published annual reports, commemorative issues, appeals and financial statements), including a number of private and often very confidential sources (management and medical committee minutes, personal papers, special reports, staff and patient registers). Common to all six maternity hospitals considered (the Newcastle, Liverpool and Birmingham Lying-in Hospitals, the Jessop Hospital, Sheffield, and St. Mary's and the Southern, Manchester) are the annual reports, whose value is not just in the voluminous amount of background information they contain but also in the number of avenues they open to facilitate further enquiry.¹⁰² Thus, in addition to very basic details about the form and scope of provision offered, the structure of administration, the system of admission and the sources of income and areas of expenditure, the reports also provide the names of the volunteers who ran the Boards of Management and various sub-committees, those who served on the medical staff or as midwives, and the names and addresses of those who annually subscribed to the hospital. From these lists and in conjunction with medical and trade directories, newspaper obituaries, census data and library bibliographies, it will be possible to re-create personal profiles of the lay volunteers and professional staff, to provide information about their families, where they lived, their

occupational and social interests and, in the case of the last, their medical qualifications and experience.

The problem with the annual report, the most comprehensive and abundant source of hospital information, is that as a publicity feature, and therefore intended to play on people's sympathies and ultimately coax them into giving money, it presents the hospital in the best possible light. This meant that much went unsaid; patient figures were forever fluctuating, as were the number of subscribers, the rules and regulations were constantly being altered and staff and volunteers came and went, but no explanation is ever offered 'nothing but vague general statements'. The material is, as Roy Porter remarked, 'familiar and bland ...uplifting, uncontroversial and soothing', as infuriating to contemporary observers as it is to historians today.¹⁰³ The editor of the Birmingham Daily Post, for example, took the city's maternity hospital to task in March 1867 for its presentation of its patient statistics. The hospital's annual reports, he wrote,

tell us in gross numbers how many patients have been treated during the last year, distinguishing sick from midwifery cases, and in-patients from out-patients. But they do not tell us how many of the sick patients are children: they give no information of the numbers of beds in the house or the number occupied; they tell us nothing whatever of the duration, or the nature of the cost of these cases: and they are entirely silent as to the proportion of deaths to recoveries. In fact, in these documents all the details what should be found in hospital reports, are conspicuous by their absence.¹⁰⁴

What was not disclosed in public, however, may well have been recorded in private, in either the Management and Medical Committee minutes, which exist for four of the six hospitals, excluding the Southern and the Birmingham Lying-in Hospitals, or in the maternity registers, of which there are still examples for the Southern and Jessop. With respect to the former sources, which focuses on the weekly and monthly meetings of the Board of Management and Medical Committee and also, in the case of the Jessop, the Ladies' Committee, the minutes offer some substance to the published evidence. They may, for example, account for the sudden departure of members of the Board of Management, detail the struggle to appoint female doctors and Board members, explain the philosophy behind the rejection of single women or highlight the pitfalls of training medical students and pupil midwives. Moreover, if attention is paid in the minutes to those proposing, amending or objecting to any one of these particular issues, be it a Governor of the Board, a member of the Ladies' Committee, a subscriber or an Honorary Medical Officer, then group ideologies and interests can also be identified, the interplay of these can be monitored, the predominance of one over the other can be noted and their impact on hospital provision assessed.

As for the recipients of such provision, the information as to who they were and what they experienced whilst in hospital, can also be partly derived from the minutes, but the ideal source for this is the maternity

register, for which only one exists for the Southern (December 1899 - January 1901) and one for the maternity department at the Jessop (May 1879 - October 1896). Listing name, age, address, marital status and previous number of labours, including, in the case of the Southern, miscarriages and notes about their obstetric histories, it is possible to assess who these women were, the areas of the city and types of housing from which they came and the difficulties they were likely to encounter in labour. Once in hospital, from the data concerning admission, delivery and discharge dates, the timing of the various stages of labour (at the Southern only), the nature of the complication, if any, and the outcome of birth for mother and her newborn may all be discovered. It will also be possible to gain an impression of what sort of work the hospital actually did, what complications they could not deal with, how well, if at all, women survived the experience and how long they remained in hospital. In the absence of a long series of registers, however, identifying changes over time, perhaps as a result of a medical discovery or innovation, the appointment of a new doctor or an alteration in admissions procedure will remain difficult.

Nonetheless, what information the registers do provide is important, provided that it is placed in context and like other institutional evidence, is used in conjunction with non-hospital material. Thus in all five cities under review (Manchester, Liverpool, Birmingham, Sheffield and Newcastle) sources include local Medical

Officer of Health Reports, housing and sanitary surveys, local health society papers, newspaper editorials, relevant Parliamentary enquiries and independent research by local doctors and former health officials. From this material it will then be possible to identify the categories and proportion of local parturient women who were confined by the maternity hospital and assess its role, if any, in influencing local mortality profiles. Those sources will also be used to consider the quality of alternative obstetric practice and the range of other possible causes of the local maternal mortality rate.

In addition, contemporary midwifery texts, specialist obstetric journals, maternal mortality reports, newspaper editorials and the British Medical Journal and Lancet, will be used extensively to provide a context for the changing trends in obstetric provision, focusing, for example, on the choice of treatments at a complicated labour or on the reasons for various decisions and actions taken by a hospital's medical staff in certain circumstances. The first objective, however, using non-institutional sources, will be to draw on Burdett's Hospital and Charities Annual, Parliamentary Commissions, Returns, Memoranda and Reports, Chief Medical Officer of Health Annual Reports, medical journal surveys and the Journal of the Royal Army Medical Corps, to give a provincial perspective of maternity hospital provision in relation to other forms of institutional maternity care, including workhouses, general hospitals,

military establishments and from the 1920s, maternity homes.

One of the difficulties appreciated by Lara Marks, Ann Oakley and others who have consulted this kind of material, particularly institutional sources, is that most of it is compiled by those who provided the service rather than those who received it, namely working-class women, about whose views and recollections of a hospitalised birth we know very little.¹⁰⁶ Given that the thesis concentrates largely on the late Victorian and Edwardian period it was not considered feasible to conduct oral interviews.¹⁰⁷ With regard to what little literature there exists by working-class women on the subject, most notably, Maternity, a published collection of letters by members of the Women's Co-operative Guild on their reproductive experiences between 1880 and 1910, there is also a distinct lack of references to a hospitalised birth. Of the 160 letters included in Maternity, which addresses a whole number of issues indirectly related to this study (maternal ignorance, the stress and trauma of birth, obstetric malpractice and post-natal difficulties) only two of the correspondents were sent to hospital, one following poor midwifery treatment at home, the other in an emergency. A third and fourth were attended in their own homes by a hospital midwife and a doctor respectively. Neither of the women sent to hospital recollected their experiences whilst there, but both, who were dealt with by doctors, felt they had been saved from incompetent general

practitioners and midwives outside it. The woman who was attended by the practitioner in her home added, 'I may say I had a black doctor and was never better attended in my life'.¹⁰⁸

The most vivid account of a hospitalized birth in Victorian England that is readily available comes from a novel written in 1894 by a 42 year old man, George Moore, whose heroine, Esther Waters, enters Queen Charlotte's Lying-In Hospital to deliver her illegitimate son.¹⁰⁹ It was the first time in literary history that a hospital confinement was the subject of a running commentary, cataloguing every experience, from the time Esther had to go in search of a ticket to secure admission, to the moment she was visited, by a 'well-to-do clergyman', after a very traumatic and painful birth, also the first time that such an event had been described in a novel. Though, arguably, 'the relationship of literature to reality is tenuous', Moore, as Professor Hughes remarked, 'has no axe to grind; he shows people behaving as they do behave', and all Moore wanted to do, explains George Watt, was, on the basis of first-hand observation and contemporary news articles, to tell the truth about working-class lives, including the realities of childbirth.¹¹⁰ So 'unique and controversial' was Moore's description of Esther's hospital delivery that Mr Faux of Smith's Circulating library, 'one of the mid-Victorian bastions of literary taste', banned the publication because 'we are a circulating library and our subscribers are not used to detailed description of a lying-in

hospital'.¹¹¹ These detailed descriptions will be used throughout the thesis to provide a much-needed patient perspective.

Thesis Outline

With the exception of Chapter 1, which presents an overall view of institutional maternity care, with regard the various forms it took, and where and in what numbers it was provided, the chapters adopt both a thematic and case-study approach. Thus, Chapters 2 and 3, based on a study of Manchester's two maternity hospitals and a community with a high general death rate, but a relatively low maternal mortality figure, challenge current interpretations about the role of the maternity hospital. It will be stressed that, contrary to current belief, the maternity hospital had a very positive part to play, effectively utilising a competent and distinguished body of doctors, successfully attending large numbers of impoverished women and providing Manchester with its main source of 'well-trained midwives'. Whilst comparing roles between the two Manchester hospitals and the Liverpool Lying-In Hospital, the main objective of Chapters 4 and 6, based on a study of the latter institution, is to trace the history of ideas, policy and practice behind the running of this hospital. Until the mid-1890s, the hospital, to all intents and purposes, was managed by a large contingent

of very active and very prominent female supporters and a body of medical staff whose only means of asserting their views was to withdraw their labour and boycott the hospital, which is exactly what they did in 1896, which will be the subject of Chapter 6.

The representativeness of these institutions and the conclusions drawn will be examined in Chapter 5, alongside a study of the maternity hospitals at Sheffield, Newcastle and Birmingham. These were much smaller establishments, but nonetheless have an important contribution to the wider debates. At Jessop, Sheffield, for example, the nature of hospitalised care can be explored more thoroughly because of the existence of an admissions register spanning 18 years, and at Birmingham, where the maternity hospital was closed in 1867 and re-opened in 1908, it will be possible not only to dwell on the reasons for this, but also on what both the absence and presence of the maternity hospital meant to local maternity care. Returning to Liverpool, Chapter 6 will focus on a coup at the hospital in 1896 which firmly placed it under medical control. It will also explore some implications of this for its female management, student instruction and the hospital's demographic relevance. Finally the effects of the so-called medicalisation of childbirth will be reviewed in Chapter 7, drawing on evidence from all five maternity hospitals (the Southern having merged with St. Mary's in 1905). Whether or not as a result of this medicalisation process the maternity hospital's relationship with its host

community and its influence on local maternal mortality rates changed, favourably or otherwise, will be the subject of the final chapter. This could not be completed, however, without reference to other possible causes of local maternal mortality variations, socio-economic, as well as clinical.

Notes to Introduction

1. Willaim Farr, *39th Annual Report of the Registrar General of Births, Deaths and Marriages in England and Wales, Abstracts for 1867*, p.242.
2. Sylvia Pankhurst, *Save the Mothers* (London, 1930), p.242.
3. Pankhurst, p.16. D. Baird, 'The Evolution of Modern Obstetrics', *Lancet*, 10 September 1960, p.557.
4. Common problems following such a birth, included: prolapse of the uterus, the development of a fistula and the inflammation of an unsutured perineal tear. Janet Campbell, 'Maternal Mortality', *Reports on Public Health and Medical Subjects*, 25 (London, 1924), pp.iii-iv. W. Blair Bell, 'Maternal Disablement', *Lancet*, 30 May 1931, p.1171-77.
5. Elizabeth Roberts, *A Woman's Place* (Oxford, 1984), p.109.
6. *Maternity: Letters from Working Women*, ed. by Margaret Lllewelyn Davies London, 1915 repr. (London, 1978) pp. Introduction, case no.8 p.27. case no. 9 p.28. case no. 43 p.69.
7. *Dear Dr.Stopes: Sex in the 1920s*, ed. by Ruth Hall (London, 1978), p.37. see also pp.18,23. For similar evidence, dating from the seventeenth century, of women's fears of childbirth, a practice 'imbued with dread', see: Patricia Crawford, 'The Construction and Experience of Maternity in Seventeenth-Century England', in *Women as Mothers in Pre-Industrial England*, ed. by Valerie Fildes (London, 1990), pp.3-38 (pp.17,20,22); Linda Pollock, 'Embarking on a Rough Passage: the Experience of Pregnancy in Early-Modern Society', in *Fildes*, pp.39-67 (pp.45-49).
8. Annette Rubinstein, 'Subtle Poison: The Puerperal Fever Controversy in Victorian Britain', *Historical Studies*, 20 (1983), 420-38 (p.420).
9. Willaim Farr, *30th Annual Report of the Registrar General of Births, Deaths and Marriages in England and Wales, Abstracts for 1867*, p.225.

10. The figures for 1926-30 for continuity, are based on the pre-1911 classification table which excludes details attributable to puerperal nephritis and albuminuria. Once these are directly related to childbirth (from 1911 onwards) then the maternal mortality figures are much higher, registering 4.40 deaths per 1,000 live births, (1930) and 4.27 deaths per 1,000 live births, (1926-30). *Annual Reports of the Registrar General of Births, Deaths and Marriages in England and Wales, Abstracts for 1866-70, 1926-30*
11. For difficulties in interpreting maternal mortality figures, see: Rubinstein, p.421; Willaim Gilliatt, 'Modern Mortality-Still Birth and Neonatal Mortality', in *Historical Review of British Obstetrics and Gynaecology, 1800-1950*, ed. by J. M. Munro Kerr, R. W. Johnstone and M. H. Phillips (Edinburgh, 1954), pp.257-93 (p.257); F. B. Smith, *The People's Health* (London, 1979), p.13; Irvine Loudon, 'Deaths in Childbed from the Eighteenth Century to 1935', *Medical History*, 30 (1986), 1-41 (pp.22-27); Marjorie Tew, *Safer Childbirth ? A Critical History of Maternity Care* (London, 1990), p.203.
12. William Williams 'Puerperal Mortality', *Transactions of the Epidemiology Society*, 15 (1895-96), 100-33; idem, *Deaths in Childbirth: A Preventable Mortality* (London, 1904). Andrew Topping, 'Maternal Mortality and Public Opinion', *Public Health*, 49 (1935-36), 342-49. Veitch Clark, 'Maternal Mortality', *Journal of the Royal Sanitary Institute*, 55 (1934-5), 684-95. H. E. Collier, 'A Study of the Influence of Certain Social Changes Upon Maternal Mortality and Obstetrical Problems, 1834-1927', *Journal of Obstetrics and Gynaecology*, 37 (1930), 27-31.
13. Robert Boxall, 'The Mortality of Childbirth', *Lancet*, 1 July 1893, pp.9-15, 'Mortality in Childbirth both in Hospital and in General Practice', *The Journal of Obstetrics and Gynaecology of the British Empire*, 7 (1905), 315-343. C. J. Cullingworth, 'Undiminished Mortality from Puerperal Fever in England and Wales', *Obstetrical Society of London Transactions*, 37 (1897), 91-114.
14. Janet Campbell, *Maternal Mortality, 'The Protection of Motherhood'*, *Report on Public Health and Medical Subjects*, 48 (London, 1927). Arthur Newsholme, *Supplement*

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 27. For the respective studies on sexual class and London's maternal mortality variations, see: Gilliatt, pp.271-72; Cullingworth, pp.101-05; Loudon, 'Deaths in Childbed', pp.27-34; idem, 'Maternal Mortality', p.222.
 28. Gilliatt, who first presented the evidence on social class which Loudon used, attributed the differential 'to the fact that they [poorer women] have been delivered by midwives or in hospital'. Loudon, for whatever reason, omitted to mention the latter influence. Gilliatt, p.271.
 29. Loudon, 'Deaths in Childbed', pp.34-35; idem, 'Maternal Mortality', pp.222-23.
 30. Loudon, 'Maternal Mortality', p.183.
 31. Loudon, 'Maternal Mortality', pp.220-22.
 32. Thomas McKeown, 'Medical Evidence Related to English Population Changes in the Eighteenth Century', *Population Studies*, 9 (1955), 119-

- 41 (pp.122-23); *idem*, *The Modern Rise of Population* (London, 1976), pp.103-06.
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40. Campbell, 'Maternal Mortality', p.32.
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42. Kerr, pp.61,253,301-04,326. Arnold W. Lea, *Puerperal Infection* (London, 1910) pp.25-26. Henry Jellett, *The Causes and Prevention of Maternal Mortality* (London, 1929), pp.13-15.
43. Chamberlain, 'Life and Death', p.33. Roberts, pp.106-07. Lewis, *The Politics of Motherhood: Child and Maternal Welfare in England, 1900-39* (London, 1980), p.141. Sarah Robinson, 'Maintaining the Independence of the Midwifery Profession: A Continuing Struggle', in *Politics of Maternity Care: Services for*

- Childbearing Women in Twentieth-Century Britain* ed. by Jo Garcia, Robert Kilpatrick and Martin Richards, (Oxford, 1990), pp.61-91 (p.61).
44. Mrs Maria Martin, *Select Committee on Midwives' Registration*, BPP 1892 (289), vol.XIV, Qs.690-5. quoted in Smith, p.46.
 45. Mrs Gamp, a 'callous, drunkardly and unscrupulous woman', was a fictitious character, first mentioned in Charles Dickens', *Martin Chuzzlewit* (1843), but she quickly came to represent 'the archetype of the uncaring and uneducated midwife...', dependent on 'drink, cunning and old wives tales'. Riley, p.64. Pankhurst, *Save The Mothers*, p.94. Carter and Duriez, pp.90-1. Rubinstein, p.436.
 46. Oral evidence quoted in Angela Holdsworth, *Out of the Doll's House: The Story of Women in the Twentieth Century* (London, 1988), p.87. For a review of obstetric instruction, key dates and reforms, see Janet Campbell, 'Notes on the Arrangements for Teaching of Obstetrics and Gynaecology in the Medical Schools', *Reports on Public Health and Medical Subjects*, 15 (London, 1923).
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 49. Baird, p.557. Leading Article, 'Maternal Mortality in Childbirth', *Lancet*, 19 April 1924, p.809.
 50. William Fletcher Shaw, *Twenty-Five Years: The Story of the Royal College of Obstetricians and Gynaecologists, 1929-54* (London, 1954), p.12.
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 53. See for example, Pankhurst, *Save The Mothers*, p.103.
 54. Edward Shorter, 'The Supposed "Failure of Maternal Mortality to Decline": A Case Study of British Exceptionalism?' *Paper Presented*

at Conference on Infant, Child and Maternal Mortality, University of Liverpool, 11-12 April, 1988, p.2.

55. Shorter, *A History of Women's Bodies*, pp.100, 131,315. Shorter, 'The Supposed Failure of Maternal Mortality to Decline', pp.1-19.
56. See note 53.
57. Evory Kennedy, *Hospitalism and Zymotic Diseases, as more especially illustrated by Puerperal Fever or Metria* (London, 1869) pp.44-51. William Farr, *33rd Annual Report of the Registrar General of Births Deaths and Marriages, Abstracts for 1870*, p.407. A. B. Steele, *Maternity Hospitals: Their Mortality and What Should Be Done with Them* (Liverpool, 1874) pp.16-18. Florence Nightingale, *Introductory Notes on Lying-In Institutions*, (London, 1875) p.368.
58. Erichsen, quoted in Steele, p.28.
59. Nightingale, p.3. Farr, p.407. Dr.Barnes, *Obstetrical Society of London Transactions*, 12 (1871), p.127.
60. *Lancet*, 18 October 1862, p.423; 6 April 1867, p.423; 28 March 1868, p.422; 24 May 1879, pp.746-7; 16 July 1881, p.117.
61. *Lancet*, 14 April 1894, pp.943-45.
62. *Lancet*, 21 March 1885, p.534; 13 March 1886, p.508; 14 April 1894, p.943.
63. *Lancet*, 13 March 1886, p.508. Similarly, the collective maternal mortality rate for the four London Lying-in Hospitals was 19 per 1,000 births (1879), 'a truly formidable ... unjustifiable mortality', but in the advent of antiseptics, it averaged 8.5 per 1,000 births (1880-87) which was deemed, 'a very satisfactory result'. Leading article, 'Lying-In Hospitals', *The Medical Press*, 28 March 1888, p.323-29.
64. Cullingworth, pp.93-94, Boxall, 'The Mortality of Childbed', p.9.
65. *Lancet*, 1 July 1893, p.9.
66. Campbell, 'Maternal Mortality', p.50.
67. Campbell, 'Maternal Mortality', pp.43-44,51. Newsholme, pp.8-9.

68. Alfred Meadows, 'Meadows on Craniotomy', *The British Gynaecological Journal*, 2 (1886), 309-21 (p.309).
69. John Clay, 'Maternal Mortality', *The Ingleby Lectures, The Birmingham Review*, 7 (1878), 364-79 (p.369).
70. Caesarian section was increasingly successful, following improvements in techniques introduced by Eduardo Porro (1876) and Max Sanger (1882) for general accounts, of obstetric progress, see Walter Radcliffe, *Milestones in Midwifery* (Bristol, 1967), especially Chapter Nine, 'Maternity Made Safer' pp.87-96.
71. Presidential Address, *Obstetrical Society of London Transactions*, 14 (1877), pp.22-23.
72. Sinclair, *Lancet*, 18 September 1897, pp.760-61, Byers, p.437 Murray, pp.22-23, see also, Pat Jalland, *Women, Marriage and Politics 1860-1914* (Oxford, 1986), pp.143-44, 148.
73. O'Donnell D. Browne, *The Rotunda Hospital* (Edinburgh, 1947). p.237. Derek Dow, *Rottenrow: The History of the Glasgow Royal Maternity Hospital, 1834-1984* (Glasgow, 1984), pp.67-70.
74. For general reviews on improvements in hospital provision, changing from a place of refuge to places of care and curing, see Smith, p.249. Gerald Rivett, *The Development of the London Hospital System 1823-1982* (London, 1986), pp.25,102.
75. Enid Fox, 'Powers of Life and Death: Aspects of Maternal Welfare in England and Wales Between The Wars', *Medical History*, 35 (1991), 328-52 (pp.333-34).
76. Loudon, 'Maternal Mortality', pp.196-98. For further, but still limited evidence on the importance of nutrition and environment to maternal mortality, see; Tew, p.199-200, who nonetheless believes medical incompetence was the principal cause, pp.208,211,213-14; Lewis, pp.174-76.
77. Loudon, 'Maternal Mortality', p.209.
78. *Annual Report of the Work of the Central Midwives Board for 1920* (London, 1921), p.21.
79. Campbell, 'Maternal Mortality', p.28.

80. Campbell, 'Maternal Mortality', pp.29-30.
81. *Annual Report Upon The Health of Blackburn, 1920*, p.74.
82. *Annual Report Upon The Health of Blackburn, 1923*, p.76.
83. Campbell, 'Maternal Mortality', Appendix A.
84. Campbell, 'Maternal Mortality', p.iv. Newsholme, p.38.
85. In Bury, for example, it was not until 1920 that institutional arrangements for maternity cases were made with the town's voluntary hospital and even then, only 12 maternity cases were delivered there in 1922. In Blackpool, institutional provision was restricted to a maternity home of eight beds, which was not opened until 1920. In Halifax, whilst good maternity accommodation was available, it was restricted to the local Poor Law Infirmary which Dr. Bank, the town's Medical Officer of Health, felt was insufficient to meet the needs of the town, Campbell, 'Maternal Mortality', pp.26-28.
86. Loudon, 'Maternal Mortality', p.191. Jane Lewis also makes the same point that 'childbirth was potentially as safe as in the home and in many hospitals the precautions were undoubtedly superior to those of midwives or doctors in domiciliary practice', but like Loudon, Lewis presents only one example, the City Lying-in Hospital, London. Jane Lewis, p.179.
87. *Interim Report of the Departmental Committee on Maternal Mortality and Morbidity* (London, 1930) p.103.
88. On London's East End, see; Lara Vivienne Marks, 'Irish and Jewish Women's Experience of Childbirth and Infant Care In East London 1870-1939; The Responses of Host Society and Immigrant Communities to Medical Needs' (unpublished doctoral thesis, Wolfson College, University of Oxford, 1991) Chapters Six and Seven; idem, 'Hospital and Community: London Hospital and its Place in the Provision of Maternity Health Care in East London, 1870-1939', in *Women and Children First: International Maternal and Infant Welfare, 1800-1950*, ed.by Valerie Fidles (Wellcome, forthcoming). See also, Jane Lewis, *Politics of Motherhood*, for

- intermittent references to the East End Maternity Hospital. On Glasgow see: J. Wilcocks and A. A. Calder, 'The Glasgow Royal Maternity Hospital 1834-1984: 150 Years of Service in a Changing Obstetric World', *Scottish Medical Journal*, 30 (1985), 247-54; Derek Dow. On Edinburgh see, John Sturrock, 'Early Maternity Hospitals in Edinburgh, 1756-1876', *British Journal of Obstetrics and Gynaecology*, 65 (1958), 122-31. On the Rotunda, Dublin, see: T. D. Browne; Charles Curran, *The Rotunda Hospital: Its Architects and Craftsmen* (Dublin, 1947); Cormac ò Gràda, 'Dublin's Demography in the Early Nineteenth Century: Evidence from the Rotunda', *Population Studies*, 45 (1991), 43-54.
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90. Guenter Risse, 'Hospital History: New Sources and Methods', in *Problems and Methods in the History of Medicine*, ed. by Roy Porter and Andrew Wear (London, 1987), pp.175-203 (pp.175-76,201). F. B. Smith, p.256. Anders Brändstrom and Göran Broström, 'Life-Histories For Nineteenth Century Swedish Hospital Patients: Chances of Survival', *Journal of Family History*, 14 (1989), 195-209 (p.195).
91. Peregrine Horden, 'A Discipline of Relevance: The Historiography of the Later Medieval Hospital', *Social History of Medicine*, 1 (1988), 359-374 (p.359). For a random selection of such publications see: A. H. T. Robb-Smith, *A Short History of the Radcliffe Infirmary* (Oxford, 1970); C. T. Andrews, *The First Cornish Hospital* (Penzance, 1975); P. M. G. Russell, *A History of the Exeter Hospitals 1170-1948* (Exeter, 1976); Margaret Keeling-Roberts, *In Retrospect: A Short History of the Royal Salop Infirmary* (Wem, 1981); Margaret Railton and Marshall Barr, *The Royal Berkshire Hospital, 1839-1989* (Reading, 1989).
92. Guenter B.Risse, *Hospital Life in Enlightenment Scotland* (Cambridge, 1986). Joan Lane,

- Worcester Infirmary in the Eighteenth Century, (Worcester, 1992). O'Grada, pp.43-54. John Woodward, *To Do The Sick No Harm: A Study of the British Voluntary Hospital System to 1875* (London, 1974). Steven Cherry, 'The Role of a Provincial Hospital: The Norfolk and Norwich Hospital, 1771-1880', *Population Studies*, 26 (1972), 291-306; 'The Hospital and Population Growth: The Voluntary General Hospitals, Mortality and Local Populations in the English Provinces in the Eighteenth and Nineteenth Centuries', *Population Studies*, 34 (1980), Part 1, 59-75, Part 2, 251-265. Rivett. Lindsay Granshaw, *St.Mark's Hospital, London: A Social History of a Specialist Hospital* (London, 1985).
93. F. B. Smith, Book Review, *Victorian Studies*, 20 (1978), 89.
 94. McKeown and Brown, 'Medical Evidence', pp.122-125.
 95. For discussion concerning the hospital's role see: note 90 above; Thomas Forbes, 'Mortality at St.Bartholomew's Hospital, London 1839-1872', *Journal of The History of Medicine*, 38 (1983), 432-449; E. M. Sigsworth, 'Gateways To Death?: Medicine, Hospital and Mortality, 1750-1850', in *Science and Society 1800-1900*, ed. by Peter Mathias, (Cambridge, 1972), pp.97-111; Carol Pennington, 'Mortality and Medical Care in Nineteenth Century Glasgow', *Medical History*, 23 (1979), 442-450; Smith, pp.249-284.
 96. Versluisen, p.22. Wertz, p.140.
 97. Branca, p.63.
 98. Tew, p.7.
 99. Oakley, p.52.
 100. Shorter, *A History of Women's Bodies*, pp.139-40.
 101. Wally Seacombe, 'Starting to Stop: Working Class Fertility Decline in Britain', *Past and Present*, 126 (1990), 151-88 (p.182).
 102. There was a change in the hospitals' title from 'Lying-in Hospital' to 'Maternity Hospital' in Liverpool (1908), Newcastle (1907) and Birmingham (1908). The records for The Newcastle, Liverpool, and Birmingham maternity hospitals are to be found in their respective city record offices and central

reference libraries. The printed material for the Southern and St. Mary's can be found in the Medical Collection at John Rylands University Library Manchester. The minutes and registers for the two hospitals are still to be found at St. Mary's, whilst all the extant material for the Jessop is to be found at the hospital.

103. Roy Porter, 'The Gift Relation: Philanthropy and Provincial Hospitals in Eighteenth Century England', in *The Hospitals in History*, ed. by Lindsay Granshaw (London, 1989) pp.149-78 (p.151).
104. *Birmingham Daily Post*, 21 March 1867.
105. Ann Oakley, *The Captured Womb* (Oxford, 1984), p.6. Lara Marks, 'Dear Old Mother Levy's: The Jewish Maternity Home and Sick Room Society, 1895-1939', *Social History of Medicine*, 3 (1990), 61-88 (p.87).
106. for oral accounts see: E. Roberts, pp.109-10; Mary Chamberlain, *Fenwomen A Portrait of Women in an English Village* (London, 1975) p.74.
107. Llewelyn Davies, case nos 2,37,144,146, pp.20,65,173-75.
108. George Moore, *Esther Waters*, London, 1894, repr. (Chicago, 1977) For the relevance of this text to our historical understanding of childbirth see: Riley, pp.xi, 28-29; Mary Prior, 'Conjugal Love and the flight from Marriage: Poetry as a Source for the History of Women and the Family', in *Women as Mothers in Pre-Industrial England*, ed. by Valerie Fildes, pp.179-203 (p.179).
109. Professor Hughes, quoted in J. A. V. Chapple, *Documentary and Imaginative Literature, 1880-1920* (London, 1970), p.61. George Watt, *The Fallen Woman in the Nineteenth Century English Novel* (Beckenham, Kent, 1984), p.182.
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Chapter One

Institutional Midwifery:

A Provincial Perspective

Institutional Midwifery: A Problem of Sources

Special Maternity Hospitals seldom exist, we believe, except in London (which has less than a dozen), Dublin (three, including one large one), Edinburgh and Glasgow, though there are sometimes maternity wards in the general hospitals.¹

So concluded the principal authors of The Minority Report of the Poor Laws (1909), Sidney and Beatrice Webb, who in their comparative study of voluntary and Poor Law maternity institutions rejected even the idea of a provincial maternity hospital. John McVail, on the other hand, who submitted a similar survey on 'Poor Law Medical Relief' for The Majority Report on the Poor Laws, published the same year, presented a very different view. He neither doubted the existence, nor challenged the role of the voluntary maternity hospital but merely assumed that,

The excellent work done by the maternity hospitals is well known. If or where these are sufficient for the locality which they serve, they might be supplemented by additional rate-supported institutions.²

Utilizing maps, bed-patient figures and textual accounts, to chart the changing spatial and quantitative nature of institutional maternity provision, the aim here is to address such confusion and ambiguity by identifying where exactly institutional midwifery could be found, in what form it was available, in what quantity it existed and to what extent it changed over time.

TABLE 1.1: CATEGORIES OF PROVINCIAL HOSPITALS APPROVED AS TRAINING SCHOOLS FOR MIDWIVES 1906

	Location of Institution	In-Patients	Out-Patients
General Hospitals	Bristol: General	14	316
	Royal	15	463
	Newport\Monmouth		165
Specialist Maternity Hospitals	Birkenhead	108	
	Brighton & Hove	15	1,022
	Liverpool	322	1,847
	Manchester	263	2,334
	Newcastle	144	530
	Sheffield	296	800
Workhouse and Union Hospitals	Birmingham: Wk'h	200	
	King's Norton	59	
	Liverpool:Walton	173	
	Brownlow Hill	330	
	Manchester	151	
	Nottingham	94	
	Sheffield	109	
	West Ham	180	
Military Family Hospitals	Aldershot	235	
	Chatham	123	
	Devonport	75	
	Portsmouth	84	

Source: Names of Institutions Approved as Training Schools for Midwives BPP (309) 1906 vol 98

TABLE 1.2: PINKER'S DATA SET FOR MATERNITY INSTITUTIONS 1861-1933

	1861	1891	1911	1921	1938
Number: of Hospitals	12	16	8	14	235
Maternity Homes				199	176
No. of Beds: Hosps.	139	210	311	462	3,587
Mat. Homes				2,463	6,442
Av. No. of Beds:					
Hosps.	11	13	39	39	15
Mat. Homes				12	36
Av. No. of Occupied					
Beds: Hosps.	85	133	217	391	3,124
Mat. Homes				2063	4,452
No. of Beds per 1000					
of the pop.: Hosps.	0.01	0.01	0.01	0.01	0.09
Mat. Homes				0.07	0.16
% of Mat Beds of					
Hosp Bed Total:Hosps	0.94	0.71	0.72	0.82	4.12
Mat. Homes				4.76	5.22

Source: Robert Pinker, English Hospital Statistics 1861-1938

For a substantial number of years historians have relied all too heavily on Robert Pinker's somewhat dated English Hospital Statistics 1861-1938, to provide the answers, but without much success.³ Though fruitful for drawing conclusions about the scope of hospital provision on a highly generalised scale, providing information on the total number of hospital beds, occupancy levels and availability per 1,000 of the population, Pinker's data are of little use for the provincial maternity study. From a general perspective, he fails either to make a clear, consistent distinction between London and the provinces, or to provide patient figures. Only bed to total population ratios are offered, which indicates the potential, theoretical capacity to hospitalise rather than the numbers that were actually hospitalised. From a specialist perspective, his data are even more limited, for his categorical review falls well short of encompassing the breadth of institutions, beside maternity hospitals, that delivered pregnant women. Also included should be the maternity wards of general hospitals, military establishments and workhouses, as first outlined by the Central Midwives Board (1906), when it selected several institutions from each category for midwifery training (Table 1.1).⁴ Though Pinker mentioned maternity hospitals and from 1921, 'public health maternity homes', he failed to discuss individual aspects of such provision, and providing only bed to population ratios, gave no indication as to the true extent of the maternity hospital's use by parturient women (Table 1.2).

By resorting to Pinker's own principal source of information, Burdett's Hospital Annual and Year Book of Philanthropy, many of these shortcomings relating to voluntary provision can be overcome.⁵ An annual publication dating from 1893 and surviving under the same title and format until 1930, Burdett's has proved to be an indispensable source for data concerning individual voluntary hospitals, including notes about their location, year of foundation, bed totals, occupancy rates, in- and out-patient figures and even their staff composition, annual accounts and rules of acceptance. From this one source and using selected years (1892, 1900, 1910, 1921, and 1928), it has been possible not only to glean information about the spatial distribution and size of specialist maternity hospitals, but also to trace the expansion of specialist maternity facilities within general hospitals and the growth of maternity homes in the 1920s. Burdett's data is flawed, in the latter two categories, by inconsistencies and inaccuracies in the presentation of the data. It is also heavily dependent on the co-operation and diligence of the hospital officials to complete the returns for Burdett's, fully and accurately (which was not always the case). However, it has been possible to supplement information on general hospitals with published hospital histories and, on maternity homes, with Chief Medical Officer of Health Reports, and therefore still offer a fair representation of the extent and nature of voluntary, institutional midwifery.

Relevant Poor Law material proves more difficult to find, for despite the voluminous extant material on the Poor Law generally, childbirth, like the care of the sick pauper, was rarely an item for discussion until the Poor Law reforms of the 1860s when, for the first time, 'separate accommodation for lying-in women, with separate labour room' was requested by the central Poor Law authorities, but only for the larger workhouses.⁶ Despite such belated interest, it is quite evident, from Parliamentary returns, memoranda and reports, conducted during these reform years, that lying-in facilities were an integral feature of even the smallest workhouse long before the Poor Law's governing body took an interest. Where the difficulty lies is in gleaning general details about workhouse midwifery facilities and not just about those establishments that were cited in special case studies. The British Medical Journal pressed this point, requesting in a leading article in February 1867,

information as to the details of the lying-in wards, their size, the minimum, maximum and average number of patients in them at a time: we want the mortality amongst the infants and the proportion of still-born, we want information as to the relation of the lying-in wards to other wards. It is, of course, also desirable to distinguish the single from the married women; and especially not to omit to ascertain whether the women have had children before. All these points are necessary in order to form a correct judgement.⁷

The request was of little significance, for twenty years later, Heywood Johnstone MP, found his proposal in Parliament, simply to release figures showing the total number of workhouse confinements, was rejected, due to

'pressure on the statistical branch' of the Local Government Board.⁸ Whilst the information was never forthcoming, the interest shown in the Poor Law's midwifery services, by members of Parliament and major medical journals, does at least underline the service's importance to maternity care.

Viewed with the same degree of indifference, despite their significance 'to writers on obstetrics, and that new and important branch of state medicine known as Infant Hygiene', military-related maternity data proved equally elusive. The Army Medical Department Annual Reports, the most likely source of information on maternity provision, offered detailed accounts about the state of health of her Majesty's troops from Bermuda to Mauritius, and even dedicated a section to 'Officers, Women and Children', but never made any reference to the estimated 1,000 women confined by military personnel each year. 'The Army Medical Department Reports are very highly valued by all statisticians', wrote Major R.J.Blackman, Royal Army Medical Corps, 'but it seems a remarkable fact that they give no information with regard to the large amount of work in obstetrics which is annually performed by officers of the Royal Army Medical Corps'. What references there are, have come from contemporary journals, including, but not exclusively, The Journal of the Royal Army Medical Corps, which throughout the period (1903-32) published only four articles on military family hospitals and midwifery.⁹

FIGURE 1.1: GENERAL HOSPITAL BUILDING
Provincial England and Wales 1799-1929

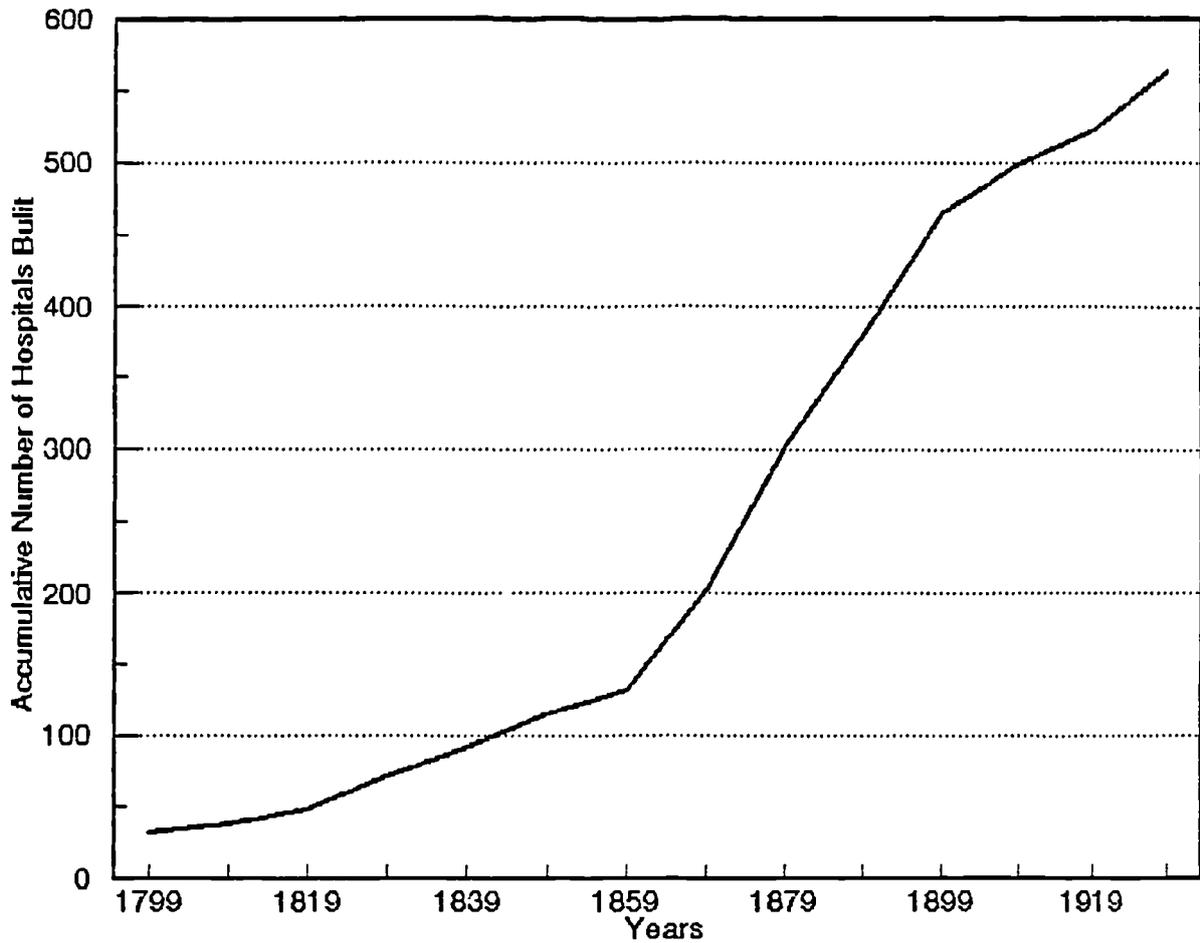
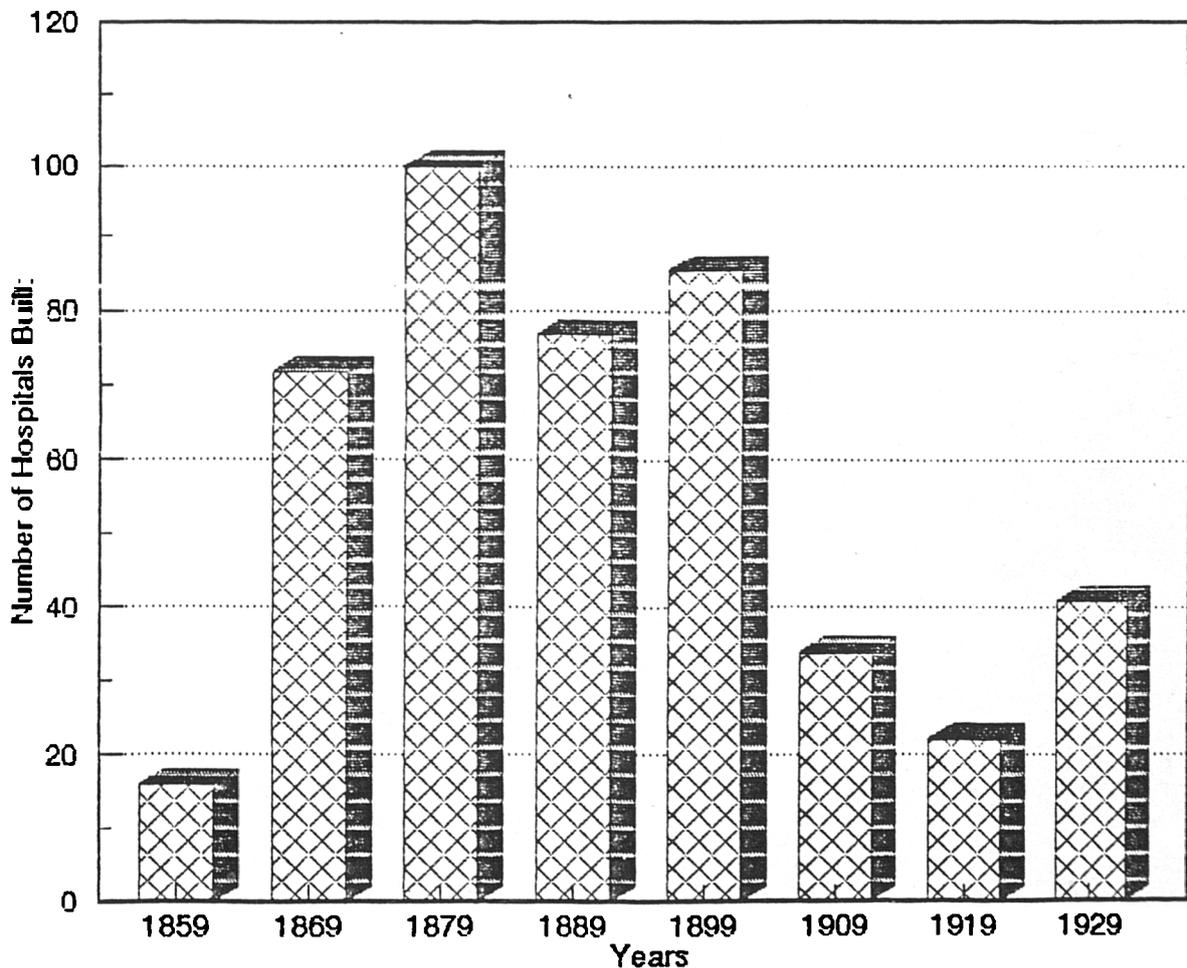


FIGURE 1.2: DECENNIAL GROWTH IN GENERAL HOSPITALS
PROVINCIAL ENGLAND AND WALES 1850\59-1920\29



Source: Burdett's Hospital Year Book 1894-1930

 No. of Hospitals

General Hospital Maternity Departments.

Despite the great proliferation of general hospitals, with no fewer than 70 such establishments built in any one decade between 1860 and 1900, few accepted maternity in-patients, and where they did, the schemes soon appear to have been abandoned for political as well as professional reasons (Figures 1.1 and 1.2). The Middlesex, Soho, is a case in point, for it opened a five bed lying-in ward only two years after it was founded in 1745 and then, on moving to the new premises in 1756, designated 34 of its 64 beds for midwifery cases. Such was the rapid growth of the maternity department that there was a real possibility of its being transformed into a specialist maternity institution, but the fear of such an event provoked numerous disputes, resignations and dismissals, and ironically, the closure of its maternity wards in 1807.¹⁰ The Royal Infirmary, Edinburgh, founded in 1729, similarly provided a lying-in ward (1755) in the attic of its east wing and allocated four beds for the purpose. Five years later the number of beds rose to six and from 1762 the department remained open for eight as opposed to only six months of the year. Demand was so great, as much from students and pupil midwives as women themselves, that a purpose-built lying-in hospital was eventually opened in Edinburgh in 1793. The Infirmary's own maternity department closed and the redundant space was utilized for fever cases.¹¹

**TABLE 1.3: BURDETT'S GENERAL HOSPITAL MIDWIFERY RETURNS
PROVINCIAL ENGLAND AND WALES 1892-1928**

	1892	1900	1910	1921	1928
Leeds General	688	547	509		
Queen's, Birmingham	256				
Boscombe	12				
Bournemouth Royal Victoria	71	79			
Bristol Royal		501	592		
Tetbury Cottage Hospital		35			
Whitchurch Cottage Hospital		45	60		
Brixham Cottage Hospital			109	91	66
Mortonhamstead Cottage Hosp.			25		
Wivelscombe			7		
Waterloo Cottage Hospital			62	36	
Ashby-De-La-Zouch				67	58
Bradford Municipal				401	723
Pembroke Dock				93	14
Thongsbridge				23	
Liverpool Royal					340
Royal Halifax					371
Worthing Hospital					79
Coventry & Warwickshire					282
Brignall					31
Darlington					121
Hayes					3
Willingham, Gainsboro					3
Axminster Cottage Hospital					7
Shipston-On-Stour					47
Haslamere Cottage Hospital					22
Beasworthy Cottage Hospital					19
Horley Cottage Hospital					50
Preston					275
Torbay					10
Trowbridge Cottage Hospital					72
Totals	1,027	1,207	1,364	711	2,593

Figures refer to both in-patients and out- but they were almost definitely out-cases only (1892-1910). Source: Burdett's Hospital Yearbook 1894-1930

Whilst Burdett's provides no reliable information on this point, it appears that few, if any, provincial general hospitals ever accepted maternity cases as in-patients in the nineteenth century (Table 1.3). The fatal experience of King's College Hospital, London, no doubt influenced that decision. With funding from Florence Nightingale, King's College Hospital opened a maternity ward and training centre for midwives in 1862, only to close it five years later when one in every 29 of the 781 women that had been delivered there died, two-fifths of them from septicaemia or pyaemia.¹² A pregnant woman, like a case of tuberculosis or a young child with scarlatina, was considered too high a risk to accept into a general hospital. This was particularly the case in the wake of the discoveries by Semmelweis, the disastrous experiment at King's College and the puerperal fever debates of the 1860s, which collectively highlighted 'the downright reprehensibility of having midwifery wards in connection with general hospitals'.¹³ 'A Lying-In hospital or ward', the Lancet postulated in September 1869, 'ought never again in our opinion, to form part of a general hospital...'.¹⁴

For the most part it never did, or at least not until the mid-1920s, when encouraged by local authority grants and renewed public interest, general hospitals gradually began to open maternity wards and make special provision for obstetric cases. From 1924, for example, the Royal Hampshire County Hospital, Winchester, arranged with the Hampshire County Council to admit normal

maternity cases and the East Kent and Canterbury Hospital, Victoria Hospital (Deal), The Royal Victoria Hospital (Folkstone), the West Kent Hospital (Maidstone), the General Hospital (Tunbridge Wells) and the General Hospital (Gravesend), agreed to accept Kent County Council-sponsored maternity cases. 'At all of these hospitals special arrangements have been or will be made for the reception of midwifery cases', commented the Chief Medical Officer of Health in 1924.¹⁵ At Addenbrookes, Cambridge, the hospital had been under special contract with the local council since October 1917 to accept cases 'where special difficulties may occur in connection with the confinement' which eventually led to the opening of maternity wards in June 1928.¹⁶ Elsewhere, voluntary effort was the key to the opening of maternity wards, as at the Royal Berkshire Hospital which opened a seven bed maternity ward in 1927, after being petitioned by the Berkshire Federation of Women's Institutes and sponsored by the Ladies' Hospital Ball Committee.¹⁷

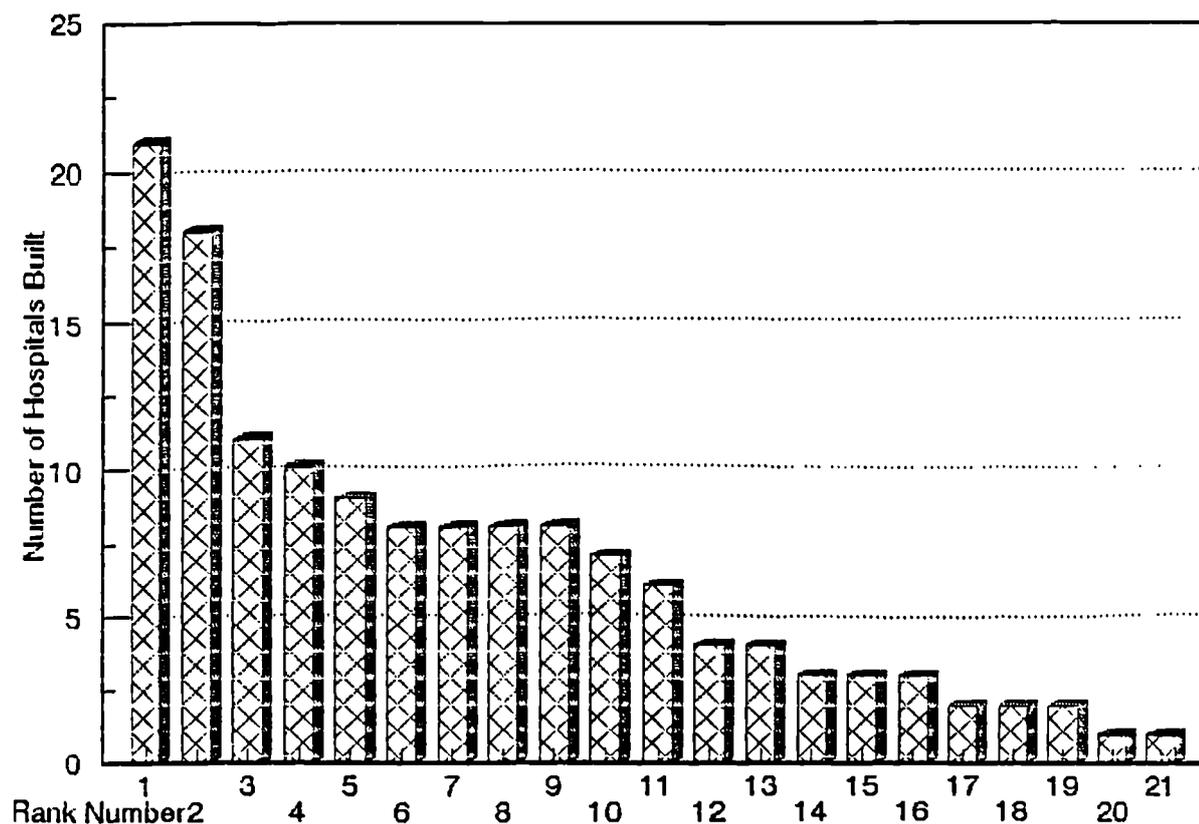
Where a few general hospitals did become involved in midwifery prior to the 1920s was in the running of a domiciliary maternity service, which avoided the puerperal fever risks associated with lying-in wards but still met the requirements of medical schools. Except for a two year lapse (1869-71) the Queen's Hospital, Birmingham, for example, continued to send surgeon teachers and medical students to the homes of the 'ordinary manual classes' and attend on average, 300

**TABLE 1.4: SPECIALIST HOSPITAL DEVELOPMENT
Provincial England and Wales 1801-1900**

	Rank No.	No. of Hospitals Built
Types of Hospital:		
Children	1	21
Eye	2	18
Occupational Specific	3	11
Women	4	10
Women and Children	5	9
Accident	6	8
Chest and Consumption	7	8
Ear/Ear&Nose/Ear.Nose&Throat	8	8
Homoeopathy	9	8
Eye and Ear	10	7
Dental	11	6
Maternity	12	4
Skin,Cancer and V.D.	13	4
Hydrotherapy	14	3
Skin	15	3
Women and Maternity	16	3
Eye, Ear and Throat	17	2
Lock (V.D.)	18	2
Orthopaedics	19	2
Cancer	20	1
Fistula	21	1
Grand Total		139

Occupational Specific included hospitals for sailors, miners, railway workers company employees, two hospitals for Jews and one for French people

**FIGURE 1.3: SPECIALIST HOSPITALS
PROVINCIAL ENGLAND AND WALES 1801-1900**



Source: Burdett's Hospital Yearbook 1894-1930

confinements a year (1871-1900).¹⁸ At Bristol General, a similar service had been organised from there since 1854 when Dr. Joseph Swayne was appointed Physician Accoucheur.¹⁹

The number of hospitals which became involved in this type of work markedly rose after the mid-1880s, once antiseptics had become widely accepted and midwifery a compulsory element of the medical syllabus (1886). Hence, at the specific request of the city's medical school, the opening of a district midwifery service at the General Infirmary, Leeds, (1885) and the appointment, two years later, of Bristol Royal Infirmary's first Obstetric Physician, Ernest Wedmore, to organise student instruction in the woman's own home.²⁰

Specialist Maternity Hospitals: 'The rise and fall...'

The general hospital's restrictive admission policy was, in part, the specialist hospital's source of motivation, her *raison d'être*.²¹ This accounts for the opening of the first provincial maternity hospital at Newcastle in 1760, the building of eye hospitals, starting in Exeter in 1808, the establishment of a Lock hospital for venereal diseases in Manchester in 1818, and the foundation of children's' hospitals, beginning with the Liverpool Children's Infirmary in 1851 (Table 1.4).²² The fact, however, that the maternity hospital was one of the earliest forms of specialist provision was not just

Map 1: Voluntary Maternity Hospitals 1860-1930



due to the restrictive admissions policies of general hospitals. It was also due to the avid professional interest in midwifery, as reflected in the early eighteenth century by the publication of several midwifery texts and by the opening of schools for obstetrics and a growth in private maternity practice.²³ There was also, as Jean Donnison remarked, a 'real upsurge of organised private benevolence', part of which was generated by women for women and part by men who increasingly regarded women as an important group of society, if only to ensure that their offspring were sufficient in number and health to meet the ever increasing demands of industry and empire.²⁴

As a result, ten maternity hospitals were established throughout the British Isles (1745-1800), beginning with the building of the Rotunda Lying-in Hospital, Dublin, ending with the opening of a second maternity institution in Southern Ireland, the Cork Lying-in Hospital, Erinville (1798), and including the founding of two English provincial, maternity hospitals at Newcastle (1760) and Manchester (1790) (Map 1). During the nineteenth century a further 16 maternity hospitals were founded: three more in Southern Ireland, four in Scotland, two in London and seven in the English provinces (Map 1). Included in this latter group were maternity hospitals at Brighton (1830), Liverpool (1841), Birmingham (1842), Birkenhead (1845), Sheffield (1864), Manchester (1866) and Bristol (1894), which were all rapidly expanding towns with a perceived mortality

problem and an affluent middle class 'sufficient to stimulate and sustain the voluntary efforts required to maintain these expensive hospitals'.²⁵ The maternity hospitals opened at Leeds (1905), Leicester (1911), Rochdale (1918) and Cardiff (1921), were relatively late arrivals, but at a time when maternal and child welfare concerns were becoming an important public issue, they were no doubt seen as an immediate response to the high infant maternal mortality rates in their respective localities (Map 1).

When it is considered that there were only nine provincial maternity hospitals by 1905, despite a four-fold increase in the population of England and Wales (1801-1901), and a multiplication of other specialties (18 eye hospitals, 21 children's hospitals, ten women's hospitals and eight hospitals for chest and consumption), it is perhaps surprising that the maternity hospitals at Leeds and Leicester arrived at all (Figure 1.3).²⁶ Though the situation was never as extreme as the Webbs would lead us to believe, the relatively small number and apparent 'rise and fall of lying-in hospitals, their almost total extinction [sic] and resuscitation...' during the Victorian period, does require some explanation.²⁷

The main reason for this was the maternity hospitals' vulnerability during the early Victorian period to puerperal fever, which prompted calls, throughout Europe, either to reduce them to cottage type institutions or abolish them altogether. Many favoured

the latter solution, including the Lancet, which led the anti-maternity hospital campaign in Britain. Referring to the unfavourable mortality figures of London's four maternity hospitals compared with those of the City's Royal [outdoor] Maternity Charity, the Lancet initiated its campaign in October 1862, by casting doubts on the maternity hospital's right to exist and suggesting that it was ten times more fatal for a woman in London to be delivered in a hospital than in her own home. It then proceeded to develop this argument by producing statistics of outdoor lying-in charities which delivered women only in their own homes and achieved rates of one death in every 335 deliveries (Royal Maternity Charity, 1857-61) and one in every 223 deliveries (out-patient department, Coombe Hospital, 1858-64), compared with one death in every 32 hospital deliveries (The Rotunda, 1858-64). By 1867, the evidence, according to the Lancet, was conclusive,

that the lying-in hospitals are institutions which no obstetric skill and no ventilation yet devised can make otherwise than dangerous, and that they should be given up.²⁸

Many doctors agreed, including those associated with the very institutions which had employed them, sponsored their research and enhanced their reputations. Amongst them were A. B. Steele, Physician to the Liverpool Lying-in Hospital, Denis Phelan, secretary of the Board of Superintendents of the Dublin Hospital and former consulting physician to Queen Charlotte's Lying-in Hospital, London, Dr Copeland.²⁹ None, however, was more

forceful and influential than Sir James Simpson, who had for many years been associated with the Edinburgh Maternity Hospital and which after his death was named after him, and Dr. Evory Kennedy, a former master of the Rotunda (1833-40). Although Simpson referred to - 'Puerperal Fever, the greatest curse of obstetric hospitals' and quoted the relevant figures in his major paper on the subject 'Hospitalism and its Effects' (March, 1869), he was generally more concerned with the hospital movement as a whole.³⁰ Despite having 'the best professional attendance, the kindest nursing, and outward comforts...', Simpson found hospitals were usually so big and overcrowded and so full of 'hygienic evils', as to be detrimental to the patients; 'The man operated on in a surgical hospital was exposed to more chances of death than the Soldier on the field of Waterloo'.³¹ The answer, Simpson argued, was to isolate patients, ventilate wards and increase personal space, by converting hospitals 'from wards into rooms, from stately mansions into simple cottages, from stone and marble palaces into wooden, or brick, or iron villages'.³²

Dr Kennedy's work, 'Zymotic Diseases as more especially illustrated by Puerperal fever or Metria', read before the Dublin Obstetric Society (May 1869), less than two months after the publication of Simpson's paper, concentrated on lying-in institutions and 'drew up a terrible bill of indictment against all lying-in hospitals except the very small ones'.³³ Hypothesizing that puerperal fever was due to the generation and

absorption of a poisonous miasma by parturient women, was propagated by the atmosphere and the birth attendant and was active in proportion to the number of females cohabiting at the time of their confinement, Kennedy called for the abolition of large maternity hospitals and their replacement by Swiss or Italian style châteaux 'with only one, or, at most, two beds in each isolated room'. Had this been done for women confined in Dublin's Lying-in Hospitals (1862-68) then, Kennedy claimed, at least seven out of every nine women who died would, 'in all probability', have remained alive. As it was, Kennedy concluded,

poor women flock to these hospitals under the impression that they are going to a safe asylum in the hour of trial and distress; little do they imagine that they are, in their ignorance, taking a step that adds to their risk of death, in a ratio, at the very lowest calculation, of 3 to 1, and at the highest at 20 to 1, against their lives.³⁴

Since the emphasis was on architectural improvements, sanitary reform, new ventilation methods, more cubic space and greater isolation, rather than on the actions of the birth attendant, it is hardly surprising to find little improvement in institutional midwifery and doctors abandoning the cause of the maternity hospital. Both Simpson and Kennedy believed in contagion, the transmission of puerperal fever from the birth attendant to the parturient or lying-in woman, but neither could explain or follow through the implications and make the connection between Pasteur's germ theory (1864), Lister's antiseptic precautions (1867) and the

personal cleanliness of patient and doctor. Yet even the theory of contagion was still doubted by many of the leading members of the medical profession.³⁵ Indeed, 'in one way or another all the speakers [at the Dublin Obstetric meeting] derided Kennedy's ideas'.³⁶ Dr Churchill, for example, could not accept that a doctor was a possible carrier of infection from one patient to another, whilst Sawyer, at the Coombe, ridiculed Kennedy's proposals to reduce the Rotunda to a group of sheds and McClintock remained unconvinced about the influence of contagion, particularly where doctors had taken the 'ordinary precautions' but puerperal fever had still occurred.³⁷ The inability to comprehend, for whatever reason, that 'ordinary precautions' did not simply mean 'a wash and shave' without a thorough cleansing of the hands, or 'a change of suit' whilst still using soiled instruments, served only to strengthen Kennedy's demands for maternity hospital closures.

As well as doubting contagionist theories (acceptance of which was a fundamental pre-requisite if Lister's work was ever to be accepted), the pro-maternity hospital protagonists spent an equal amount of time discrediting the Simpson - Kennedy data, rather than devising positive and original solutions to the problem of sepsis. Dr Matthews Duncan's published response to Kennedy's claims On the Mortality of Childhood and Maternity Hospitals (1870), is a case in point. Given that the Registrar General's maternal mortality returns, unlike the hospital figures, included only deaths from

childbirth and not in childbirth, Duncan claimed that comparative studies of institutional and domiciliary figures were grossly exaggerated and unjust to hospitals. If the Registrar General's figures were adjusted to take account of omissions, errors of calculation and definition, and included incidental deaths in childbirth (such as deaths from pneumonia, heart disease and tuberculosis) then Duncan claimed, the average maternal mortality rate for the country would be no better than one female death in every 120 women delivered, as opposed to the Registrar's estimation of one death in 189, Simpson's calculation of one in 212 and Kennedy's figure of one in 223. Against this backdrop, the Rotunda's maternal mortality rate of one death in every 100 delivered, was, Duncan concluded, 'good enough to compare with any kind of practice' and evidence of what a 'well-known and well-managed institution' could achieve.³⁸

Yet Duncan's calculations for the Rotunda were just as suspect as either those of Simpson or Kennedy, for they were based on specially selected years, between 1826 and 1863, and were not compatible with other figures such as those of Kennedy who calculated one death in 64 for the Rotunda (1854-68) and Denis Phelan's figure of one death in 32 (1857-64).³⁹ Regardless, however, of such statistics, which were obviously moulded to suit whatever stance and whichever argument was made at the time, both schools of thought on this subject remained obsessed with the patient's surroundings, rather than the physician's carrier role which was still underestimated and little

understood, even by the 1870s. This pre-occupation with 'the inanimate environment of disease', no doubt explains Duncan's interpretation of 'well-managed' institutions purely in terms of quarantine, the use of alternating wards, periodic closure and sanitary reform, and Kennedy's emphasis on 'the construction and arrangement of lying-in hospitals'; they all looked to the architect and sanitary engineer for the answers and consequently wondered why limited progress was made.⁴⁰

Until this imbalance was addressed, until self-interest and esteem, which instinctively thwarted new ideas, was repressed, and until Pasteur's germ theories and Lister's complicated antiseptic methods were perfected and more widely understood 'by the plodding and practical English surgeon', then puerperal fever continued to plague maternity hospitals.⁴¹ The result, in the case of one institution, the Birmingham Lying-in Hospital, was the closure of its in-patient service in 1867, which was also, albeit temporarily (1881-85), the fate of the Liverpool Lying-in Hospital.⁴² In the case of Jessop's, Sheffield, even the idea of opening a maternity hospital was shelved at the last minute in favour of opening a hospital specialising in women's diseases (1864), which only later encompassed a large maternity department (1874).⁴³ Equally, the Southern and St. Mary's, which opened maternity departments in 1888 and 1889 respectively, had long before this operated very extensive domiciliary services, which is where their

TABLE 1.5: BURDETT'S PROVINCIAL MATERNITY

HOSPITAL RETURNS 1892-1928

	1892	1900	1910	1921	1928
1st Row: Bed Totals					
2nd Row: In/Out Cases					
Newcastle Maternity	12	12	16	16	70
Hospital (1760)		32\ 165	241\ 1087	1102\ 1096	2253\ 829
St. Mary's Manchester	50	55	160	179	211
Mat\Wrm\Chld (1790)	1000\13135	1288\15809	1681\16890	4855\11057	5184\13545
Brighton Maternity &	5	7	9	12	38
Women's Hosp (1830)	30\ 721	95\ 1578	165\ 1612	337\ 2370	348\ 1955
Liverpool Maternity	15	18	23	27	81
Hospital (1841)	156\ 1781	172\ 1760	620\ 2011	853\ 1247	1876\ 2071
Birkenhead Maternity	20	12	15	22	35
Hospital (1845)	90\ 250	80\ 145	173\ 278	412\ 124	406\ 111
Jessop's Sheffield	45	45	72	116	191
Mat & Women (1864)	403\ 1821	435\ 2541	1136\ 2709	1733\ 2659	3117\ 3732
Bristol Maternity	--				28
Hospital (1865)					142\
The Southern M/C	12	12	--	--	--
Mat\Wrm\Chld 1866-1905	121\ 1063	183\ 1168	--	--	--
Leeds Maternity	--	--			75
Hospital 1905	--	--			1908\
Birmingham Maternity	--	--		30	65
Hsp. 1842-1887\1908-				818\ 1453	1648\ 2894
Leicester Maternity	--	--	--		23
Hospital (1911)	--	--	--	457\ 207	535\ 148
Princess Royal M/C	--	--	--		60
Mat & Wom (1915)	--	--	--		510\ 2300
Springfield Mat.	--	--	--	26	20
Hsp. Rochdale (1918)	--	--	--	230\	130\
Brunswick Mat. Hosp.	--	--	--		19
Bristol (1921)	--	--	--		368\ 149
Cardiff Maternity	--	--	--		31
Hospital (1921)	--	--	--		518\
Chester Maternity	--	--	--	--	8
Hospital (1925)	--	--	--	--	181\ 736

St. Mary's and Jessop's: Gynaecology and Child Cases also included

Blank Spaces: No information available

Source: Burdett's Hospital Yearbook 1894-1930

collective strength lay, in the confinement of women in their own homes.⁴⁴

It was not until the early twentieth century, in the wake of the 1902 Midwives Act, which increased demands on the maternity hospital as a training centre and the growing interest in infant and maternal welfare, that hospitalised midwifery became a significant phenomenon. At the Newcastle Maternity Hospital, for example, the bed complement, according to Burdett's figures, rose six times, from 12 to 70 beds (1900-28), and the number of ward confinements, from 32 a year, or one practically every two weeks, to 2,253 deliveries a year, or more than six a day, every day (Table 1.5).⁴⁵ At Liverpool and Brighton maternity hospitals, their bed complements rose five and seven times respectively during the same period, whilst the Leeds and Birmingham maternity hospitals, which were only opened in 1905 and re-opened in 1907, respectively, were, by the late 1920s, managing an average of 70 beds each and over 1,700 hospitalized confinements a year (Table 1.5). Such accelerated and sustained growth, coupled with the building of maternity homes, particularly after the 1918 Child and Maternal Welfare Act, which promoted local authority sponsorship of maternity hospital patients, suggests that, contrary to the conclusions of Deborah Dwork and Anna Davin, the child and maternal welfare movement was far more than just a hygiene-education and prevention programme and one that actually wielded a positive influence on the development of hospital services.⁴⁶

Poor Law Maternity Wards

In the midst of the debates about the future of the voluntary maternity hospitals it is surprising to find that workhouses, which were vigorously denounced for their neglect of the sick and their 'excessive', general mortality rates were, in the interim, applauded for their relatively safe childbirth practices.⁴⁷ In the mid-1860s, when the Lancet dismissed workhouse medical arrangements as 'a disgrace to our civilisation', and two Poor Law Board Inspectors, Mr. Farnell and Dr. Smith, claimed that 13 of the Metropolitan's 40 workhouses were unfit for use as hospitals, the British Medical Journal drew attention to the 'comparatively superior', maternal mortality rates of these same institutions.⁴⁸ The British Medical Journal found from its own extensive research of workhouse medical care that 'Deaths after delivery are most rare, and puerperal fevers, comparatively speaking, almost unknown in workhouse lying-in wards', which left them somewhat perplexed 'that women in the comparatively small and ill-ventilated wards live more securely on their puerperal couch than do women in our luxurious hospitals'.⁴⁹

Others drew the same conclusion. 'In none of these institutions', commented Florence Nightingale in 1875, 'is there any great refinement of construction or of sanitary appliances', but 'their death-rates have

**TABLE 1.6: CASE SAMPLE OF WORKHOUSE MATERNITY
STATISTICS (NINETEENTH CENTURY)**

	No. of Deliveries	% 1st Birth	% Women Single	% Still- Births	No. Mat. Deaths
Liverpool Workhouse	1,396	38	67	14	6
1868-1870	(465p.a.)				
1895-1896	635	49	65	8	3
	(317p.a.)				
Birmingham Workhouse	1,300				2
Jan. 1861-June 1866	(237p.a.)				
Brighton Workhouse	223		80	17	1
1862-1868	(37p.a.)				
Halifax Workhouse	200	77	92	4	0
1871-1880	(20p.a.)				
Lambeth Workhouse	1,807				14
1871-1880	(181p.a.)				

Source: Lancet, 23 May 1863, 4 June 1881, 16 July 1881, 28 August 1897

E. Smith, 'Sufficiency of Existing Arrangements...In forty-Eight Provincial

Workhouses 1867-1880 (4th ed. 1881) pp. 1-10

been much lower than those of maternity institutions generally' (Table 1.6).⁵⁰ 'Notwithstanding all these conditions', including the admission of single women, many of whom were 'in a starving condition' and 'the subject of syphilis', Robert Lloyd, the Medical Superintendent of the Lambeth Infirmary, similarly found that the workhouse compared 'most favourably with the general lying-in hospitals...the charnel houses for parturient women' (Table 1.6).⁵¹ These learned opinions also had the support of contemporary specialists on hospital construction and management, including F. Oppert, Lawson Tait, Frederick Mouat and Saxon Snell, who went so far as to suggest that voluntary maternity hospitals would drastically reduce sepsis rates and greatly improve service if only they ran on the same lines as workhouses. This would have meant in practice withdrawal of clinical instruction, minimum communication with other hospital departments, regular inspection, ample cubic space for each patient and a much smaller case load.⁵²

The rapid growth of maternity facilities in almost every workhouse, as well as their comparative success under the New (1834) Poor Law, which 'had little to say on matters of workhouse policy beyond the general principle of restricting out-relief through the deterrent use of workhouses', provides yet another twist of irony.⁵³ This was particularly the case for women, more so than any other category, because they were for many years, an ignored, underestimated quantity, singularly

viewed as non-wage earning dependants, and consequently, accepted, categorised or refused help, on the basis of their husband's relief status.

If the husband entered the workhouse, the wife would have no choice but to follow. A destitute wife could be refused entry to the workhouse if her husband would not enter, or permission to leave if he would not leave. If a male pauper was officially classified 'not able-bodied', so was his wife, whatever her personal physical condition. If he received outdoor relief, including medical relief (until 1886), for himself alone, she was also listed as a pauper.⁵⁴

'With regard to the really baffling problems presented by the widow, the deserted wife of a husband resident in another parish or another country...', many of whom could have been of childbearing age and expectant mothers, the 1834 Act remained silent.⁵⁵

Compelled, however, 'to relieve the destitute whatever their status', encouraged to provide treatment in the workhouse, 'in the interests of [economies of] scale and efficiency' and facilitated by the creation of more flexible and financially strengthened Unions, a 'silent revolution in policy' took place and workhouse provision for parturient women, 'spontaneously', 'extensively' and 'rapidly' developed.⁵⁶ In a random survey of 48 provincial workhouses (June 1866 - March 1867), for example, Dr Edward Smith, the Poor Law Board's newly appointed Medical Inspector, found one or more lying-in wards provided in every workhouse he visited even though many were rural, with hardly any form of

**TABLE 1.7: DR EDWARD SMITH'S REVIEW OF '48'
PROVINCIAL WORKHOUSES DURING 1866 AND 1867**

Location of Workhouse	Number of Cases	Number of Sick	% of Case Total Sick	Number of Sick Beds	Number of Maternity Beds	Detached Infirmary?	Number of Paid Nurses	Medical Officer (£ Salary)
Liverpool	3,194	1,031	32	1,190	33	No	49	75
Birmingham	1,926	582	30	650	25	Yes	22	250
Portsea Island	1,475	186	13	259	15	Yes	0	315
Manchester	1,319	830	63	822	20	No	14	140
Sheffield	844	288	34	163		Yes	5	100
Nottingham				278	8	No	2	150
Warrington	750	238	32	273	10	Yes	2	200
Norwich	730	130	18	119		Yes	2	
Bath	650	251	36	250	3	Yes	6	150
Leeds	542	206	38	152		Yes	4	120
Dudley	526	287	54	199	6	No		
Leicester	481	88	14	120	9	Yes	3	80
Stockport	470	84	18	104		Yes	2	
Edmonton	422	127	30	124	5	Yes	2	60
Devonport	417	115	27	137	7	Yes	1	120
Ipswich	382	111	31	113	4	Yes	2	80
Gloucester	353	45	13	120		Yes	2	40
Ecclesal	338	91	27	90		No	5	90
Cheltenham	316	132	42			No	1	45
Derby	309	52	17	75	4	No	2	75
Chelmsford	300	81	27	84	6	Yes	1	84
Cardiff	287	78	27	101	7	No	2	50
Bedminster	261	49	19	67	4	Yes	1	
Dartford	227	40	18	68		Yes	0	85

Liverpool, Manchester and Birmingham Workhouses employed residential staff (in the case of Liverpool x3, hence the £75)

Details only exist for 47 Workhouses, not the 48 as stated in the source

Location of Workhouses	Number of Cases	Number of Sick	% of Case Total Sick	Number of Sick Beds	Number of Maternity Beds	Detached Infirmary?	Number of Paid Nurses	Medical Officer (£ Salary)
Worcester	208	70	34	102	4	Yes	1	35
Lincoln	207	36	17	65	8	No	1	65
Totnes	197	50	25	47		No	1	
Heraford	181	86	53	71	5	No	1	
Wimbor	158	21	13	20		No	0	
Loughborough	148	58	39	54	7	Yes	0	100
Atcham	145	52	36	35	5	Yes	0	
Grantham	145	33	23	50	7	No	1	
Fareham	128	72	56	58	5	No	1	
Bosmere	122	23	19	32		No	1	30
Keynsham	119	39	33	47	3	No	0	
Bigglesworth	104	32	31	37		No	1	45
Ruthin	90	17	19	43	3	No	0	25
Carmanthen	89	25	29	74	4	No	0	
St Asaph	88	6	7	18		No	0	
Alberbury	86	23	27	25		No	0	40
Blandford	84	20	24	38		Yes	0	20
St Neots	79	4	5	27		Yes	0	40
Armesbury	77	23	30	19		No	0	155
Hatfield	68	26	38	20		No	1	30
Winsbourne	68	9	13	19	3	No	1	20
Chesterton	30	15	50	57	3	No	1	50
Barton On Inwell				74	2	yes	1	

Blank Spaces: no information available

Source: Dr Edward Smith's Review of the State of the Poor and Treatment of

classification and only a handful of beds and patients (Table 1.7).⁵⁷

There was, however, 'extraordinary diversity of policy' 'in the construction, size and internal arrangements', of workhouses and their maternity departments, which were as 'different from each other as light and darkness'.⁵⁸ The extent and scope of workhouse maternity provision depended very much upon local circumstance and management, for it was the locally elected Guardians for each of the Poor Law Unions and not the central Poor Law Authorities, which generated, administered and dispensed the necessary funding, and therefore called the tune. The latter 'could cajole, encourage, recommend, inspect, but could not compel unions'.⁵⁹ Social need, however, was not always a high priority and often took second place to saving the rates and conditioning the poor to be provident, self-disciplined and independent, by deterring them from seeking relief and failing that, treating them 'on hard and plain lines'.⁶⁰ So it was only in some of the more highly industrialized cities such as Birmingham, Manchester and Liverpool, where social needs were greatest and Union Boards more liberal, that Guardians provided separate maternity wards of 'large and ample dimensions', staffed by trained nurses, midwives and residential doctors (Table 1.7).⁶¹ In more rural areas, such as Amesbury Union workhouse, Wiltshire, the lying-in ward was nothing more than 'a small room with narrow beds', in a workhouse with 'very little furniture of any

kind except beds', no paid nurse and a medical officer who was responsible for district as well as workhouse cases. Similarly, at Grantham Union workhouse, Lincolnshire, the lying-in wards were used by 'imbecile women' and by children, leaving parturient women to be attended in one of 'two small rooms, or properly speaking, wooden boxes', deemed by the Poor Law Inspector, H. B. Farnell, 'wholly unfit for the purpose'.⁶²

Though admittedly 'not much midwifery is done in rural workhouses', the disparity between urban and rural institutions was never as obvious as might be imagined. Carmarthen workhouse for instance, 'an average specimen of the workhouses in Wales', filled its lying-in wards with the general sick and at Ipswich and Edmonton, two relatively large workhouses, accommodating over 350 and 400 paupers respectively, the maternity ward was nothing more than 'a small one-storied room, unsuited for its purpose' (Table 1.7). At Loughborough, which was noted for its 'homely aspects', providing each female patient with a tea-tray, towel, comb, brush, soap, hand basin, urinal, a locker, crockery and clothes basket, there were no water closets in the infirmary building, no fixed baths and no distribution of hot and cold water. In addition, there was only one pauper nurse, deserted by her husband ten years earlier, to act as nurse and midwife. On the other hand, Fareham Union Workhouse, Southampton, which was a much smaller, rural institution, accommodating no more than half a dozen midwifery cases a

**TABLE 1.8: POOR LAW MATERNITY (WARD) CASES
18 DECEMBER 1869**

	Total No. of Wkths	No of Wkths with Mat case	% of Wkths with Mat case	No. of Ward Deliveries	Other Mat. Cases	Mat. Case Total	Case Ratio Per wkth
Metropolis	42	36	86	181	15	136	4.9
South East	99	54	54	104	32	138	0.8
South Midlands	66	27	41	47	7	54	0.6
Eastern	56	18	32	27	4	31	1.1
South West	79	38	48	80	7	87	1.1
West Midlands	84	49	58	106	9	115	1.4
North Midlands	45	27	60	53	2	55	1.2
North West	48	22	41	95	11	106	2.2
York	63	26	41	39	3	41	0.6
Northern	41	16	39	28	2	30	0.7
Wales	47	21	45	44	3	47	1.0
Provincial Totals	628	298	47	623	79	702	1.1
Grand Totals	670	334	50	814	94	908	1.3

**TABLE 1.9: POOR LAW MATERNITY (HOME) CASES
18 DECEMBER 1869**

	Total No. of Unions	No of Unions with Mat case	% of Unions with Mat case	No. of Home Deliveries	Other Mat. Cases	Mat. Case Total	Case Ratio Per Union
Metropolis	30	29	97	219	83	302	10.1
South East	95	89	94	363	76	439	4.6
South Midlands	64	61	95	188	91	279	4.3
Eastern	56	55	98	250	67	317	5.7
South West	79	62	78	225	63	288	3.6
West Midlands	83	65	78	235	51	286	3.4
North Midlands	45	41	91	99	20	119	2.6
North West	40	31	77	126	30	156	3.9
York	60	34	57	64	29	93	1.6
Northern	39	21	54	56	5	61	1.5
Wales	53	31	58	102	15	117	2.2
Provincial Totals	614	490	80	1,708	447	2,155	3.5
Grand Totals	644	519	81	1,927	530	2,457	3.8

FIGURE 1.4: PERCENTAGE OF PROVINCIAL WORKHOUSES ATTENDING MATERNITY WARD CASES 18 DECEMBER 1869

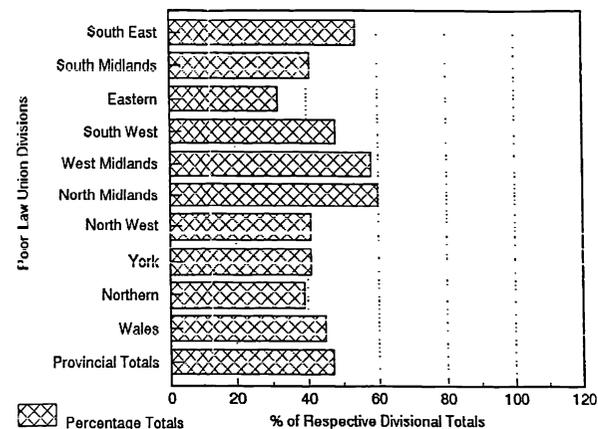
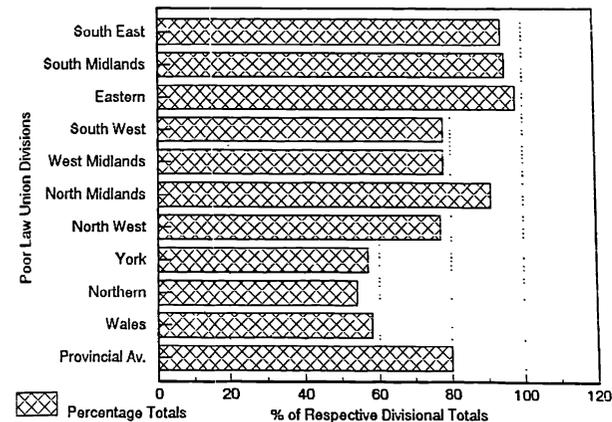


FIGURE 1.5: PERCENTAGE OF PROVINCIAL UNIONS ATTENDING MATERNITY HOME CASES 18 DECEMBER 1869



Source: Return of Numbers of Paupers on District and Workhouse Medical Officers' Relief Books in England and Wales 1870-1879 (1881) LVII

year, had a five bed maternity ward, a paid nurse and Guardians who 'readily provide all extra diets and medical appliances'.⁶³ The extent, quality and scope of maternity provision, as the Webbs concluded, bore 'no relation to the character of the district, to the needs of the mothers or to the rate of mortality', only to the views of the Guardians and their own perceptions of the problem.⁶⁴

Another, more geographically-comprehensive survey was completed two years after Dr. Smith's work, based on one day only, on returns made on Saturday, 18 December, 1869, but involving 615 provincial Poor Law Unions and 633 workhouses, distributed throughout provincial England and Wales. On that one day alone, there were 623 ward deliveries and 79 other cases 'connected with and consequent on parturition', including pregnancy, miscarriage, post-natal debility and breast disorders. Of the 628 provincial workhouses which submitted a return for 18 December, 43 per cent had at least one confinement case on the registers and another 4 per cent had a case of pregnancy or problematic, post-labour recovery. Practically half, therefore, of all provincial workhouses had, on that one day, a maternity case to attend (Table 1.8).

It also appears, as far as anything can be made from data collected on one day, that there was a regional bias to these figures. It seems that fewer workhouses were dealing with ward labours in the southern, rural districts than in the northern, industrialized regions of

TABLE 1.10: THE STATISTICS OF CHILD BIRTH IN UNION
WORKHOUSES 1871-1880

Divisions and Union Counties	Total No. of WKhs	No. of Deliveries	Av. No. per WKh p. a	% Women Single	1 Maternal Death in:
THE METROPOLIS	46	22,427	49	73	114
STH EAST:Surrey	10	1,637	16	78	66
Kent	26	2,442	9	76	124
Sussex	26	1,712	7	86	157
Southampton	26	1,821	7	86	80
Berkshire	12	738	6	88	152
Divisional Total	100	8,350	8	83	101
STH MDLND:Middlesex	6	874	15	92	99
Hertford	13	517	4	65	132
Buckingham	8	317	4	93	115
Oxford	9	577	6	74	294
Northampton	12	644	5	73	161
Huntington	3	153	5	86	78
Bedford	6	294	5	81	143
Cambridge	9	670	7	67	682
Divisional Total	66	4,046	6	79	153
EASTERN: Essex	17	1,388	8	81	157
Suffolk	18	945	5	92	138
Norfolk	22	1,432	6	87	146
Divisional Total	57	3,765	6	87	147
STH WEST:Wiltshire	18	930	5	80	96
Dorset	12	561	5	92	82
Devon	20	2,148	10	85	136
Cornwall	13	1,689	13	90	192
Somerset	17	1,434	8	85	132
Divisional Total	80	6,762	8	86	133
WST MDLND:Gloucester	18	2,345	13	88	99
Hereford	8	458	6	91	153

WKh Totals based on return for December 1869

Divisions and Union Counties	Total No. of WKhs	No. of Deliveries	Av. No. per WKh p. a	% Women Single	1 Maternal Death in:
Salop	17	795	5	95	266
Stafford	16	2,507	16	81	78
Worcester	13	1,078	8	88	137
Warwick	13	2,437	19	79	138
Divisional Total	59	7,040	11	87	110
NTH MDLND:Leicester	11	881	8	79	98
Rutland	2	75	4	96	77
Lincoln	14	1,629	12	86	138
Nottingham	9	975	11	85	110
Derby	9	685	8	81	87
Divisional Total	45	4,225	9	85	110
NTH WEST:Chester	11	1,382	12	79	173
Lancashire	37	12,037	33	65	95
Divisional Total	48	13,399	22	72	99
YORK DIV. Wst Riding	37	4,214	11	70	102
Est Riding	10	1,163	12	80	208
Nth Riding	16	731	5	92	186
Divisional Total	63	6,108	9	84	124
NORTHERN:Durham	15	1,668	11	80	106
Nthumberland	12	911	8	84	135
Cumberland	10	732	7	92	106
Wstmoresland	4	197	5	95	201
Divisional Total	41	3,508	9	88	116
WELSH DIV:Monmouth	6	682	11	87	213
Nth Wales	14	1,165	8	84	143
Sth Wales	28	1,579	6	94	201
Divisional Total	48	3,376	8	88	143
Provincial Totals	633	63,179	10	84	113
Grand Totals	679	85,606	13	78	115

Source: Local Government Board Report 1881-1882 Appendix No. 35 pp.160-163

the country. In the Eastern Counties for example, of Essex, Suffolk and Norfolk, only 32 per cent of the 56 workhouses had a confinement case, where as in the five North Midland and two North Western Counties, 60 and 46 per cent of the 45 and 48 workhouses, respectively, dealt with a confinement case that day (Table 1.8 and Figure 1.4). Indeed, in four of Lancashire's workhouses, namely Ashton-under-Lyne, Chorlton, Liverpool and Manchester (New Bridge Street), there were between 10 and 20 ward deliveries on that one day alone, hence the North West with the largest ratio of maternity cases to workhouses (Table 1.8).⁶⁵

The decennial survey on childbirth in Union workhouses (1871-80) confirms these geographical variations.⁶⁶ Whilst, on average, 33 women were delivered annually in each of Lancashire's 37 workhouses compared to a national figure of 10 confinements for each workhouse, per annum, there were only about four or five workhouse deliveries each year in the Southern-rural counties of Hertford, Buckingham, Wiltshire and Dorset, to name but four (Table 1.10). In these latter counties, as it will be explained, greater emphasis was placed on home, as opposed to ward deliveries.

Nonetheless, referring to England and Wales as a whole, there were, during the 1870s, as many as 9,000 workhouse deliveries a year, well over 6,000 of which took place in provincial workhouses, a far cry from the situation in 1834 when the New Poor Law made no provision whatsoever for delivering women within its own

institutions (Table 1.10). Writing 60 years after the introduction of the New Poor Law the Webbs still found that few people appreciated the extent to which Poor Law institutions had, in effect, become maternity hospitals. Whilst in the smaller rural establishments there continued to be 'perhaps only half a dozen confinements each in a year', in the town workhouses they were 'numbered by dozens or by scores. And in such populous Parishes or Unions as Liverpool, West Derby, Belfast, and Glasgow, a baby is born in the Workhouse nearly every day'. 'From such statistics as are available', which were in reality very few, the Webbs concluded (1909) 'that the annual number of births in the Poor Law institutions of the United Kingdom probably exceeds 15,000'.⁶⁷

Outside the workhouse, the number of home births conducted under the auspices of the Poor Law Unions probably exceeded twice that number, despite Rosemary White's conclusions to the contrary.⁶⁸ Whereas, for example, there were 623 workhouse deliveries on 18 December 1869, there were simultaneously, 1,708 home deliveries sponsored by the Poor Law, and whereas 47 per cent of all workhouses dealt with a maternity case that day, 80 per cent of all Poor Law Unions, submitting returns, attended a home delivery (Tables 1.8 and 1.9). In only six of the 44 Poor Law counties, all Northern based, were there more pauper women confined in the workhouse that day than there were in their own homes.⁶⁹ As late as 1910, the Webbs found that a domiciliary

confinement was still 'one of the most usual occasions' for which the services of a District Medical Officer were required.⁷⁰

Not surprisingly, the probability of a pregnant woman applying for poor relief and being confined in her own home, as opposed to the workhouse, depended upon the area in which she lived. There was more chance of this happening in the Southern and Eastern Counties, where as few as 5 per cent of pauper women were attended in the workhouse, compared to 30 to 50 per cent amongst industrialized Northern Unions, where '...midwifery work forms, as a rule, only a small part of a district medical officer's duties'.⁷¹ According to McVail, one principal reason for this was the prevalence, in Urban Unions, of certified midwives and voluntary organisations who conducted a large number of the domiciliary confinements. Also rural workhouses, which, generally allocated no more than two or three beds to midwifery cases, were rarely used for 'hospital patients in the ordinary sense', but largely for the old and infirm; they were simply not equipped to deal with a sudden complication or provide twenty-four hour attendance by a qualified nurse or midwife.⁷²

With regard to ward deliveries, the emphasis really lay with the urban workhouse, which from the 1880s began to provide a Poor Law Infirmary, an administratively and physically separate unit from the workhouse. Located, by the early 1900s, in 'the sixty or seventy largest provincial centres', either, as in the case of Salford,

'quite outside of Salford and away from the workhouse', or as at King's Norton, Birmingham, in the workhouse grounds, but, 'under entirely separate government', these Poor Law Infirmaries spearheaded the dissolution of the ideological and financial mould that had practically paralysed the Poor Law medical services.⁷³ Their creation, in the advent of the Poor Law reforms of the 1860s, 'marked a new departure in the Poor Law's treatment of the sick...as invalids to be cured rather than paupers to be penalized' and signified a 'growing respect for professional treatment', no more so than in the field of maternity care.⁷⁴

Despite, for example, John McVail's analogy of Poor Law medical relief, as 'a cripple supported on two crutches', dependent on voluntary hospital provision and gratuitous medical aid, he was nevertheless 'impressed with the admirable work done in maternity wards of the large city infirmaries'.

The wards are nearly in all cases, models of comfort and cleanliness, the nurses are well trained, the instruments and appliances are beyond criticism, and medical assistance is available whenever required.⁷⁵

At King's Norton Union, Birmingham, for instance, which admitted on average, only 47 confinement cases a year (1903-07), there was nonetheless a two-storey building at the north end of the Infirmary allocated to maternity cases. Containing two labour wards and two general wards of five beds each and supervised by a trained, registered midwife, the facilities were 'in every respect

satisfactory' and even included midwifery training. Similarly, at Prescott Union, St. Helens, where the maternity department accepted fewer than 40 cases a year, the wards were clean, with good cross ventilation, and cases were generally attended by the resident medical officer, though the night nurse was also a certified midwife. At Salford, where about 80 women were annually attended by a trained midwife and if necessary a doctor, the Poor Law Lying-in wards, despite being in the workhouse, were very popular, 'So much so that working men's wives occasionally declare themselves deserted in order to get admission'.⁷⁶ Using the above examples, McVail concluded that,

there can be no comparison between the comfort and safety and results of midwifery practice in such surroundings [large city infirmaries] and that conducted in the homes of the labouring classes. Quite certainly the future health of the mother is infinitely better protected in the former, than in the latter.⁷⁷

The Poor Law institution, though often the brunt of negative sentiment, had, in the realms of midwifery at least, played a very positive and forthright role.

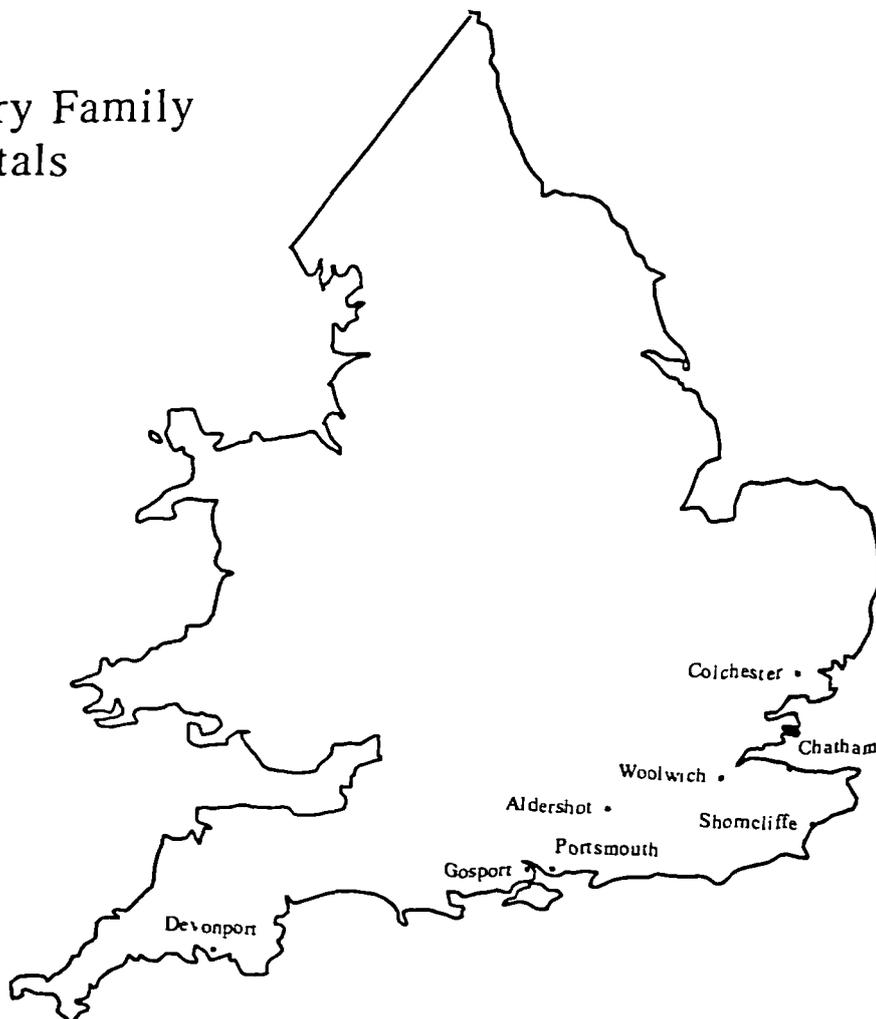
Military Family Hospitals

Catering for a transient body of women 'here to-day and off to-morrow, unable to form local ties', the military family hospitals, 'chiefly intended for cases of parturition' held an equally impressive record.⁷⁸ At Aldershot, for example, the largest provincial military

	1860's	1871	1880'S	1905	1911
Aldershot	234 p.a. (1857-1869)	358		235	510
Chatham	57 p.a. (1863-1869)	56		123	
Colchester	50 p.a. (1865-1870)	67	53 (1881-1882)		
Devonport	20 p.a. (1861-1869)	44		75	
Gosport	66 (1861)				
Portsmouth	34 p.a. (1861-1869)	63		84	
Shorncliffe	??	47			
Woolwich	125 p.a. (1863-1869)	138		114	

Source: see note 60

Map 2: Military Family Hospitals



Source: see note 80

hospital for confinement cases, attending over 230 women a year, there were 31 maternal fatalities or one female death for every 98 confined (1857-69). At the smaller institutions the results were even more favourable. At Shorncliffe, which over the same period admitted fewer than 60 labours a year, there were four maternal deaths, or one for every 175 attended, and at Colchester, which had registered 252 deliveries (1865-70), there were no deaths.⁷⁹

There were eight military family hospitals, 'administered and controlled on identical lines by a central authority', which attended the pregnant wives of soldiers, a section of the regiment accounting for 6 per cent of its total force.⁸⁰ Though all located in the South East of England, one of these hospitals, at Woolwich, was London based (Map 2). Collectively attending over 1,000 cases each year and possessing nearly 200 beds (1907), these hospitals, 'for statistical purposes, [constituted] one huge maternity hospital, almost equalling the aggregate number of beds of Queen Charlotte's, the Rotunda and York Road Lying-in Hospitals'.⁸¹ As individual establishments, however, with the exception of Aldershot, they were very small (Table 1.11). At Shorncliffe, the maternity wards were nothing more than 'an old wooden hut of the simplest construction...scarcely more than a makeshift', and at Colchester, the lying-in hospital was,

simply a double wooden hut, joined at an angle and...divided into a confinement room of 1,386

cubic feet, and a lying-in ward of 2,520 cubic feet, and four small rooms which act as a kitchen, office, storeroom, and matron's room.⁸²

The simplicity of the structure, located away from the main hospital, and the receipt of women into separate, thoroughly ventilated and clean wards, attended by the army's own trained midwives, was, in the eyes of many contemporaries, the principal reason for the military hospital's success as a maternity establishment.⁸³

Maternity Homes

Eulogized as the ideal 'lying-in hospital', the military family hospital was partly responsible for engendering the idea of the maternity home, for though a twentieth century phenomenon, it had its roots firmly embedded in the previous century.⁸⁴ As early as 1848, James Simpson had suggested the abolition of hospitals, in favour of 'villages or cottages, with one, or at most two, patients in each room', to reduce the problem of 'febrile and inflammatory attacks'.⁸⁵ Twelve years later and disturbed by the 'excessive', often 'appalling' mortality rates associated with the maternity hospital, the Registrar General, William Farr, also sought to replace it with a 'natuary' which was a small wooden hut, 'clean and ventilated, armed with proper appliances, and a midwife on the spot' and 'sufficiently distributed in the right quarters about towns'.⁸⁶ The inspiration for this was Florence Nightingale's account of the two military establishments at Shorncliffe and Colchester

which, as already noted, confined about 50 women a year in small wooden huts 'of the simplest construction' with practically no maternal fatalities and 'not a single death from any puerperal disease'.⁸⁷ It is along such lines that Evory Kennedy envisaged a reformed Rotunda, calling for the conversion of the main building into a hospital for Women's Diseases and the erection of small Swiss or Italian style Châlets in the hospital's grounds, to accommodate the 1,000 or so confinements normally attended in the main building.⁸⁸

Though Kennedy's proposals for the Rotunda never materialized, partly because of the hospital's successful use of antiseptics from the 1880s and partly because of the impracticality of it all, maternity hospitals at the time, nonetheless responded to the ideas of Kennedy, Simpson and others, and emulated certain features of the maternity home. At Liverpool, for example, the new maternity hospital was opened in November 1884, comprising three separate, two-storey buildings, only two of which contained maternity wards, three on each floor, containing one bed each, twelve beds in total. Retained in isolation for 14 days, there was neither the demand nor the capacity to deal with very large numbers of women, on average, 160 a year (1886-95).⁸⁹

Once the medical profession became more intimately involved in maternity hospital practice and once this institution became the focus of community attention, then the number of hospitalised deliveries, at it has been seen, increased rapidly. Following a professional coup

in 1896, 'great strides in popularity' were made at Liverpool's Lying-in Hospital, to the extent that by 1915 the bed capacity had almost doubled, 22 of the 23 beds were used daily and the hospital was filled to 'overflowing'.⁹⁰ By 1928 a new maternity hospital had been built, the bed capacity had trebled and the number of ward confinements was ten times what it was in 1892 (Table 1.5).

It was during this same period of intense activity and national anxiety over the quantity and quality of the indigenous population, that the maternity home emerged as a separate and distinct entity from the maternity hospital.

Maternity homes, on the one hand, exist primarily as homes - places provided with every facility for rendering the natural process of labour as comfortable as is humanly possible ...Maternity hospitals, on the other hand, exist mostly for the purpose of dealing with the abnormal and not with the normal confinement.⁹¹

Their physically small size, containing no more than 10 to 15 beds, and located 'almost entirely' in converted houses, proved as much a restriction to their work as any predetermined policy, though their bed total was arranged in consultation with the Ministry of Health and after 1926 all homes had to be registered and subject to a whole range of regulations and restrictions.⁹²

As for the statistics, Robert Pinker placed the total number of maternity homes in 1921 at 199, with 2,463 beds, of which 2,063 were annually occupied, and attributes the increase to Local and Central Government

TABLE 1.12: VOLUNTARY AND MUNICIPAL MATERNITY HOMES: ENGLAND 1921-1926

	Number of Homes	Number of Beds	Number of Deliveries	% Attended By Midwives
1921	95	1,034	14,674	81
1922	107	1,300	18,550	82
1923	118	1,442	17,167	79
1924	107	1,334	18,741	78
1925	116		21,559	81
1926	117		22,237	78

Source: Annual Reports of The Chief Medical Officer of Health 1921-1926

TABLE 1.13: ENGLISH MATERNITY HOMES AND HOSPITALS APRIL 1929

	Voluntary:		Municipal:		Grand Totals:	
	Total	Bed No.	Total	Bed No.	Total	Bed No.
Old Established						
Maternity Hospitals:	13	566			13	566
New Wards in Old						
Hospitals:	12	235	5	91	17	326
Maternity Homes and						
Hospitals:	37	632	63	849	100	1,481
Small Wards in						
General & Ctge Hsps:	17	66	5	19	22	85
Totals:	79	1,521	73	959	152	2,480

Source: Annual Report of the Chief Medical Officer of Health 1928 (London, 1929) p.31.

grants made available under the terms of the Maternal and Child Welfare Act, 1918 (Table 1.2).⁹³ Cross reference, however, with Pinker's own source, the Annual Report of the Chief Medical Officer of Health For The Year 1921, reveals that 104 of these institutions were homes for unmarried mothers and whilst they could accommodate over 1,400 women and existed 'to ensure a safe and suitable confinement', the actual delivery took place in a hospital. A further 45 of the 199 'homes' were not maternity homes at all, but infant hospitals and observation wards for 'ailing babies'. In fact, there were only 95 maternity homes, 'not including hospitals', housing 1,034 beds and confining 14,674 women, 11,906 of whom, or 81 per cent, were delivered by staff midwives, the remainder by doctors (Table 1.12).⁹⁴

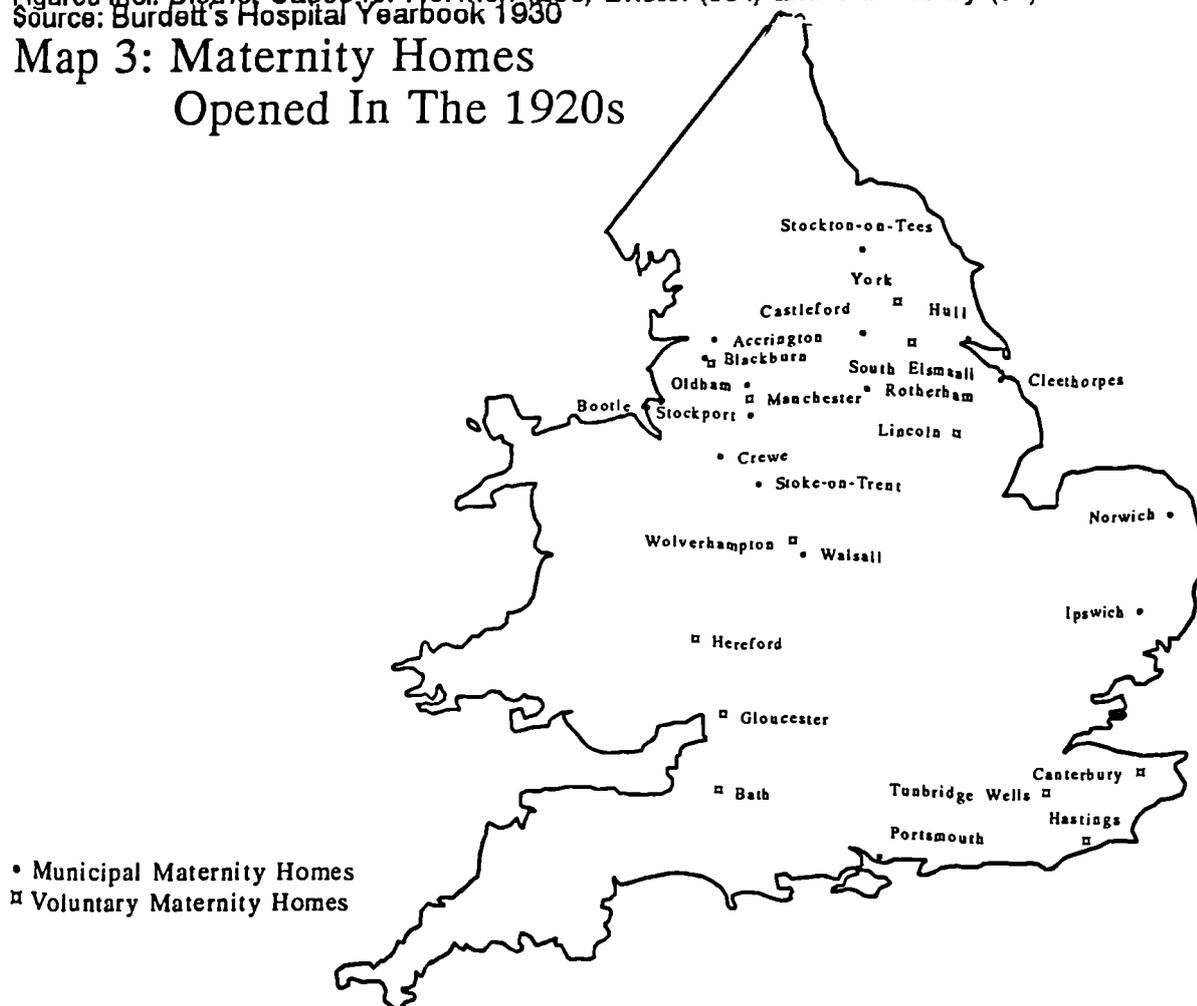
No further details about the 95 homes are available, so that it is difficult to determine whether, for instance, these homes were voluntary or publicly funded or were provincial or London based. By April 1929, the Chief Medical Officer of Health, Sir George Newman, reported that the number of maternity homes had increased slightly, to 100 establishments and 1,481 beds. In addition, there were 13 'Old established Maternity Hospitals', 17 'New Wards in Old Hospitals' and 22 'Small Wards in General and Cottage Hospitals' providing another 1,000 beds (Table 1.13). Whilst the various institutions in this latter report were identified as either being municipal or voluntary funded, the figures still say little about their location and distribution.

TABLE 1.14: BURDETT'S PROVINCIAL MATERNITY HOME RETURNS 1928

	Bed\Case Nos.		Bed\Case Nos.
Municipal Mat. Homes		Voluntary Mat. Homes	
Accrington (1927)	8\	Bath (1886)	6\ 804
Blackburn (1923)	\225	Blackburn (1896)	\1731
Bootle (1922)	\137	Canterbury (1881)	6\ 171
Castleford (1929)		Gloicester ??	10\ 166
Cleethorpes (1929)	10\	Hastings ??	13\ 83
Crewe (1921)	8\	Hereford (1887)	\ 623
Hull ??	36\651	Lincoln	7\
Ipswich ??	7\125	Manchester (1864)	18\265
Norwich ??	\506	South Elmsall (1929)	4\
Oldham (1928)	12\	Tunbridge Wells (1925)	9\158
Portsmouth (1929)	16\	Wolverampton ??	\562
Rotherham (1921)	12\238	York (1788)	
Stockport (1921)	16\		
Stockton-on-Tees 1919	12\280		
Stoke-on-Trent (1928)	30\342		
Walsall ??	10\		

Voluntary Homes Dates refer to the date the Charity (not the home) was founded
 Figures incl. District Cases for Norwich (265) Bristol (694) and Canterbury (94)
 Source: Burdett's Hospital Yearbook 1930

**Map 3: Maternity Homes
 Opened In The 1920s**



Albeit a limited sample, omitting to refer even to the country's first municipal maternity home at Bradford (1915), Burdett's registration of maternity homes does suggest a Northern bias, particularly in the high infant and maternal mortality areas of East Lancashire (Map 3). Here, homes were opened in Nelson(1919), Blackburn(1923), Accrington(1927) and Oldham(1928). The peripheral location of a maternity home, to the far north, at Stockton-on-Tees, was similarly a local municipal response to what was known to have been an exceptionally high infant and maternal mortality area.⁹⁵ The southern location of some of the maternity homes and dispensaries were the efforts of long established domiciliary maternity charities and nursing associations, such as those at Canterbury (1881) and Bath (1886) (Table 1.13).

In the light of the maternity home's belated appearance in the 1920s, the general hospital's outright rejection of midwifery cases and the maternity hospital's slow recovery from the puerperal fever scandals of the 1860s, the general workhouse and later, the Poor Law Infirmary, was the principal form of institutional confinement. Though an important point and one worthy of further investigation, it ought not to detract from the importance of the maternity hospital as an institutional force of local significance, as the following chapter on Manchester will highlight, and as one Poor Law official, Dr Henry Bygott, District Medical Officer of Aston Poor Law Union, alluded to in 1909:

The following question was addressed some time ago to busy general practitioners:- You are a workman earning 30s a week, your wife expects to be confined. Do you, outside the Lying-in Charity [Birmingham Maternity Hospital], know of any decent and respectable woman whom you could afford to pay, whom you would trust to attend your wife? No satisfactory reply was ever received.⁹⁶

Notes to Chapter 1

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3. Robert Pinker, *English Hospital Statistics 1861-1938* (London, 1966).
4. Return Showing the Names of Institutions Approved as Training Schools for Midwives by the Central Midwives Board, and the Number of Midwifery Cases treated by each during the 12 months previous to the Board's approval, BPP, 1906, (309), XCVIII, 639.
5. *Burdett's Hospital Annual and Year Book of Philanthropy* ed. by Henry Burdett, 36 vols (London, 1894-1930); The volumes for the following years: 1892 (London, 1894), 1900 (London, 1902), 1910 (London, 1912), 1921 (London, 1922), 1928 (London, 1930), have been selected for this study.
6. For the sake of uniformity, centralisation and economy, the traditional agent of relief, the parish, was replaced by a Poor Law Union operated by elected Guardians and employing paid officials, all of which were supervised by a Central Poor Law Authority, which was (1834-47) the Poor Law Commission, (1847-71) the Poor Law Board and (1871-1919) the Local Government Board. Sidney and Beatrice Webb, *English Local Government and English Poor Law Policy*, 11 vols (London, 1909; repr. 1963), 10, p.136.
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 11. A. Logan Turner, *Story of a General Hospital: The Royal Infirmary of Edinburgh 1729-1929* (Edinburgh, 1937), pp.98-100.
 12. Charles Rowling, 'The History of the Florence Nightingale Lying-in Ward, King's College Hospital', *Transactions of the Obstetrical Society of London*, 14 (1872), 50-56 (pp.52-53).
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 14. *Lancet*, 4 September 1869, p.344.
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 16. Arthur Brook, Margaret Carlton and W. Graham Cannon, *The History of Addenbrooke's Hospital Cambridge* (Cambridge, 1989), pp.292, 371-73.
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- 1800-1948', in *The Hospital in History*, ed. by Lindsay Granshaw and Roy Porter (London, 1989), pp.199-220; Gerald Rivett, *The Development of the London Hospital System 1823-1982* (London, 1986), pp.44-45. For a particularly good case example of a specialist hospital, see Lindsay Granshaw, *St. Mark's Hospital, London: A Social History of a Specialist Hospital* (London, 1985).
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 63. E. Smith, Appendix, pp.58-59, 85-86, 97-100, 115-18.
 64. Webbs, Minority Report, pp.84-85.
 65. Return of Numbers of Paupers on District and Workhouse Medical Officers Relief Books in England and Wales, 1869-70, BPP 1870 (468) LVIII, 727.
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 73. For a detailed history of such a Poor Law Infirmary see, Pamela M. Pennock, 'The Evolution of St.

James's 1848-94', *Publications of the Thoresby Society* 59 (1986), 129-76.

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75. McVail, pp.56, 148.
76. McVail, Appendix XIV. p.278, Appendix XVII, pp.290, 93 XVIII, p.299.
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78. F. R. Hogg, *Transactions of the Obstetrical Society of London*, 14 (1872), 35-37 (pp.35-36).
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80. For Statistics on Military Family Hospitals see:
(For the 1860s) Nightingale, p.12. General Report of the Commission appointed by the Secretary of State for War, for improving the sanitary condition of barracks and hospitals, BPP 1861 (2839) XVI, I. Hogg pp.35-36 (For the 1880s), Forbes Dick, Report of the Military Lying-in Hospital of Colchester for 1881 and 1882, *The BMJ*, 3 February 1883, p.203 (For 1905) Return Showing the Nurses of Institutions Approved as Training Schools for Midwives, (for 1911) S. F. Green, pp.686-88.
81. By 1932 it was estimated the Army Medical Corps was responsible for no less than 2,600, which was collectively comparable to Queen Charlotte's (2,500) and the Rotunda (3,800), Blackman, p.296, E. L. Moss, p.290.
82. Nightingale, pp.62-64, Forbes Dick, p.203.
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Chapter Two

The Manchester Maternity Hospitals:
A Case Study In Demographic Relevance

1860-1905

St. Mary's Hospitals: An Introduction

Driven by increasing threats to their autonomy by migrant physicians and the 'Infirmity Revolution of 1790', which challenged their nepotistic and monopolistic practices, the two surgeon families that had dominated the running of the Manchester Royal Infirmary, father and son, Charles and Thomas White, and brothers Richard and Edward Hall, resigned and established their own lying-in hospital in May 1790.¹ The initial intention was to hospitalise a variety of maternity categories, including widows, wives of prisoners, soldiers and poorly paid apprentices, complicated cases and 'those who cannot possibly be accommodated at home', for such benevolence acted as a focus for prospective subscribers, constituting 'a more dramatic appeal than the routinely poor'.² However, culminating financial debts and a feeling that both morally and medically, institutional midwifery was unsuitable, because of high death rates and the removal of women from their familial roles, eventually led to the hospital's closure in 1813. Thereafter, the focus was on 'the delivery of poor married women in their own habitations' by hospital staff, a practice that was to characterise institutional midwifery in Manchester for the remainder of the century. When a hospital was eventually re-opened in Quay Street, in 1856, it was renamed 'St. Mary's Hospital and Dispensary for the Diseases Peculiar to Women and also for the Diseases of Children under 6 years of age',

admitting parturient women only in 'cases of danger and emergency'.³

To argue, as Pickstone does, that St. Mary's maternity work, as a consequence of treating gynaecology and childhood cases 'was deliberately played down' and a 'real change in function intended', is to ignore the ever increasing numbers of women attended by the hospital's midwives and the re-emergence of maternity wards in 1889.⁴ Moreover, the official change of title and the new admission policies, reflecting national trends towards medical specialisms and managerial efforts to widen the hospital's charitable appeal, did not fully meet initial aspirations. Within three years of opening the Quay Street premises, the Board of Management was forced to offer admission to any woman from any part of the United Kingdom because many of the hospital beds remained empty and local demand proved insufficient to fill them.⁵ There was also a considerable period (1889-1904) when the hospital's twenty-six bed children's wing remained empty, despite such inducements as inviting mothers to remain with and suckle their young, extending the age limit from six to ten years of age, allowing up to four weeks' residence, reducing the ward fee from one guinea to 10s 6d and reforming the recommendation system allowing children to be accepted as out-patients without a recommendation. Owing to parents' reluctance to send children into hospital and their stoicism towards medical provision for themselves and their offspring, the number of children treated either in their own home or in the

hospital was always less in any one year than the corresponding totals of midwifery cases.⁶

The importance of institutional midwifery in Manchester was further underlined by the voluntary funding of a second maternity branch at the Manchester Southern Hospital for Diseases of Women and Children, which opened in 1866 to cater for the hitherto neglected southern and eastern quarters of the city. As was often the case when promoting a new charity, specialist medical attention for women and children was claimed to be,

utterly inadequate to the necessities of a city like Manchester; and strange to say, either by chance or inadvertence, they have all been placed at the Northern end of the city...beyond the reach (at a time when it is needed) of the immense population residing in the South and Eastern sides of Manchester.

Hence the Southern's location at 118 Grosevnor Street, Chorlton-on-Medlock, South Manchester, with three principal objectives: 'the careful and special treatment of sick children, and of Women who are suffering from ailments peculiar to their sex; together, with attendance upon poor women in their confinement'.⁷ To fulfil this latter task, a maternity hospital was opened in its own right in Upper Brook Street in 1887 and referred to as The Manchester Maternity Hospital until the Southern merged with St. Mary's in 1905, when all three hospitals were collectively known as St. Mary's Hospitals.

FIGURE 2.1: QUINQUENNIAL AVERAGES: HOME DELIVERIES ST. MARY'S AND THE SOUTHERN 1861/65 TO 1901/05

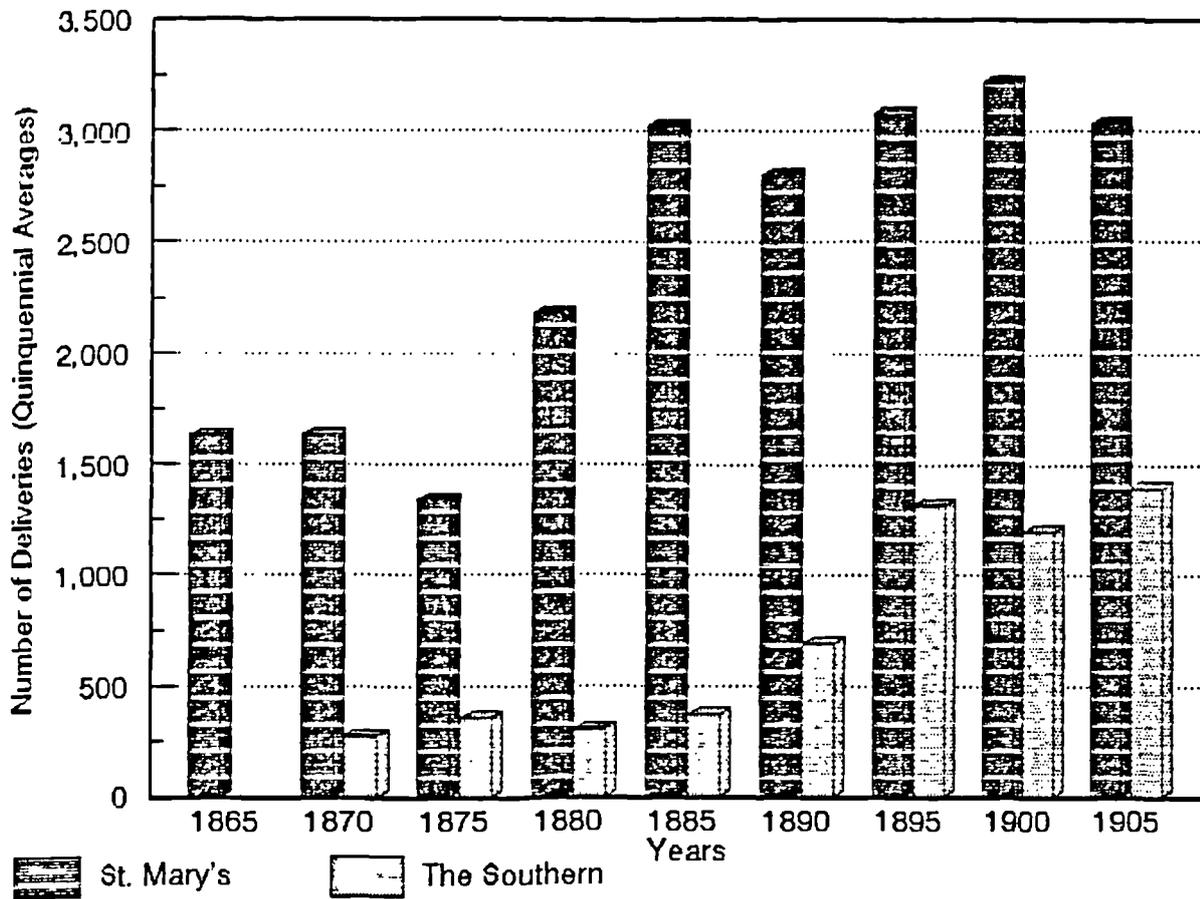
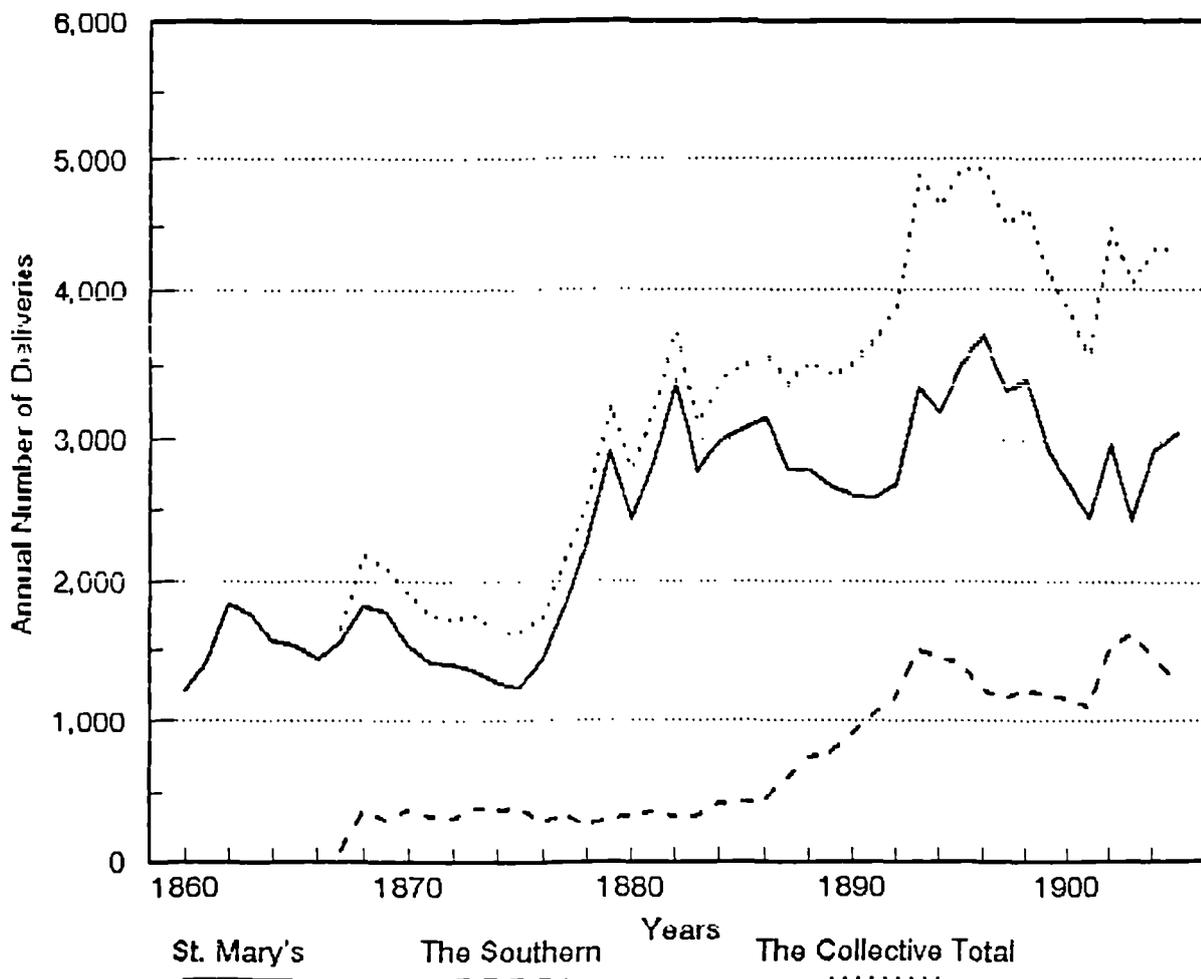


FIGURE 2.2: ANNUAL NUMBER OF HOME DELIVERIES ST. MARY'S AND THE SOUTHERN 1860-1905



Southern Figures based on 4yr Av. (1867/70) and 3yr Av. (1901/03) and annual figures estimated for years 1885/1887/1904.
 Source: Southern Annual Reports 1867-1905 & St. Mary's Annual Reports 1861-1905

Case Totals: Their Demographic Relevance

Taken as an expression of institutional growth, rising confinement totals at the two hospitals were both marked and at times, immediate and rapid, particularly after the 1880s, a watershed in obstetrical advances and institutional services. Demographically, however, the emphasis must lie, until World War I at least, with the hospital's district maternity service, referring to women who gave birth in their own home but with the full support of an institutional organisation. Within this sector, where the hospital provided parturient women with all the necessary resources to deliver a child (financial, medical and material, all but the labour room) growth was most significant and progressive. At the Southern, which towards the end of the nineteenth century was annually responsible for over 1,000 home deliveries, quinquennial averages had multiplied more than four-fold, from an annual average of 281 cases (1867-70) to 1,174 (1896-1900) (Figure 2.1). Similarly, St. Mary's, whose district figures surpassed those of the major London hospitals, was, by the early 1890s, responsible for over 3,000 home deliveries a year compared with an annual figure which was practically half that, three decades earlier (Figure 2.1). Their district services alone, collectively accounted for nearly 5,000 confinements a year by the mid-1890s (Figure 2.2). As the Chairman of St. Mary's Hospital Board remarked, 'It is remarkable how few of our citizens are aware of the

TABLE 2.1: HOSPITAL MATERNITY CASES AS A PROPORTION OF THE ANNUAL BIRTH TOTAL

<u>(A) England & Wales</u> <u>Confined In 1890 By:</u>	Annual Number of Confinements	As a % of the Annual Birth Total (870,000)
Poor Law Hospitals 1871-80	8,561	1.0%
Maternity Hosps: In-Patients	2,771	0.3%
Disp\Out-Door Charities	36,066	4.1%
Independent Midwives & Docs	822,602	94.6%

<u>(B) Manchester</u> <u>Confined In 1892 By:</u>	Annual Number of Confinements	As a % of the Annual Birth Total (17,208)
Poor Law Hospitals	210	1.2%
Maternity Hosps: In-Patients	186	1.1%
Out-Patients	3,720	21.6%
Independent Midwives & Docs	13,092	76.1%

Source: (A) 'Statistics extracted mostly from the 1889 reports': in Select Cttee Report on Midwives' Registration BPP (1892) XIV, Appendix 4, p.136.
I. Loudon 'Deaths In Childbed', Medical History, 30 (1986), 1-41 (p.22).

Source: (B) Southern and St. Mary's Annual Reports 1892
Abstracts of Accounts of Chorlton and Manchester Township Unions 1892
Manchester Medical Officer of Health Annual Report 1892

great work done by our staff at the homes of the poor', a lack of appreciation many modern historians share.⁸

The maternity hospital's contribution to Victorian and Edwardian, maternal health and welfare has been constantly undervalued, not least on the grounds that as 'the vast majority of confinements were conducted at home', the hospital's role was instantly restricted.⁹ Whilst there is no denying that a nineteenth-century birth was essentially a domiciliary event, the hospital's share in this experience cannot be so readily overlooked or the implications ignored. According to Loudon's calculations based on parliamentary evidence submitted for 1890, only 0.3 per cent of all births in England and Wales were conducted in the voluntary hospital sector and a further 4.6 per cent under the auspices of dispensaries or out-patient lying-in charities, so that,

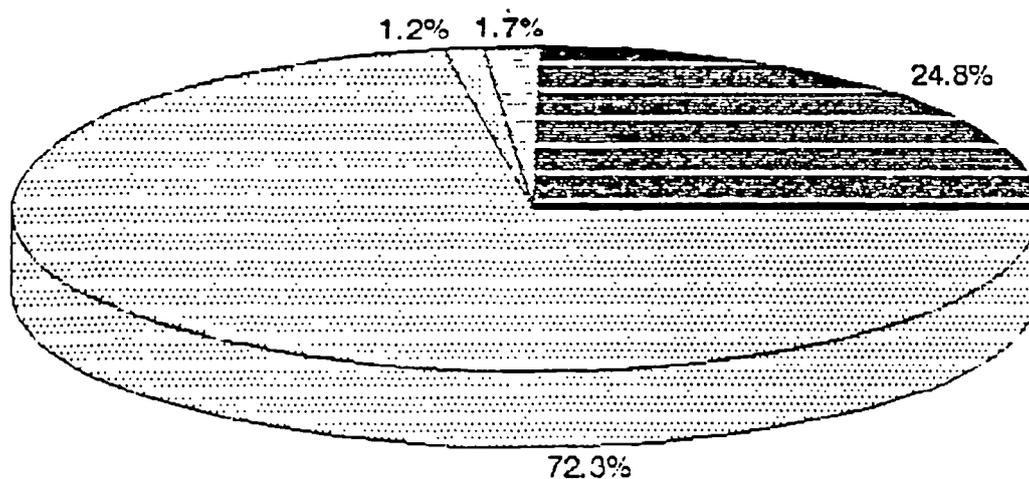
In the context of England and Wales as a whole the statistics of a hospital delivery had very little effect...The pattern of maternal mortality was essentially that of private domiciliary midwifery.¹⁰

Yet if the same approach is applied to Manchester, the hospital statistics feature far more significantly in the city's birth profiles (Tables 2.1(A) and (B)). During 1892, for example, there were 17,208 registered live births in Manchester, for which the city's major maternity institution, St. Mary's, was responsible for 2,535 domiciliary deliveries and the confinement of 53 women in its hospital wards. In addition, the Southern conducted 1,185 home labours and an estimated 133 ward

**TABLE 2.2: POOR LAW AND MATERNITY HOSPITAL CASES
MANCHESTER 1861\5-1901\5**

	Home Labours:		Ward Labours:				As a % of City	
	(A) St.Mary's	(B) Southern	(C) St.Mary's	(D) Southern	(E) Crumpsall	(F) Withington	Birth Total A-D	A-f
1861-1865	1,632				287	80	1632	1999
1866-1870	1,634	281			303	121	1915	2239
1871-1875	1,347	359			214	85	1706	2005
1876-1880	2,100	311			214	83	2411	2708
1881-1885	2,861	376			178	97	3227	3512
1886-1890	2,644	698			156	83	3342	3591
1891-1895	2,970	1,323	73	154	131	83	4520	4734
(17,174 City Births)							26.3%	27.6%
1896-1900	3,121	1,199	177	185	129	91	4682	4902
(17,588 City Births)							26.6%	27.9%
1901-1905	2,553	1,403	278	200	117	123	4434	4674
(17,418 City Births)							25.5%	26.8%

**FIGURE 2.3: PROPORTION OF MANCHESTER'S BIRTH TOTAL
ATTENDED BY MATERNITY HOSPITALS & WORKHOUSES**



Annual Birth Total
17,381 p.a. 1891-1900

	Hospital Home Cases		Hospital Ward Cases
	Poor Law Ward Cases		Private (Midwife/Doctor) Cases

St. Mary's excludes Pendleton figures. Withington figures for 1866\68\69 n.a.

Source: Hosp Annual Rpts. Annual Abstract of Accounts Chorlton & Township Unions

confinements, whilst the Poor Law institutions at Crumpsall and Withington collectively delivered 210 ward cases. In total, the voluntary hospital sector was responsible for some 4,000 births, which if conducted amongst Manchester women only, would have represented practically a quarter of the city's birth total (Table 2.1(B)). These calculations would seem representative for the decade as a whole, for the total number of women delivered in their own homes by the Southern and St. Mary's totalled, on average, 4,307 cases a year (1891-1900), which, allowing for possible twin and triplet births, accounted for about 25 per cent of the city's birth total, although at times the proportion was nearer 30 per cent (Table 2.2 and Figure 2.3). Those confined within the hospital, either at St. Mary's or the Southern during the same period, accounted for 294 deliveries a year, or another 1.7 per cent of the annual birth total, and the Poor Law Institutions for an average of 217 deliveries or 1.2 per cent of the birth total (Table 2.2 and Figure 2.3).

These figures, as with all statistics, have to be treated with a certain degree of caution because of the presumption that the hospitals' admissions referred only to women living within the Manchester boundaries. This may well have been the case with the Southern, whose district maternity cases were 'strictly confined' to Hulme, Ardwick and Chorlton, but at St. Mary's the calculations are far less certain because the hospital included part of Salford within its catchment area (Map

4). However, as only 14 of the 467 subscribers who could recommend cases to St. Mary's in 1900, for example, actually lived in Salford and as a sizeable proportion of Salford's residential districts were excluded from St. Mary's catchment area, the proportion of cases accepted by St. Mary's from Salford was negligible.¹¹

At the lowest estimate, Manchester's own Medical Officer of Health, James Niven, calculated in 1905 that 3,150 of the city's births were conducted by midwives employed by the Southern and St. Mary's Hospitals, which accounted for more than 30 per cent of all midwife deliveries (10,233) and 69 per cent of births conducted by trained midwives (7,453), but only 17 per cent of the city birth total.¹² Although this latter figure may be disputed, since it appears to refer to home deliveries involving a midwife only and not a hospital doctor, who would have been present at abnormal deliveries, it still remains much more significant than national estimates allow. Niven's calculations also illustrate the point, that not only were Loudon's 'well-trained' midwives the hospitals' principal representatives at the home deliveries, but they were also a prominent feature of the city's midwife community. Moreover, Niven's conservative estimates become even more significant, once it is realized that the hospitals concentrated their resources on the lower economic strata of the working masses, 'the weakest and most defenceless' and 'cases of the utmost necessity', 'unable to pay for medical aid'.¹³

FIGURE 2.4: QUINQUENNIAL AVERAGES: WARD DELIVERIES MANCHESTER 1861\65-1901\05

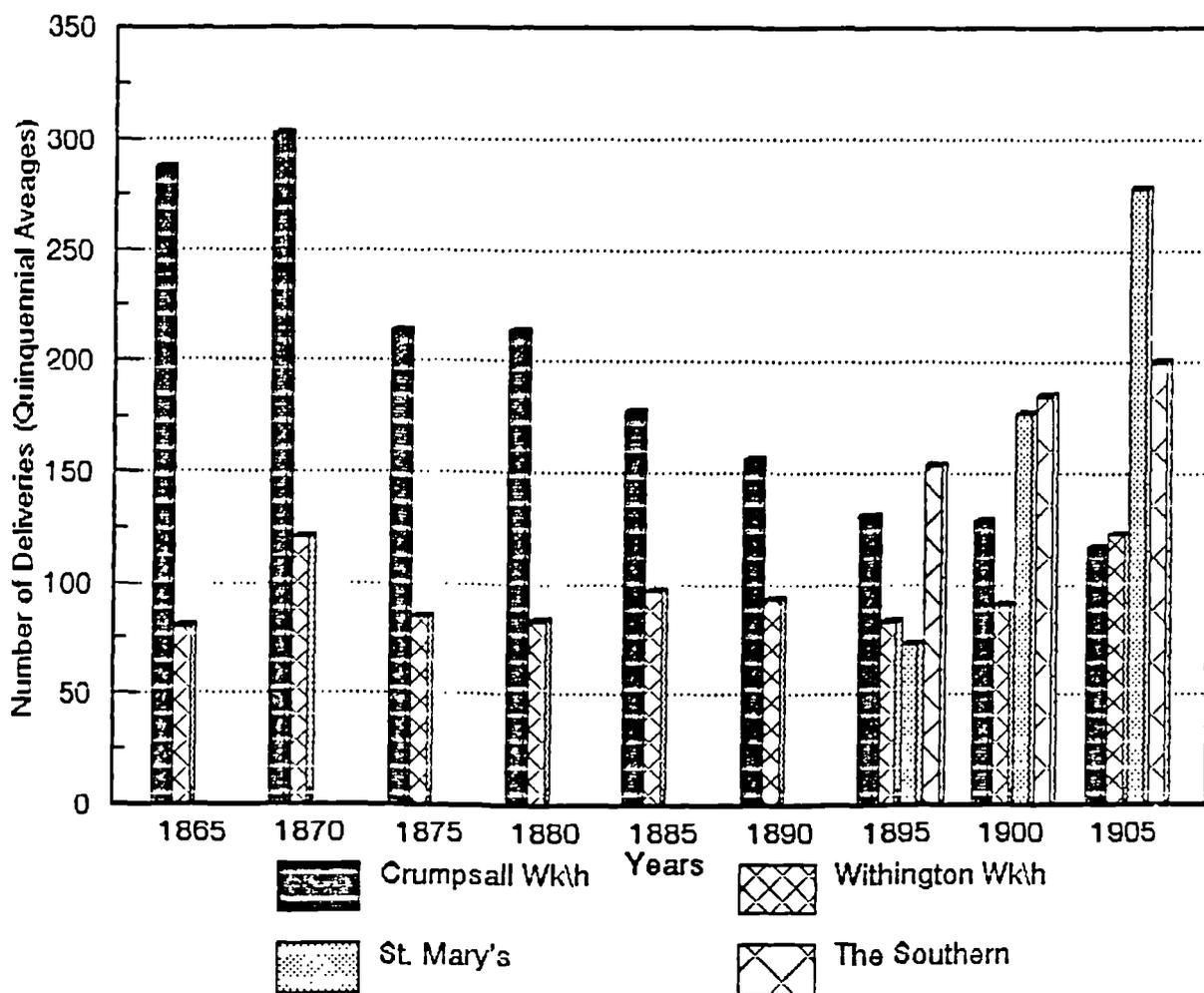
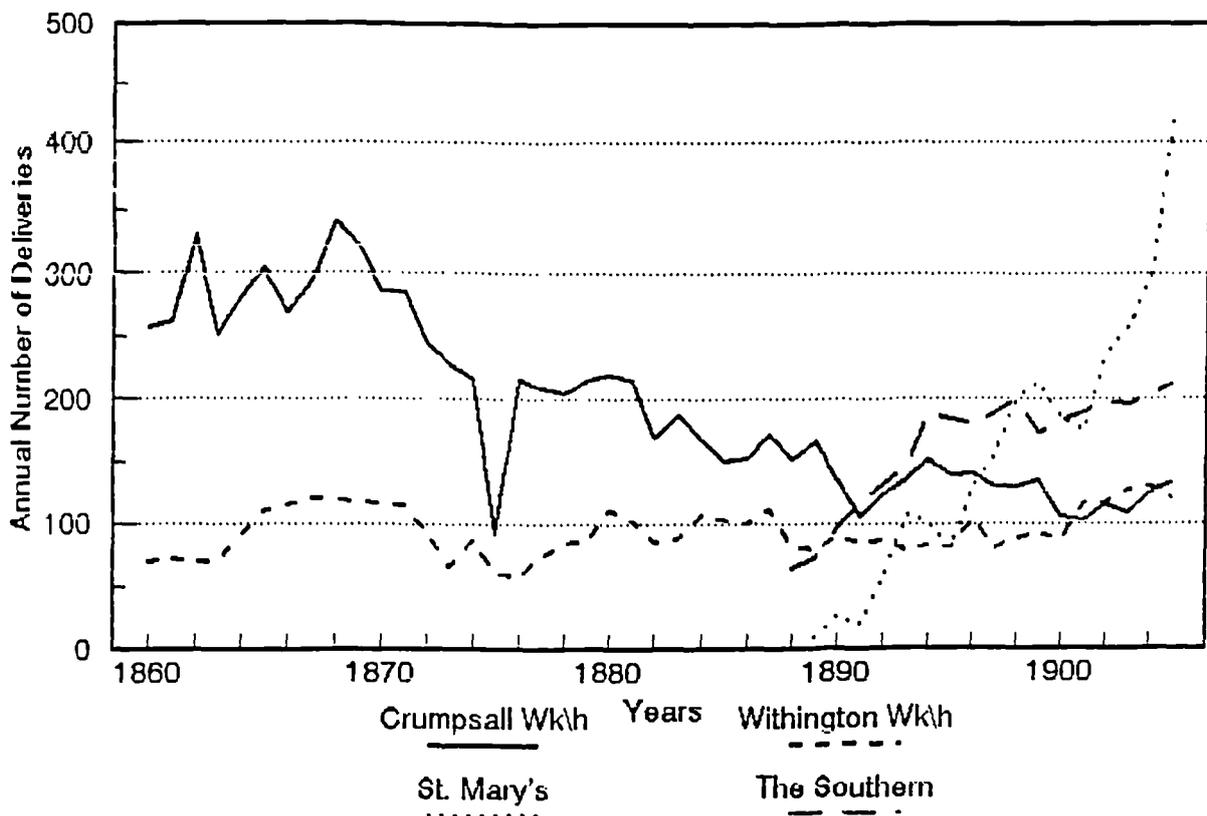


FIGURE 2.5: WARD DELIVERIES MANCHESTER 1860-1905



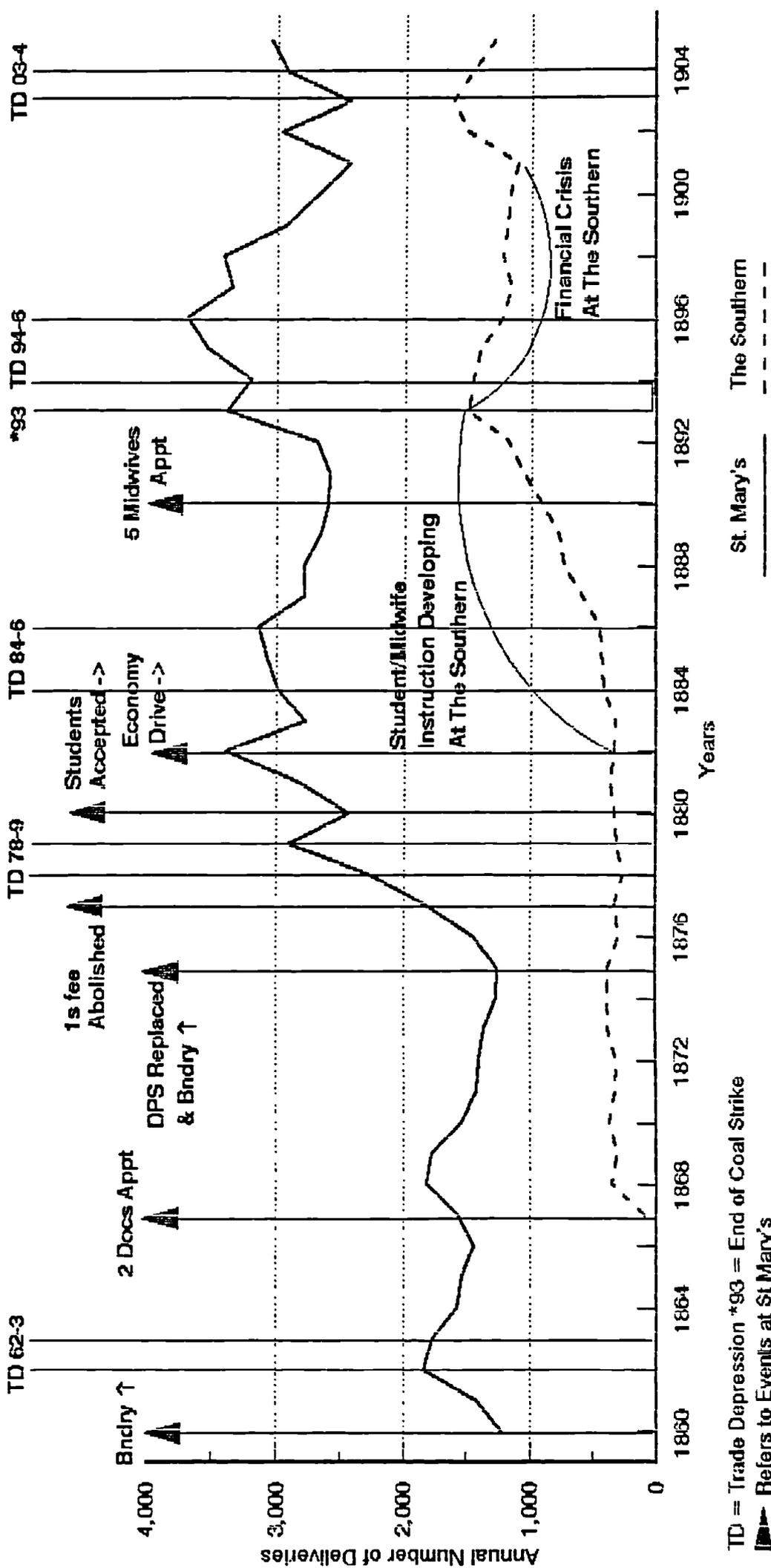
Figures n.a. 1892\1904 (Southern) 1864\66\68\69\70 (Withington)

Source: Hosp Anl Reports. Annual Abstract of Accounts Chorlton & Township Unions

Although for most of the period hospitalised midwifery totals were relatively small, they did display persistent increases and surpassed the local, Poor Law maternity figures at a very early date. The Southern, the first voluntary hospital in Manchester to hospitalise midwifery cases since the early 1800s, multiplied its maternity admissions three fold (1888-1905) and surpassed the annual number of births conducted by Withington and Crumpsall Poor Law institutions, within three and four years of opening respectively (Figures 2.4 and 2.5). Similarly, at a time when Crumpsall underwent a decline in the number of births it conducted (1890-1905) and Withington's births figure increased only very slightly, St. Mary's annual case total rose 16-fold, from 25 to 422 ward deliveries a year during the same period (Figures 2.4 and 2.5). Contrary to national trends and assumptions, a hospitalised birth in late Victorian Manchester was more readily associated with the voluntary sector than the Poor Law and presented the one 'dynamic element' in the field of local maternity care.

Whereas stagnation and regression were characteristic features of the local Poor Law maternity services, because of the presence of a charitable alternative and the pauper stigma, insufficient demand was never really a reason for the periods of slow growth within the voluntary sector. The financial predicament was, on the other hand, for invariably 'income and expenditure' were found 'balancing on the wrong side'. A 'deplorable situation' had, for example, arisen at the

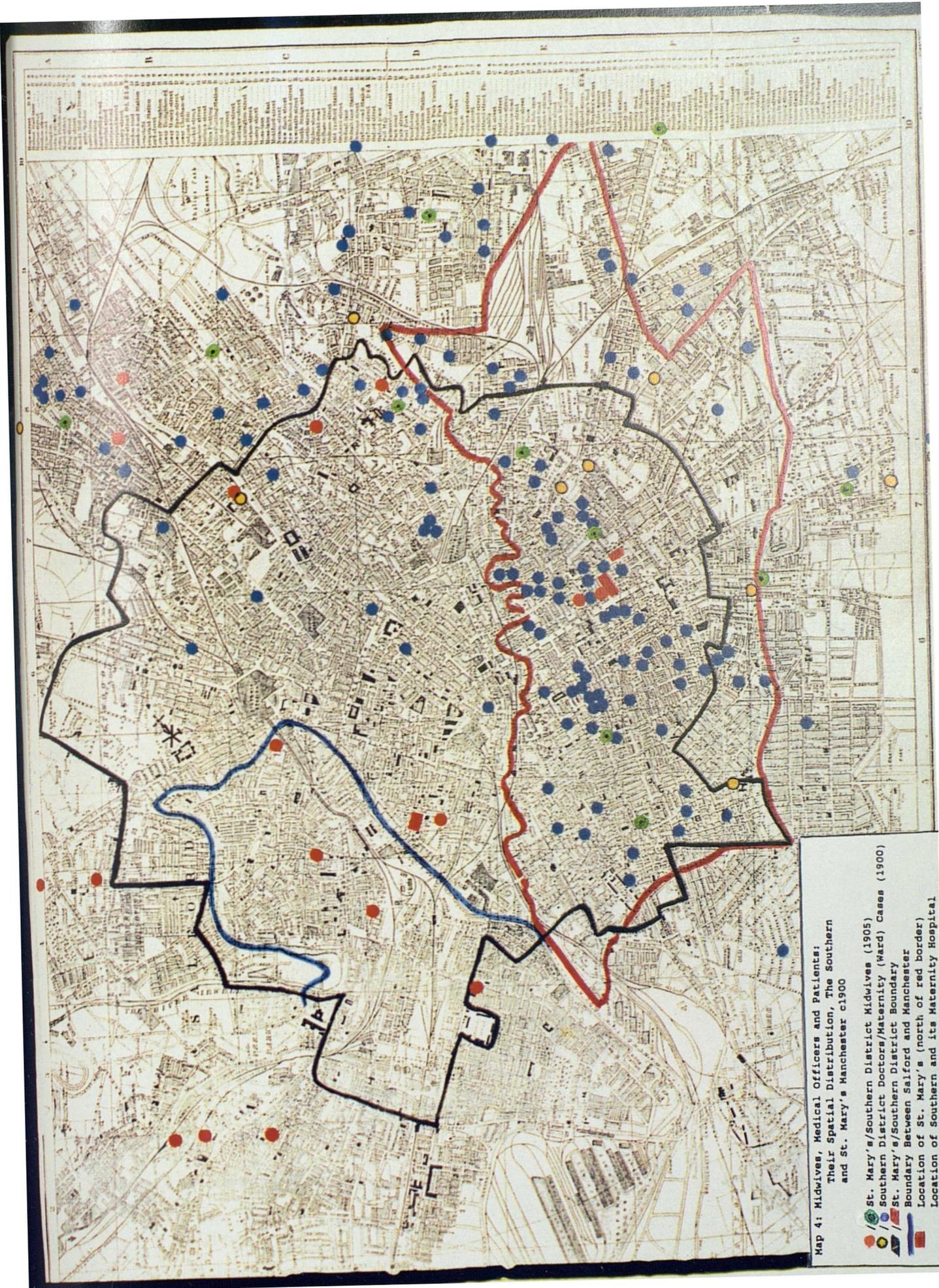
**FIGURE 2.12: ANNUAL NUMBER OF HOME DELIVERIES & EXTERNAL INFLUENCES
ST. MARY'S AND THE SOUTHERN 1860-1905**



TD = Trade Depression *93 = End of Coal Strike

▲ Refers to Events at St Mary's

Source: Southern Annual Reports 1867-1905 St. Mary's Annual Reports 1860-1905



Map 4: Midwives, Medical Officers and Patients:
 Their Spatial Distribution, The Southern
 and St. Mary's Manchester c1900

- / ● / ● / ● St. Mary's/Southern District Midwives (1905)
- / ● / ● / ● Southern District Doctors/Maternity (Ward) Cases (1900)
- / / St. Mary's/Southern District Boundary
- / Boundary Between Salford and Manchester
- Location of St. Mary's (north of red border)
- Location of Southern and its Maternity Hospital

Southern by the 1890s, when its annual revenue fell by £565 to £2,420 (1890-1900), due to fewer donations, and its annual deficit correspondingly rose by 155 per cent, to £955 per annum. Financial difficulties inevitably affected performance for district case totals fell, in-patient admissions stagnated and during the employment crisis of 1895 to 1896, which inflated St. Mary's district figures to heights not witnessed since the 1830s, the Southern remained unable to respond to the additional demand such a crisis provoked (Figures 2.2, 2.4, 2.5 and 2.12). The consequent and inevitable refusal of 'many deserving and urgent cases' and the growing frequency of 'times when the hospital was so full that it was impossible to find a bed...', meant admissions were increasingly restricted to 'those requiring special treatment, operations, or from other causes making it necessary that they should be attended to in the Hospital'.¹⁴

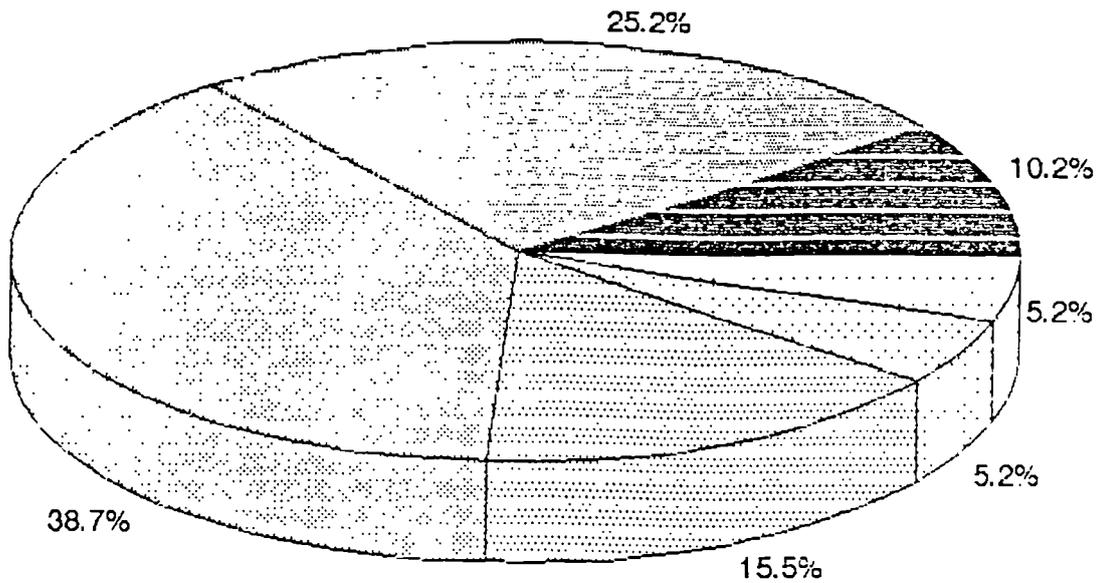
In and Around Manchester: The Hospital's Catchment Areas

Although an ailing financial situation frequently compromised the Southern's case capacity it was, along with St. Mary's, still in a commanding position to play an effective role, at least until World War I. This was partly due to the stringent geographical boundaries imposed, beyond which maternity applicants were firmly rejected (Map 4). Of the 926 maternity applicants refused assistance at St. Mary's (1869-77), 48 were

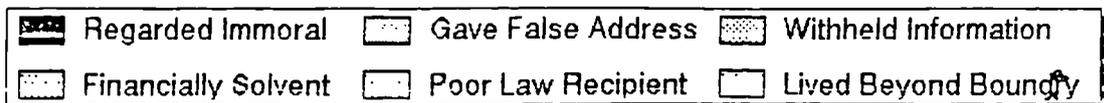
TABLE 2.3: CATEGORIES OF MATERNITY APPLICANT REFUSED ASSISTANCE BY ST. MARY'S 1869-1877

Rejected Because:	1869	1870	1871	1872	1873	1874	1875	1876	1877
Immorality: Unmarried	31	10	13	6	4	3	1	4	17
in 'House of Ill-Fame'								3	
Adultrress								2	
Gave False Address	53	18	24	14	17	12	25		70
Withheld Information		116	84	52	27	32	47		
Financially Solvent	5	49	41	17	10	6	4		11
Poor Law Recipient	11	12	11	4	4	3	0		3
Lived Beyond Boundry	7	2	3	5	4	9	6		12
Total Refused	107	207	176	98	66	65	83	9	113
% of Total Applicants	6	13	12	7	5	5	7	1	6

FIGURE 2.6: PERCENTAGES REFUSED ADMISSION ST. MARY'S 1869-1877



Total Refused Admission
924 (1869-1877)



Source: St. Mary's Annual Reports 1869-1877

rejected because they lived beyond the prescribed boundaries (Table 2.3 and Figure 2.6). Home deliveries had to live within a 1½ mile radius of the hospital, except in the direction of Salford, which was only partly included, whilst and ward deliveries had to live within a three mile radius of the Manchester Corn Exchange (Map 4). Encouraged by the Pendleton Ladies' Charity, St. Mary's did extend its domiciliary service in 1860 to include Pendleton, which was north-west of Salford. Later in 1908, sponsored by the United Sisters Maternity Society and prompted by the employment of two Jewish midwives, the hospital also agreed to attend all Jewish women living beyond the district boundaries.¹⁵

In practice, most of Manchester was within St. Mary's catchment area and what remained beyond those limits, to the south of the City, was from 1866 the province of the Southern, which specifically aimed its resources at 'the immense population residing in the South and East sides of Manchester' (Map 4). In the case of in-patients, however, the boundaries were not so geographically specific, for whilst the Southern's district services was restricted to Hulme, Ardwick and Chorlton, ward cases were also admitted from Ancoats, Miles Platting and Cheetham (Map 4). An important reason for imposing geographical limits and for establishing a second maternity hospital was that the longer a patient was in transit, the greater the likelihood of problems arising. Travelling by cab from her home in Openshaw, at least three miles from the Manchester Maternity

Hospital, a 'Mrs M', already in 'a very bad condition', 'pale' and 'full of cold', delivered en route, and though her still-birth may not have been avoidable, the woman's difficulties were undoubtedly exacerbated by the cab journey, during which the cabman had lost his way and spent more than an hour looking for the hospital.¹⁶

Nonetheless, the hospitals' extensive catchment areas and strategic location of midwives and doctors, from around whom maternity cases would have been drawn, ensured their services were accessible to the overwhelming majority of city residents. Moreover, the fact that there were two voluntary maternity hospitals 'almost at opposite ends of the town', not only meant an all encompassing service, but one that was also duplicated in the most impoverished and over-populated districts.¹⁷ Included in this superimposed zone, where women were catered for by both St. Mary's and the Southern hospitals, were some of Manchester's most poverty-stricken areas, including elements of Hulme, Chorlton-on-Medlock, Ardwick and Ancoats.

The city's working-class districts, constituting in the mid-nineteenth century, 'the great mass of smoky, dingy, sweltering and toiling Manchester', in which 'the vast proportion of cases' were 'crammed into filthy, overcrowded and insufficiently drained habitations', had altered very little by the end of the century. Though cellar dwellings had been eliminated and back-to-back houses with 'but one convenience for about twenty houses', considerably reduced in number to fewer than

3,000 by 1900, late Victorian Manchester, according to its own Medical Officer of Health, was still nothing more than 'a squalid, crowded, conglomeration of ugly, old and worn-out houses'. Endeavouring 'to avoid highly coloured pictures of life in the slums, and to put before the citizens of Manchester and Salford the bare facts', T. R. Marr, an acknowledged authority on the housing problem, presented a similar picture. Marr found many Mancunians 'living under conditions which made decent life well-nigh impossible' for the accommodation was 'frequently damp and cold...old and dirty', without a separate water-tap and only the share of a water-closet with perhaps as many as eight other households.¹⁸

Added to the problem of physically degenerating surroundings was one of 'serious overcrowding in Manchester', a 'contagion of numbers'. Amongst a sample of 2,528 residents in Ancoats in 1888, for example, 64 per cent were accommodated in lodgings where there were more than two persons per bedroom and 46 per cent where there were more than three persons per bedroom.¹⁹ Moreover, because of the ever-increasing concentration of people population densities were very high, with counts of 203 people per acre recorded and some city areas 'so crowded as almost to rival the central districts in London'. In Ancoats and Hulme, for instance, the population density averaged 113 and 140 people per acre respectively, at a time when the average density for the city was 42.²⁰

With as many as six people sleeping in a room, ten feet square, the concentration of large families in Manchester's working-class districts, 'accompanied by depressed vitality and increased mortality', had obvious implications for a home delivery. Another prime concern at the time, was a lack of privacy for the parturient woman and the practitioner, whether a midwife or doctor. The Medical Officer of Health's Survey of 1,000 confinement cases in a working-class district of Manchester as late as 1926, revealed that privacy was not possible in 54 per cent of the cases where houses were occupied by one family, and was not possible in 98 per cent of the cases where houses were occupied by more than one family.²¹ Whilst it is not entirely clear what Manchester Health officials surmised from these figures, whether for example, they were arguing from a moral stance or from a medical one, the constant presence of the mother's family and friends could have proved a serious threat, not only to the practitioner's hygiene attempts, but to their very autonomy in the labour room.

As has been suggested, certain inner city districts were more dilapidated in their appearance, more defective in their composition and far more detrimental in their impact, than even the general portrayal of working-class Manchester allows. One such district was Ancoats, where infant deaths, which were highly sensitive to environmental conditions, averaged 204 per thousand born (1899-1908) compared with a city average of 175. Angus Reach, a reporter with the Morning Chronicle, alleged

Ancoats, encompassing 'a wide-lying labyrinth of small dingy streets, narrow unsunned courts' and 'gloomy cul-de-sacs', housed 'some of the most squalid-looking streets, inhabited by swarms of the most squalid looking people which I have ever seen'.²² Perhaps such accounts, in their over-zealousness to convince and excite, exaggerated matters, but the local Medical Officer of Health, John Leigh, was equally emotive and condemnatory. He found Ancoat's residences to be

amongst the oldest in the city, the walls saturated with animal exhalation, and reeking with polluted atmosphere...No animal could live in them and flourish...and yet industrious men and women and little children live in these, and their weak frames and pallid faces tell of the surroundings.²³

Ancoats, as the Lancet concluded, was 'well known to be one of the dirtiest and most neglected [districts] in the city'.²⁴

Similarly, in the notoriously congested and insanitary district of Angel-Meadow, where numbers allegedly totalled 300 per acre, 'the great mass of this house property' was found to be 'old, dilapidated, insanitary and infested with vermin'.²⁵ In no uncertain terms, Angus Reid denounced the area as 'The lowest, most filthy, most unhealthy and most wicked locality in Manchester'. Even Manchester's largest populated district, Hulme, which Reid had regarded as 'a most cheering spectacle', with 'broad and airy streets', progressive house constructions and paved courtways, was by the early 1900s, 'fast becoming the most squalid, most

thickly populated, and most neglected part of Manchester...badly lighted and badly drained'.²⁶ Hulme's Cavalry Barracks had, for example, been closed in 1890 because of the environment's detrimental impact on the morale and physique of the soldiers. Yet local residents continued to sleep as many as eight in a room, six feet by eight, 'obliged to herd together without regard to health or decency'.²⁷ It is against this backcloth of decaying, damp, ill-repaired buildings, housing numbers beyond their capacity, without the convenience of either a water closet or a water tap, that childbirth inevitably took place.

Although sanitation, housing conditions and 'contagion of numbers', are considered to have been of minor influence on maternal mortality profiles, the notoriety of these factors in Manchester could only but serve to emphasise the importance of institutional midwifery to its host community.²⁸ The environmental effects on the indigenous populace have been well documented.²⁹ This was an age when life expectancy for a Mancunian man was 29 years, compared with the national average of 44 (1881-90), and for a woman 33 years, compared with a national average of 47. 'Defrauded by the evil surroundings of [their] birth', it is with little surprise that Manchester suffered 'the disgrace of being the city with the highest mortality in the kingdom'.³⁰

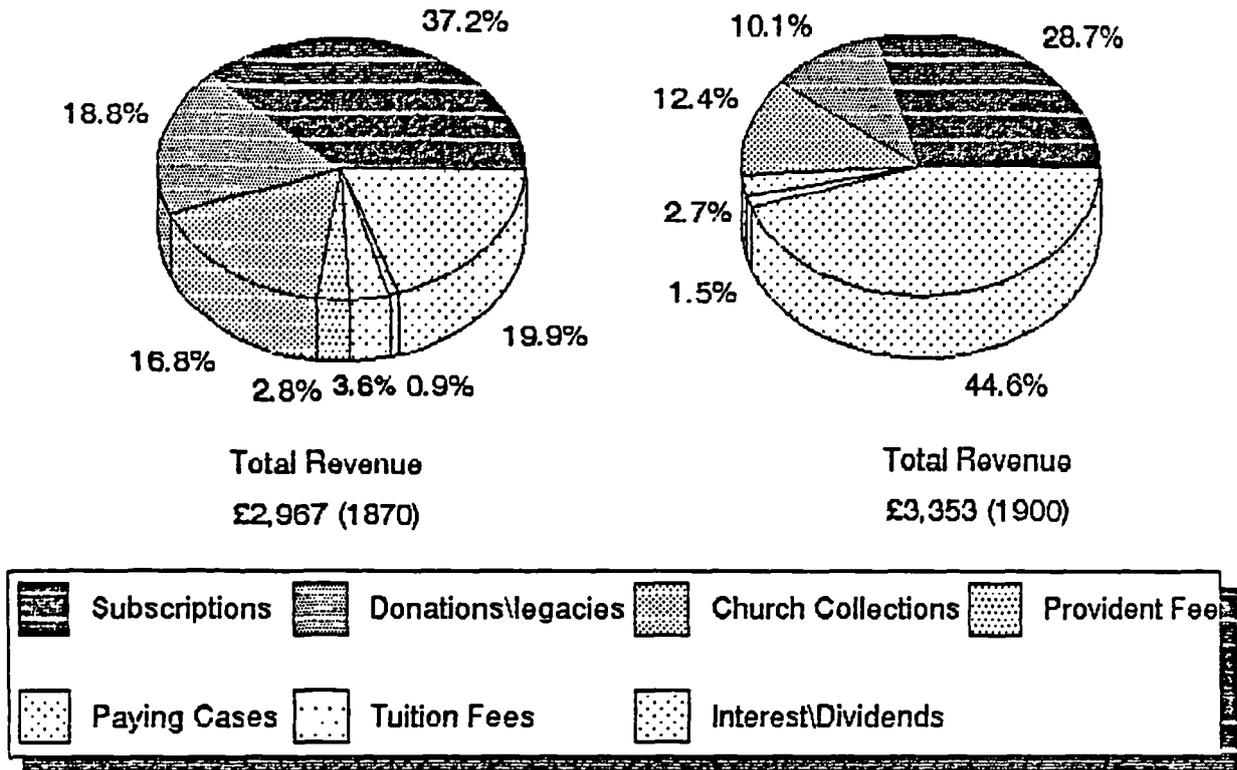
High mortality levels and low life expectancy had grave repercussions, not only on the general health of

women who grew 'stunted, weakly and even more anaemic than their feeble and ill set-up brothers', but also on the outcome of their pregnancy. Heavy physical work, unsatisfactory diet, insufficient fresh air and overcrowding, induced, amongst other things, fatigue and premature ageing, which could culminate in a delayed labour, the most common complication in childbirth. Also, if a woman was stunted and her bone structure deformed as a result of rickets in childhood, which was the fate of many of the indigent populace, then an abnormal pelvis was more than probable, which increased the duration of labour and the possibility of infection with an operative delivery.³¹

As the Mancunian's 'weak frames and pallid faces tell of the surroundings', so the admission registers proved equally revealing about the detrimental consequences of the women's environment. Entering the maternity hospital on the eve of their confinements, women were frequently described as being 'of poor health', 'pale and delicate', 'thin and badly nourished', or of a 'sickly appearance' and a 'rather delicate constitution'; if a woman's uncongenial surroundings did not immediately reduce the chances of a successful birth, then it certainly threatened the woman's own health and thus, indirectly, increased the risks at childbirth.³² It is apparent, therefore, that effective obstetrical provision in Manchester, in whatever form, had to be more pronounced than elsewhere, because adverse environmental conditions were all the more extreme. There was clearly

FIGURE 2.7: REVENUE SOURCES

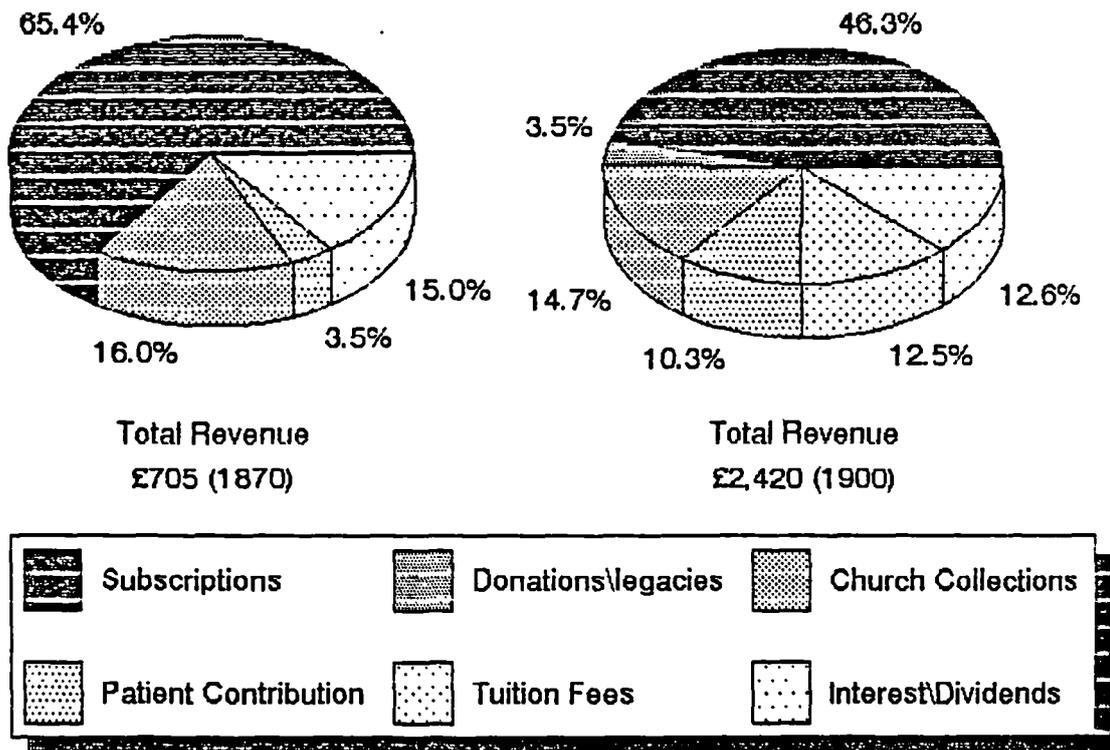
ST. MARY'S 1870 AND 1900



Provident Fee = 1s charge for maternity cases (before 1877)

Source: St. Mary's Annual Reports 1870 and 1900

**FIGURE 2.8: REVENUE SOURCES
THE SOUTHERN 1870 AND 1900**



Subscription & Donations counted as one in 1870

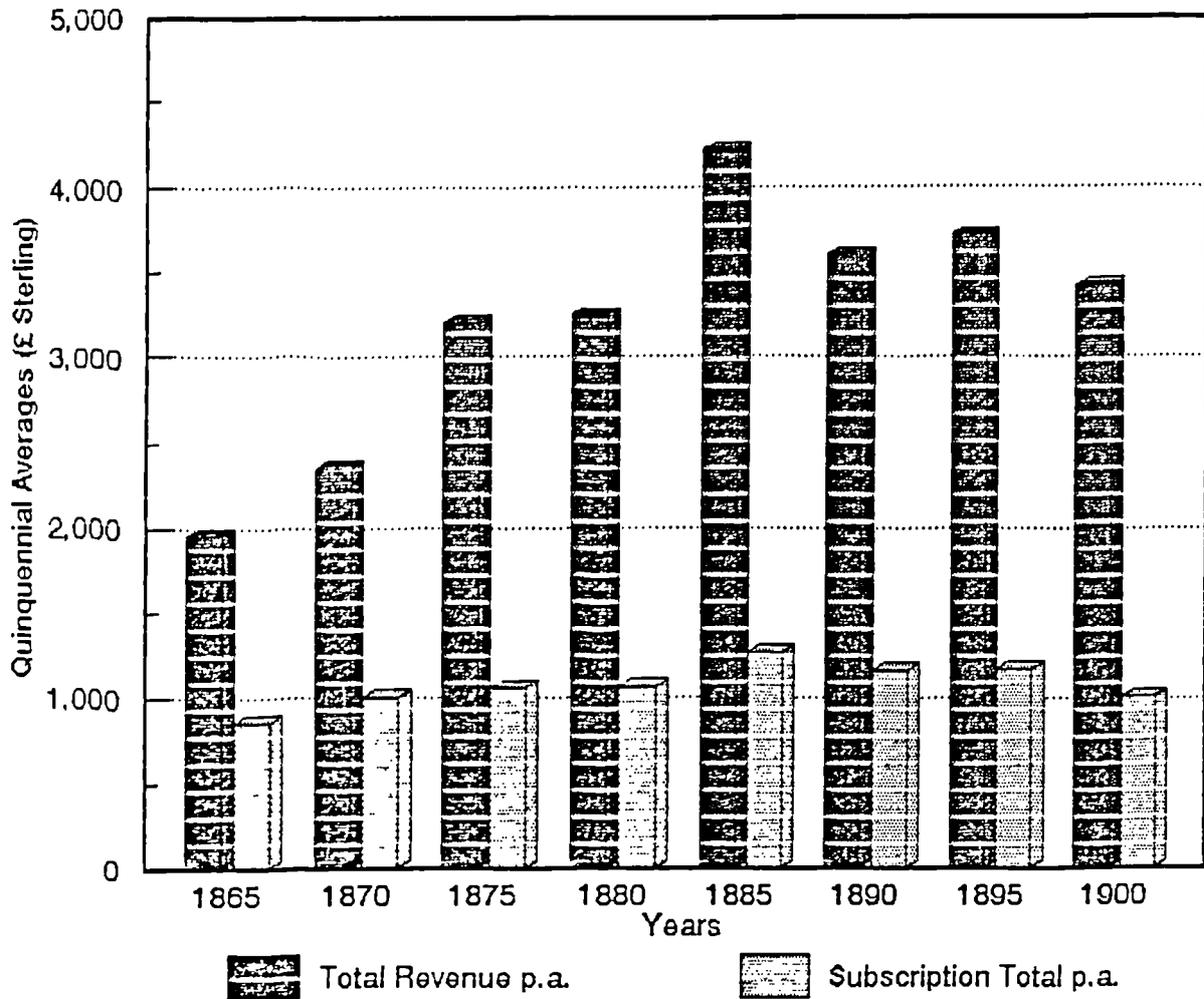
Source: The Southern Annual Reports 1870 and 1900

a role for the maternity hospital to play, to supplement, if not predominate, midwifery activity, but it remains to be considered if it were as all-embracing and effective as its supporters had hoped.

Subscribers, Subscriptions and Recommendations:

Methods of Admission

The various categories of maternity applicant that were refused assistance at St. Mary's (1869-77), gives some idea of the socio-economic determinants that influenced the hospital's selection procedures, but first the applicant had to secure a recommendation from a subscriber, which was in itself a selection process. The only alternative means of acceptance, apart from by-passing all regular channels because of the urgency of the case 'which do[es] frequently happen', was by private means, which though discussed was never a policy at the Southern or a prominent feature of St. Mary's maternity department. The latter set a fee in 1869 of one guinea for a gynaecology in-patient, half a guinea for every child admitted, 1s 6d for an out-patient, 2s 6d for a home case and 5s for a confinement. The fees, increased in 1890 to two and one guinea for out-patients and home cases respectively, still only generated, a decade later, £90 a year in revenue, a mere 3 per cent of the hospital's total income (Figure 2.7). The fact that the maternity fee remained unaltered and payments for confinement cases were rarely recorded, suggests that



Figures 1896-1900 based on four year average
 Source: St. Mary's Annual Reports 1861-1900

TABLE 2.4: SUBSCRIPTIONS AS A PERCENTAGE OF ANNUAL REVENUE AT ST. MARY'S & THE SOUTHERN 1870, 1890 AND 1900

	Total Subscription	% of Total Revenue
Sample Years: 1870	1,105	37%
(St. Mary's) 1890	1,177	35%
1900	963	29%
Sample Years: 1870	461	65%
(The Southern) 1890	925	30%
1900	1,121	46%

Currency rounded to the nearest £ sterling
 Source: St. Mary's and The Southern Annual Reports 1870 1890 1900

there was little private demand for a service which was ostensibly free for the majority of local women.³³

Throughout the period, it was to the subscriber that the hospital managers turned for a substantial proportion of their income, and because of this constant need to entice them 'to come forward and help the institution' and regularly donate 'urgently needed' and 'sadly wanted' funds, St. Mary's Board of Management maintained that it had to offer recommendation tickets in return and in proportion to the amount subscribers gave each year.³⁴ Whilst subscriptions provided an important and regular source of income, accounting for no less than 30 per cent of St. Mary's revenue total during any five year period (1861/65-1895/1900), they constituted an equally important source of income at the Southern which did not issue recommendations to subscribers (Figures 2.8 and 2.9 and Table 2.4). Indeed, towards the end of the period, the Southern's subscription total was, both in proportional and absolute terms, higher than the amounts collected by St. Mary's which was the only one of the two hospitals to offer something tangible to its sponsors in return (Figures 2.7 and 2.8 and Table 2.4).

Moreover, the commercial viability of offering recommendations for a subscription of one guinea or more was a highly questionable one. Thomas Radford, St. Mary's own distinguished consulting physician, first raised the point in a letter to the Board of Management in December 1862. He explained that in return for a one guinea subscription, the subscriber received tickets for

Sample Text 2.1

"Yes, you can see me: I'm his clerk. Have you come to be confined ?"

Esther answered that she had.

"But", said the boy, "You are not in labour; we never take any one in before."

"I do not expect to be confined for another month. I came to make arrangements,"

"You've got a letter ?"

"No"

"Then you must get a letter from one of the subscribers."

"But I do not know any."

"You can have a book of their names and addresses."

"But I know no one."

"You needn't know them. You can go and call. Take those that live nearest - that's the way it is done."

(The 'book' cost a shilling)

Excerpt from

George Moores, Esther Waters

(London, 1894), p.110

six home cases (including four confinements) and two out-patients, the true value of which was £1 18s 10d. On the basis of these calculations, he estimated that if the £769 subscription total collected that year were comprised of all one guinea subscribers who then used all their tickets, the hospital would incur a financial loss of £690; the subscription-recommendation system was far from self-sustaining.³⁵

Even as late as 1907, when management refused to disband the ticket system in the belief it attracted revenue, the one-guinea subscriber still received tickets for two out-patients, two ordinary home cases and three domiciliary confinements. The confinement tickets alone were valued at 7s each and if there were a complication and the doctor called, their value soared to 16s 8d. Neither was the deficit offset at higher subscription levels, because the two guinea subscribers were given twice the number of tickets and so on, in proportion to the amount subscribed.³⁶ Given the financial infeasibility of such a system, it is probable that the use of tickets was more of a deterrent to the applicant than a marketing strategy for the hospital.

As well as a deterrent the ticket system must have been a very humbling experience, forcing the applicants, not unlike George Moore's fictional character Esther Waters, to go knocking on doors and secure a subscriber's ticket (Sample Text 2.1).³⁷ Contemporary critics of such a policy included the city's Registrar, John Leigh, and the hospital's own consulting physician, Thomas Radford,

both of whom felt that the system deterred large numbers of potential applicants from the ranks of the 'respectable poor'. Leigh argued in 1863 that it could take several days to secure a recommendation, which was not only time consuming and frustrating in itself, but also highly humiliating for the applicant, who often regarded the whole procedure as a form of pauperism. On medical grounds, Radford felt that the subscriber was simply not qualified to adjudicate over whether or not a case was worthy of medical attention.³⁸

Oblivious of its critics, St. Mary's proved relentless in its application of the recommendation system. During the Lancashire Cotton Famine (1861-63) for example, when the hospital temporarily admitted maternity cases into the wards, Sarah Ann, whose town council, Salford, had referred her to the hospital and agreed to pay her ward fees, was most reluctant to leave her family of four children and requested that she be confined at home. Despite the financial support of Salford City Council, her acceptance as a ward case and her own personal pleas, the only way Sarah Ann could secure outdoor relief was by applying through the conventional channels and securing the patronage of a one-guinea subscriber.³⁹

As subscribers were therefore key individuals in determining who was initially selected for maternity relief, it is important to consider their accessibility, reasons for subscribing and association, if any, with the maternity applicant. When considering the composition of

TABLE 2.5: TOTAL VALUE AND NUMBER OF SUBSCRIPTIONS
ST. MARY'S AND THE SOUTHERN 1900

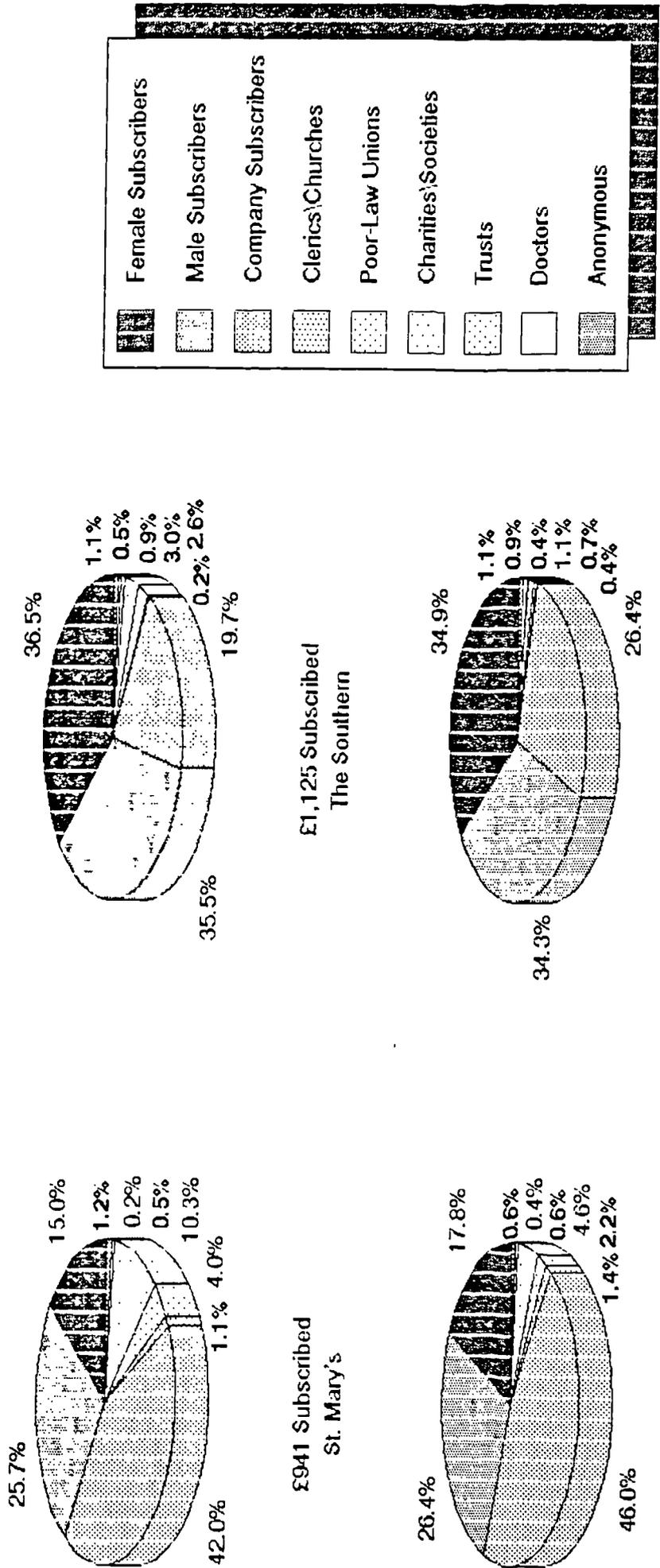
	St. Mary's		The Southern	
	No. of Subscribers	£ Sterling Subscribed	No. of Subscribers	£ Sterling Subscribed
Female Subscribers	89	£140 11s 6d	197	£ 411
	(18%)	(15%)	(35%)	(36%)
Male Subscribers	132	£241 14s 6d	194	£ 399 3s
	(26%)	(26%)	(34%)	(35%)
Company Subscribers	230	£395 15s	149	£ 221 19s 6d
	(46%)	(42%)	(27%)	(20%)
Clerics\Churches	7	£ 9 19s 6d	2	£ 1 10s
	(1%)	(1%)	(—)	(—)
Poor-Law Unions	11	£ 28 1s 3d	4	£ 29 9s
	(2%)	(4%)	(1%)	(3%)
Charities\Societies	23	£ 96 18s	6	£ 34 9s
	(5%)	(10%)	(1%)	(3%)
Trusts	3	£ 5 5s	2	£ 10
	(1%)	(1%)	(—)	(1%)
Doctors	2	£ 2 2s	5	£ 6 5s
	(—)	(—)	(1%)	(1%)
Anonymous	3	£ 11 1s	6	£ 11 10s
	(1%)	(1%)	(1%)	(1%)
Totals	500	£941 7s 9d	565	£1,125 5s 6d

At St. Mary's 2 of the females subscribed in joint names with their spouse

Southern £ Total included £180 to maintain specified cots

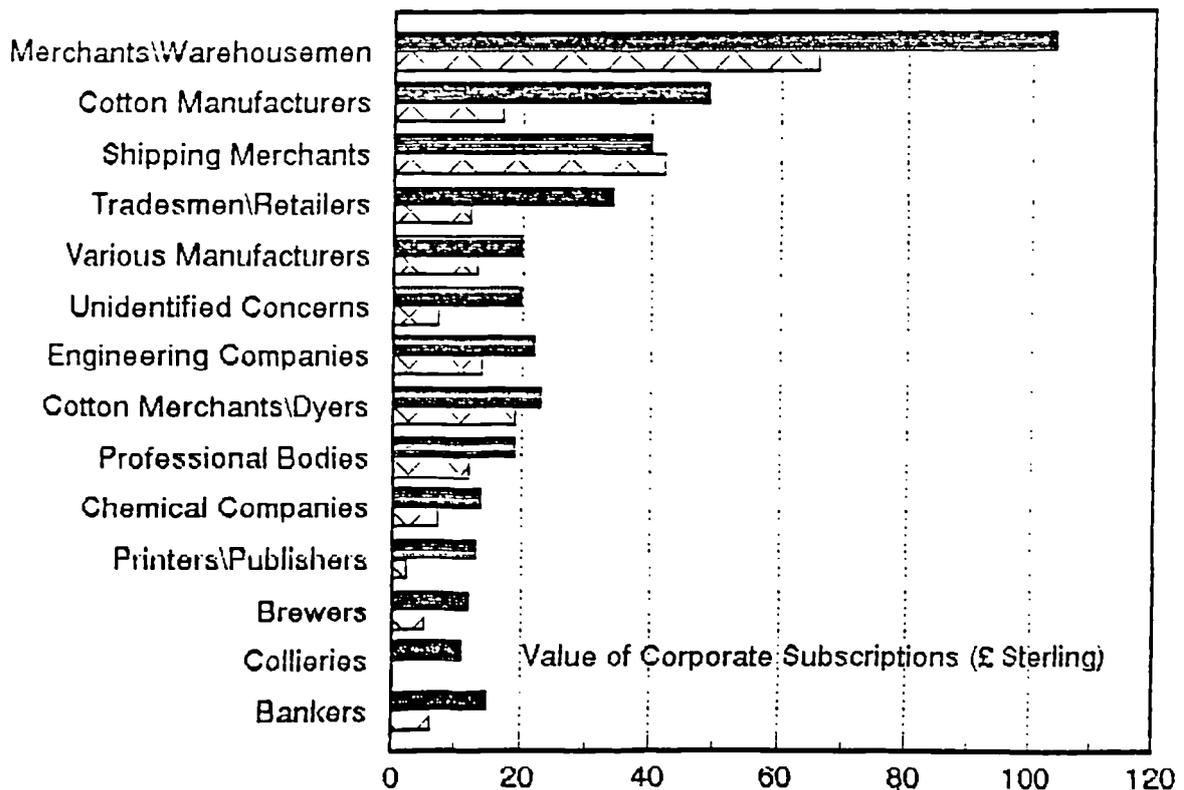
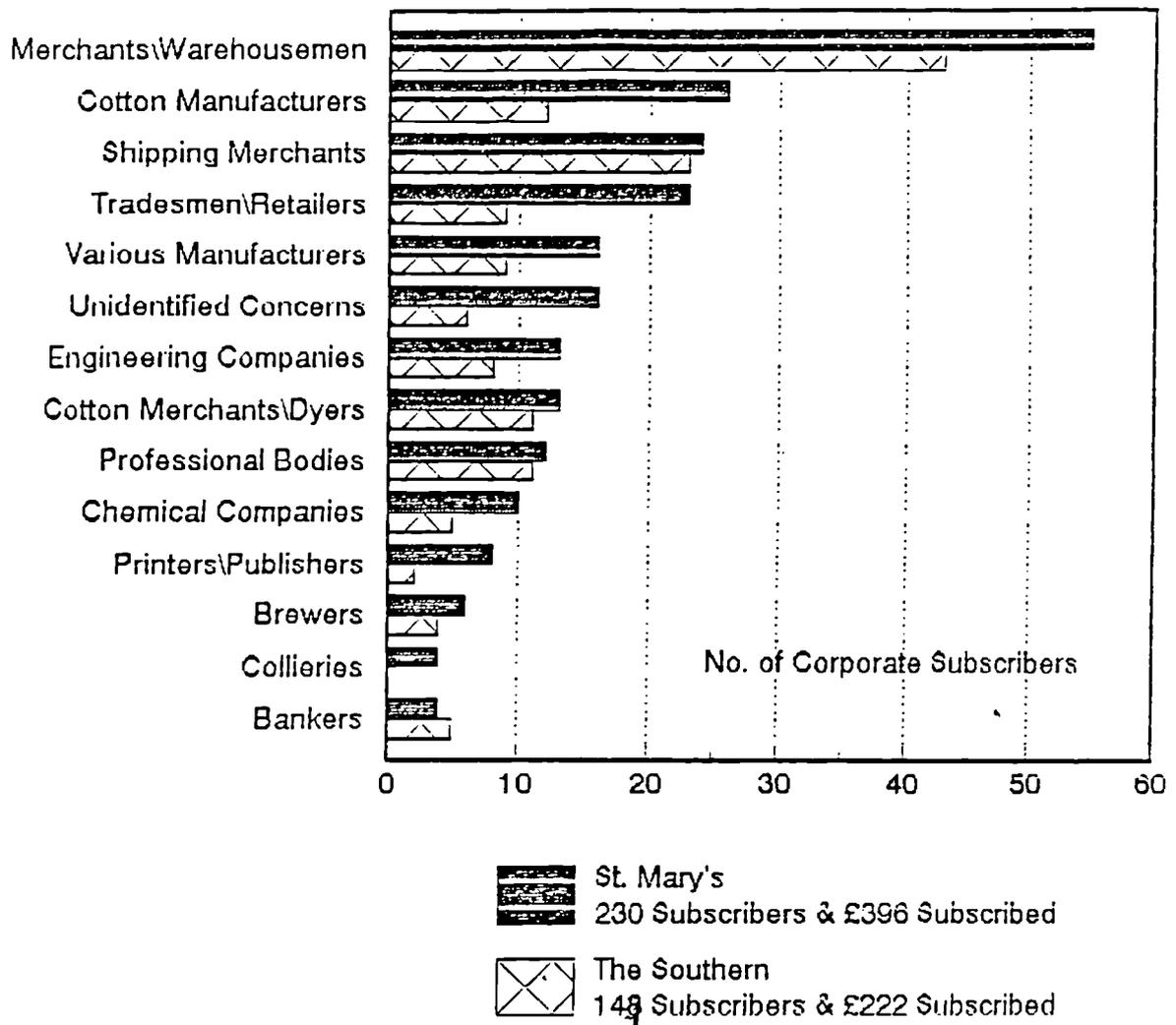
Source: St. Mary's and Southern Annual Reports 1900

**FIGURE 2.10: TOTAL VALUE AND NUMBER OF SUBSCRIPTIONS
ST. MARY'S AND THE SOUTHERN 1900**



Source: St. Mary's & Southern Annual Reports 1900

**FIGURE 2.11: CORPORATE SUBSCRIBERS AND SUBSCRIPTIONS
ST. MARY'S AND THE SOUTHERN 1900**



Values rounded to the nearest pound

Source: St. Mary's and Southern Annual Reports and Slater's Trade Directory 1900

subscribers at St. Mary's in 1900 and comparing it with the non-ticket Southern hospital, one of the most striking differences is that the strong corporate element at the former, which represented 230 named, commercial concerns, accounted for practically half of St. Mary's subscribers and more than two-fifths of its subscription total (Table 2.5 and Figure 2.10). Within this corporate structure, employers of significant numbers of local men and women were strongly represented, including cotton manufacturers, the largest single employer of females in Manchester, and merchants and warehousemen whose concerns, though small, were very numerous (Figure 2.11). The corporate structure also reflected the emergence of new, major employers to counter the economic insecurity of the 1870s, including engineers, chemical manufacturers and, following the opening of the Manchester Ship Canal in 1894, shipping merchants (Figure 2.11).⁴⁰

Amongst every category of corporate subscriber there were invariably a higher number of companies subscribing a larger amount (in the case of cotton manufacturers, printers and publishers, tradesmen, colliers, bankers and chemical manufacturers, twice the amount) to St. Mary's than to the Southern, whose corporate element accounted for just over a quarter of the total number of subscribers and for a fifth of the total subscribed to its coffers (Figures 2.10 and 2.11). Also, with regard to the amounts subscribed, 97, or 42 per cent of the 230 corporate subscribers to St. Mary's, gave more than a guinea. This compared with a list of 46, or 31 per cent,

**TABLE 2.6: COMPOSITION OF SUBSCRIBERS
ST. MARY'S AND THE SOUTHERN 1900**

Annual Subscription (£ Sterling)	ST. MARY'S				THE SOUTHERN			
	Corp.	Male	Female	Other	Corp.	Male	Female	Other
£40 00s						1	3	
£25 00s						1		
£20 00s							1	2
£10 10s	2			4		3	2	
£10 00s		1		1				
£ 6 06s		1						
£ 6 00s							2	
£ 5 05s	4	10	1	5	4	5	2	2
£ 5 00s	1	3	2	4		7	3	4
£ 4 04s				1	2	2	2	
£ 3 03s	24	3	6	7	7	9	1	1
£ 3 00s	1		1				1	
£ 2 10s							1	
£ 2 02s	63	29	23	14	33	39	30	5
£ 2 00s		1				1	4	
£ 1 11s 6d	2	1					4	
£ 1 10s							1	
£ 1 01s	123	77	53	12	90	99	77	5
£ 1 00s	1				3	3	11	2
12s 6d	1						1	
10s 6d	7	6	3	1	6	14	11	
10s					3	5	22	3
7s 6d							1	
5s	1					4	16	1
2s 6d						1	1	
2s					1			
Totals	230	132	89	49	149	194	197	25

Source: St. Mary's & Southern Annual Reports 1900

**TABLE 2.7: CORPORATE SUBSCRIPTIONS TO BOTH
ST. MARY'S AND THE SOUTHERN 1900**

	No. of Joint Subscriptions	Value of Subscriptions	
		St. Mary's	The Southern
Merchants\Warehousemen	23	£ 50 8s	£ 38 6s
Shipping Merchants	14	£ 22 7s 6d	£ 29 8s
Cotton Manufacturers	10	£ 20 4s	£ 11 11s
Engineering Companies	6	£ 12 10s	£ 7 7s
Various Manufacturers	5	£ 9 9s	£ 7 7s
Tradesmen\Retailers	4	£ 8 8s	£ 7 7s
Professional Bodies	3	£ 5 5s	£ 4 4s
Printers\Publishers	2	£ 4 4s	£ 3 3s
Brewers	2	£ 3 3s	£ 3 3s
Cotton Merchants\Dyers	2	£ 3 3s	£ 7 7s
Unidentified Concerns	1	£ 1 1s	£ 1 1s
Chemical Companies	1	£ 1 1s	£ 1 1s
Collieries	0	---	---
Bankers	0	---	---
Totals	73	£141 3s 6d	£121 5s

**TABLE 2.8: NUMBER OF SUBSCRIBERS LIVING OUTSIDE
MANCHESTER 1870 AND 1900**

Living Outside Manchester But...	St. Mary's		The Southern	
	1870	1900	1870	1900
Living Within Lancashire	165	109	49	89
Living Within Cheshire	23	36	12	74
Living Beyond Above	17	26	2	26
Total Numbers	205	171	63	189
% of Respective Subscribers	27	34	19	33

Source: St. Mary's and Southern Annual Reports and Slater's Trade Directory 1900

of the 149 corporate subscribers to the Southern. Virtually half the companies that subscribed to the Southern also subscribed to St. Mary's and, except for merchant shipping, in larger amounts (Tables 2.6 and 2.7).

The dual contribution by cotton manufacturers is an example of the corporate bias. Not only were the number of cotton manufacturers and their subscriptions to St. Mary's double the respective figures for the Southern, but of the twelve cotton manufacturers subscribing to the latter, ten also featured in the subscription lists of St. Mary's (Figure 2.11 and Table 2.7). The contributions to the Southern by the cotton manufacturers, 90 per cent of which were a guinea or less, compared to 30 per cent amongst cotton manufacturers subscribing to St. Mary's, appears to have been of a token nature, whilst the funds to the latter were much more purposeful, securing a cheap and viable form of health insurance for their own employees and spouses. Collectively, local businesses could have had a profound influence on the composition of maternity cases attended by St. Mary's, for they had the right, in 1900, to authorise the distribution of 900 outdoor maternity tickets and 35 ward confinement tickets, which if all used, could have accounted for 35 and 19 per cent of the respective case totals that year. These findings contradict David Owen's conclusions, that 'regular corporation giving [which was also prominent in the case of the Southern] was little known in Britain'.⁴¹ On the contrary, it was a most persuasive influence on

hospital funding and where tickets were issued, on the case composition.

Also represented, and more so in the case of St. Mary's than the Southern, were Friendly Societies, Co-Operative Associations and local Poor Law Boards, which collectively accounted for 14 per cent of St. Mary's subscription total in 1900, compared with 6 per cent of the Southern's subscription total (Figure 2.10). Though still few in number, accounting for no more than 7 per cent of those subscribing to St. Mary's in 1900, this was a rapidly growing movement for these representative bodies were beginning to realise the importance of maternity and medical care for their members and spouses. This would account for the ten-guinea subscriptions from the Bury Co-Operative Society, the Cotton Spinners' Association, the Co-Operative Society, Balloon Street, and the five-guinea subscriptions from the Chorlton, Prestwich, Rochdale and Salford Boards of Guardians. Though few in number, the amounts they subscribed were amongst some of the highest that year (Table 2.6). None of these particular groups, with the exception of Chorlton Union, whose own workhouse (Withington) confined about 100 women a year and whose district area included that of the Southern, subscribed to St. Mary's, but with a £20 annual subscription, Chorlton Union probably envisaged wielding some influence on the Southern's intake of cases. On the whole, however, such organisations tended to sponsor St. Mary's, where tangible returns were assured, including the Fine Cotton

Spinners' and Doublers' Association, which represented 90 local mills engaged in the spinning of fine cotton and doubling yarns and 3,500 employees.⁴² Aimed at centralising administration and the buying, selling and distribution of cotton goods, the Association also appears to have organised an employers' benevolent fund for its work force, subscribing a further £5.00 to the Southern. The cotton industry once again appeared as a financial sponsor and once again displayed undeniable preference for St. Mary's.

The desire to subscribe to realize tangible benefits and the implication of this should not, however, be over-emphasised, for no matter how much the Bury Co-Operative Society or the Rochdale Board of Guardians subscribed, they could not, because of the rigid boundary regulations, recommend maternity cases. Also, it is questionable that companies, friendly societies and Poor Law Boards, which still accounted for a quarter of the amount subscribed to the Southern, a non-ticket issuing institution, subscribed to St. Mary's solely to distribute tickets amongst their respective members and employees. Indeed, St. Mary's by the 1890s was habitually requesting that subscribers not wishing to recommend cases should return their tickets to the hospital to re-distribute them on their behalf.⁴³

As in the case of Esther Waters, for many seeking a ticket it was a matter of knocking on the doors of private households for individual men and women still accounted for a substantial proportion of the

subscription revenue, particularly in the case of the Southern, whose subscription composition emphasised the individual rather than the collective body (Table 2.5 and Figure 2.10). One reason behind private benevolence, which may have determined the types of cases that subscribers were more willing to hand over a recommendation ticket to, was as a form of investment, not in labour relations and the work force, but in class preservation and social harmony. Consequent on the middle-class exodus from the city centre to its suburbs, abandoning in their wake the inner city areas to an 'ignorant, half-starved class', susceptible to such 'corrupting influences', as disease, poverty, illiteracy and poor housing, Alan Kidd, Michael Rose and others, claim the middle class genuinely feared social conflict with the working class and the threat that posed to their social and economic well-being. There was, as Michael Rose explains, 'a growing concern about the separation of rich from poor and a realization of the need to neutralize conflict which might arise as a result of this separation', a need which was to be fulfilled by charitable aid 'the archetypal Victorian response to moral and social problems'.⁴⁴

All Embracing ? : The Socio-Economic and Medical Determinants of Hospital Relief.

Such a perspective, with the onus on the subscriber, 'to make full enquires into the position of the

applicant, before granting a recommendation', could have quite easily resulted, as Roy Porter argues, in the acceptance of only 'the handpicked members of the labouring poor', women who were selected more for their high moral virtues than their economic or medical predicament.⁴⁵ That is, of course, if firstly, subscribers distributed their recommendations, a number of which were returned each year unused to St. Mary's and secondly, if subscribers troubled themselves 'to make full enquiries into the position of the applicant before granting a recommendation', which one contemporary critic of medical charities, William O'Hanlon, claims 'was rarely made, either by the subscribers or medical men'.⁴⁶ To counter this latter difficulty, St. Mary's, like the Southern, employed Manchester's District Provident Society (hereafter, the DPS), 'the most prestigious and influential philanthropic body in Manchester', to investigate a woman's application for maternity relief, a procedure which undoubtedly produced a 'handpicked selection' of patients, but only up until the 1870s, when both institutions, for this very reason, severed their association with the Society.⁴⁷

The DPS aimed 'for nothing less than a complete transformation of working-class habits' by 'encouraging cleanly, provident and contented habits' via house visits and routine inquiries, and offering relief only to the 'deserving' and 'worthy'. This was done in the hope of discrediting indiscriminate alms-giving, the apparent cause of the demoralization, deception and mendacity

amongst the working masses. The involvement of the DPS, however, dulled the hospitals' responsiveness to the genuinely impoverished. Whilst the work of the DPS was important for infusing order and method into a situation bedevilled by unnecessary duplication, indiscriminate use of resources and by fraudulent applicants, the Society had such 'a pathological horror of indiscriminate almsgiving' that it 'ultimately invalidated all charitable giving to the lowest classes'.⁴⁸

Amongst the casualties of such a policy, where the emphasis was as much on a recipient's moral and social mores as her material well-being, and where a 'deserving status' was as much a pre-requisite of charitable aid as a 'desirable consequence', were the wives of the casually and seasonally employed, the victims of underemployment, which, as Alan Kidd observes, 'was a significant feature of the socio-economic life of large commercial centres such as Manchester'. During the unemployment crisis between 1884 and 1886, for example, the DPS, which had spent the majority of its £26,000 relief fund on casual and seasonal workers rather than factory hands during a trade depression five years earlier, refused to acknowledge serious distress and accused the seasonal worker, rejected without question, of seeking relief under false pretences. Except for 'want of work' cases where the relief applicant was a married man of 'good character and likely to obtain employment', unemployed applicants were generally deplored and re-directed to the local Poor Law Authorities at Crumpsall and Withington.⁴⁹

Working within such constraints, the Society's selection of maternity applicants could have seriously impeded the relevance of the voluntary maternity services to local women, particularly at moments of high unemployment. However, the Society's extreme fear of indiscriminate alms-giving and prejudice in favour of the 'better-off working man', did not fully materialize until the 1880s, several years after the Southern and St. Mary's 'abruptly' broke off their association with the DPS, an act which in itself suggests the Hospital Boards did not fully agree with the Society's handling of their affairs. Indeed, once its relationship with the two hospitals had been dissolved, the DPS became highly critical of the hospitals' apparently 'ineffective' inquiry systems and 'inefficient' investigators, which again suggests that there had been disagreements between the two hospitals and the Society over their respective approaches to charitable aid.⁵⁰

Both hospitals subsequently employed their own investigators to assess 'the circumstances and fitness of applicants'. In the case of St. Mary's a 'respectable man' was employed at £1 a week to conduct the work, who from July 1885 was Robert Stonex Jnr, an associate of the land and estate agents, R. C. Stonex and Sons. At the Southern, after rescinding the agreement with the DPS, it was the task of the medical officers 'to prevent, as much as possible, the admission of improper cases'. However, from 1889, on an annual salary of £10, a 'Visitor of Applicants' was officially appointed, who in the first

instance was Robert Lee, the hospital's dispenser. Whilst both men acted similarly to DPS investigators, aiming to 'prevent fraud and abuse of the Charity in every way' and ensuring successful applicants were 'fit objects of charity', the stress lay with 'an honest, faithful and humane' approach to investigative work, as nurtured by the institutions themselves.⁵¹

Consequently, following the dismissal of the DPS in October 1874, the number of home deliveries attended by St. Mary's midwives rose by 45 per cent in three years and more than doubled in six (Figure 2.12). Moreover, in 1875 the hospital's catchment area was extended and two years later the 1s fee levied on all maternity cases, 'not so much as a means of raising money ...as to encourage provident habits', was abolished. When these trends are linked to a decline in the proportion of rejected maternity applicants, from an average of 8 per cent of the applicant total (1871-73) to 4 per cent (1875-78), it is evident that a far more liberal policy toward charitable aid was adopted by the hospital management than was ever achieved under the DPS, a lay body ignorant of the material and medical needs of the labouring poor.⁵²

Such was the responsiveness of St. Mary's to social needs that by 1886 and the winter of economic distress, 23 per cent of the 2,870 cases investigated by Stonex (of which 37 per cent were maternity cases) were from unemployed families and 25 per cent were from families on short time. A further 21 per cent were from families in

regular work but unable to pay the doctor and only 31 per cent were from families who could make a small payment. No one from this latter category, in light of the abolition of the provident fee, would have been maternity applicants. The unemployed were not, it seems, discriminated against. Only 11 of the 2,870 applicants were rejected, apparently able to pay a doctor, whilst several maternity applicants were cautioned in order to deter non-deserving applicants.⁵³ On the whole, however, whilst the selectors remained cautious about charitable fraud and abuse, they appear to have been far less rigorous than the DPS in their distinction between deserving and non-deserving applicants.

Nonetheless, a woman's conduct and circumstances were all important if she were to secure charitable relief, hence the rejection of 94 women (1869-77) from St. Mary's after it was discovered that they were either unmarried, lived in a 'House of ill-Fame', or were, as proved the case in 1876, adulteresses (Table 2.3). The reference to a woman's 'conduct' invariably meant married and living with her husband, which was a regulation that St. Mary's was particularly eager to uphold, advertising in the local press in August 1875 that the hospital was 'meant wholly and entirely for the reception of married women'. This particular point of emphasis followed an incident where the House Surgeon admitted an unmarried pregnant girl. He was severely reprimanded, despite the critical nature of the case, and the woman's referee,

Thomas Rawson, was charged a penalty fee of £5.00, subsequently reduced to 2 guineas.⁵⁴

The hospital was, to a certain degree, reflecting contemporary views towards single women. It simply 'would never do, morally', wrote Florence Nightingale, 'to make special provision for them [single mothers]', lest it tempted improvidence.⁵⁵ Yet the hospital could hardly boast as it did, that it attended women from 'the weakest and most defenceless part...' of the community, 'those who cannot possibly help themselves ...[the] utterly helpless and destitute', when it rejected the one group to whom these sentiments were most aptly applied, single women, 'the unmarried, seduced and deserted'. These women were, as Lawson Tait remarked, in 'one of the greatest and most constant sources of danger' because the risks for unmarried women were at every stage greater than that for their married counterpart.⁵⁶ The hospital medical staff, if not the lay Board, recognised this and appear to have increasingly ignored the marriage clause, as the incident with the house surgeon illustrates, but the acceptance of single women probably occurred too late and on too small a scale to have had any real effect.⁵⁷

Nonetheless, 'strictly...devoted to the relief of the poor', the hospital's relevance to 'the poor married woman' cannot be underestimated.⁵⁸ 'Founded on the principle that the necessity of the patient should be the only title to the benefits of the charity', the Southern imposed an income restriction of 30s a week, refusing women whose family collectively earned more than this or

whose husband, unless the family was a large one, was on strike and therefore an improper object of charity.⁵⁹ According to Marr, this embraced a substantial proportion of local women, for 'unskilled labourers in Manchester and Salford', he explained in 1903, 'earn low wages, under 20s a week on the average, and they often have broken time when the income of the family sinks to nothing'. Similarly in 1910, William Elkin found that amongst a sample study of 103 Manchester families where the mother worked in various cotton occupations, the average family wage still averaged only 28s 11d. Amongst those families where women did not work the income rarely exceeded 22s a week, which in his opinion barely lifted the family above absolute squalor. Even at a time of 'exceptionally full employment' (1888-89), Scott found that half the 1,576 heads of households in Ancoats stating their earnings, were from families which were 'always face to face with want' whilst a further 23 per cent endured a hand-to-mouth existence.⁶⁰

Such distress was, funds permitting, often a major stimulant to increase patient intake and demand, hence the fluctuating case returns, rising one year, declining another (Figure 2.12). At the height of the blockade on cotton supplies during the American Civil War (1861-62), for example, when families were receiving as little as 1s or 2s a week, per head, the total number of home deliveries rose by 30 per cent and women, as a temporary measure, were confined in the hospital.⁶¹ Similarly, between 1878 and 1879, 'a winter of great length and

severity' because of an 'extreme depression of trade', the number of home deliveries expanded by more than 30 per cent, underlining one of the hospital's major raisons d'être, to focus on and respond to the economically disadvantaged (Figure 2.12).⁶²

The financial significance of hospital aid was made all the more pronounced by offering hospital services free, a variable considered by Loudon to be an essential factor, for as one contemporary put it, 'Efficient midwifery is not cheap'.⁶³ As a provident measure, St. Mary's had until 1877 charged maternity cases 1s before adopting the same liberal approach as the Southern. However, this was negligible compared with women paying between 7s 6d and 10s to secure private midwifery provision of a comparable quality, for these were the fees hospital midwives charged their own private cases. If the doctor were called, women could have expected to pay up to a guinea in maternity fees which deterred many from calling for competent medical attention and settling for the presence of a 'handywoman' or '6 penny Doctor'.⁶⁴

'Married' and 'poor' were therefore the principal criteria for securing the services of a hospital midwife and the right of a home delivery, but women admitted into hospital were accepted largely on the additional premise of medical necessity. Contrary to Versluysen's impression that maternity in-patients were the picture of health, free of any pathological symptoms, on the whole, both the Southern and St. Mary's reserved their beds for 'exceptional lying-in cases, attended with special

FIGURE 2.13: ANNUAL NUMBER OF WARD DELIVERIES AND 'ASSISTED CASES' ST. MARY'S 1893-1905

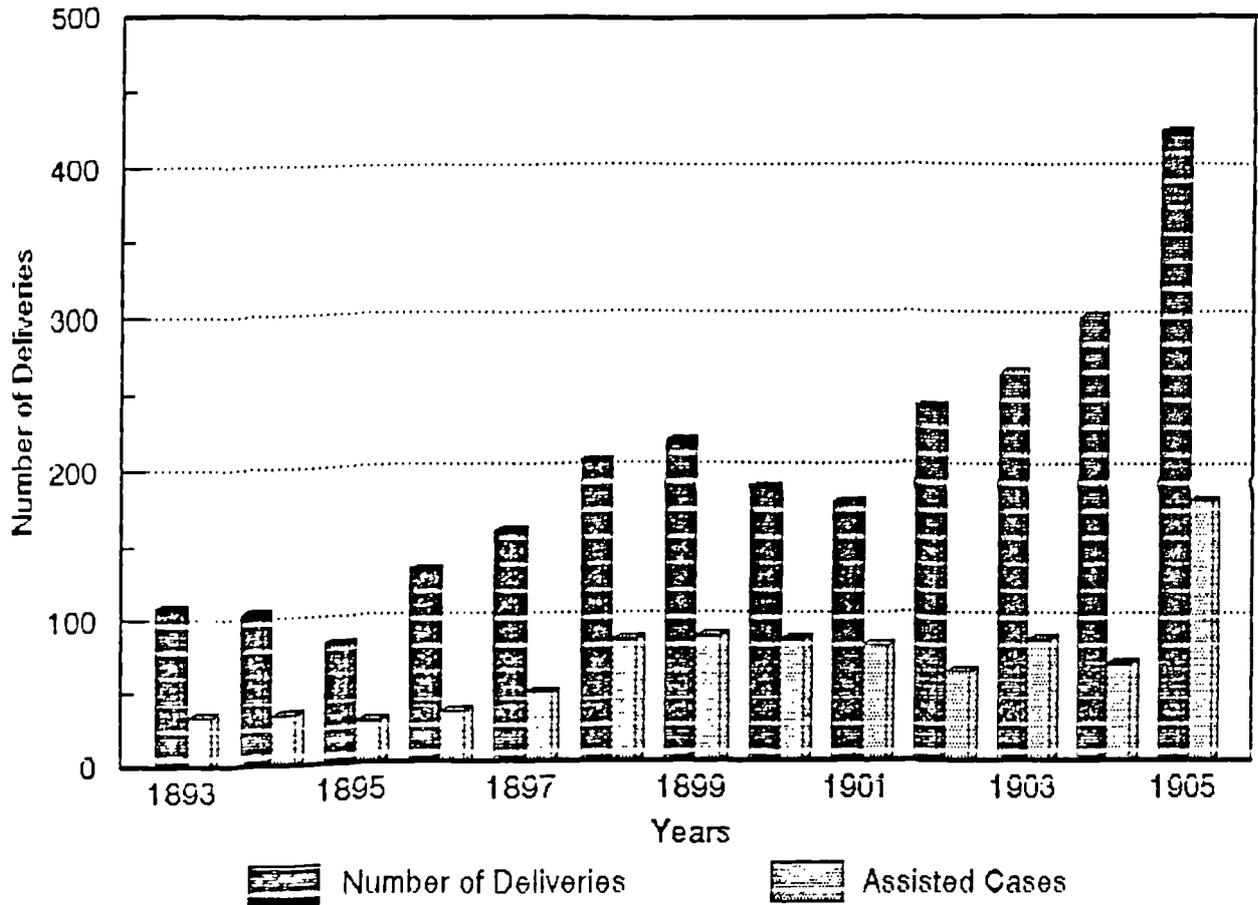
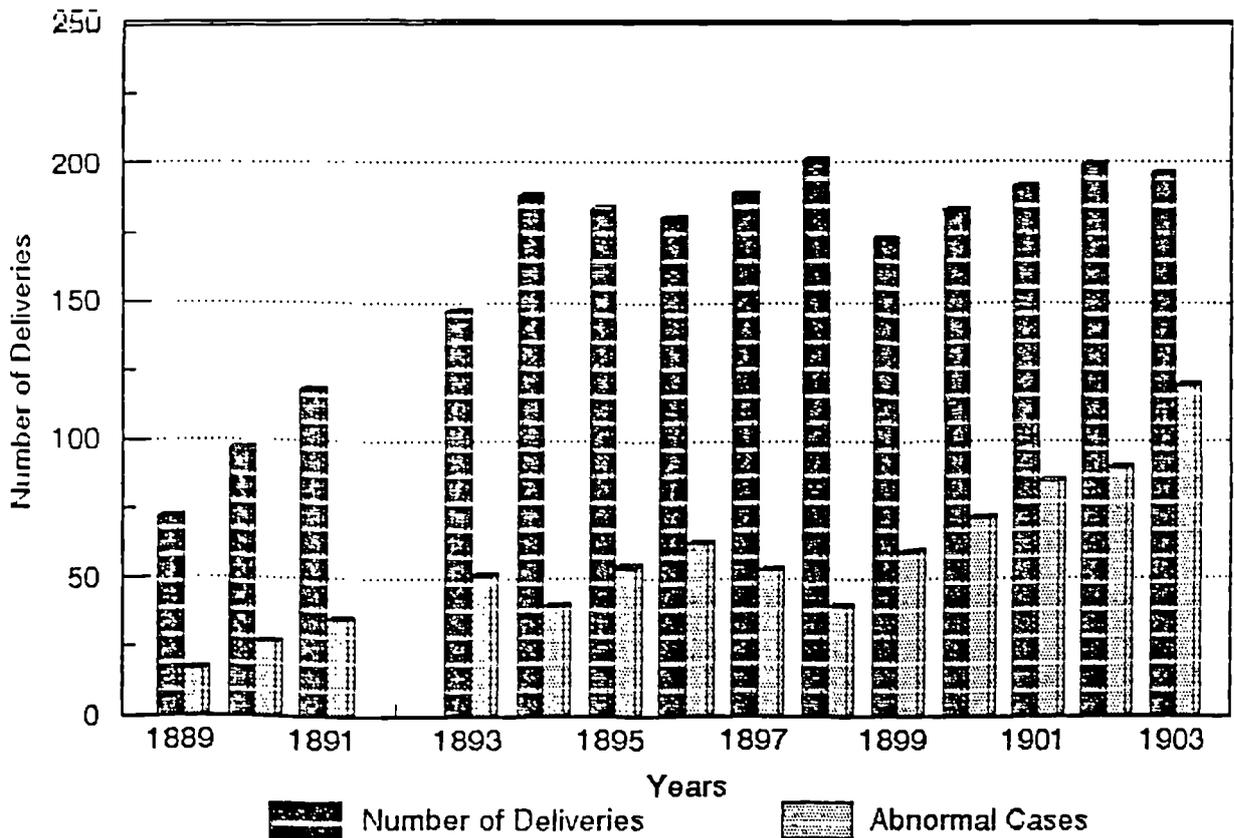


FIGURE 2.14: ANNUAL NUMBER OF WARD DELIVERIES AND 'ABNORMAL CASES' THE SOUTHERN HOSPITAL 1889-1903



Southern Figures n.a. 1892. Source: St. Mary's Annual Reports 1893-1905 and Southern Annual Reports 1889-1903

difficulty or danger', 'cases of extremely grave complications of labour, which would in all probability have been fatal if the patients had been confined in their homes'. Moreover, 'the admissibility or otherwise of applicants for admission' was decided by the Honorary Medical Staff and in their absence, by the House Surgeon or Resident Obstetric Surgeon.⁶⁵ This minimised lay interference and ensured that women were hospitalised out of personal or medical necessity rather than on a social or moral precedent, hence the illicit admission of single and recently married women.⁶⁶

It is difficult to determine from the annual reports the true number and range of the cases 'attended with special difficulty or danger', because of the emphasis, for publicity purposes, on the obstetric measures taken rather than the underlying cause. Medical necessity probably accounts for about a third of maternity admissions to both hospitals. At St. Mary's the number of 'assisted cases' averaged 34 per cent of admissions (1893-1905). This figure, however, appears to refer only to those cases in which the doctor intervened, perhaps by means of forceps or caesarean section, and not to the complication that necessitated the interference, such as a contracted pelvis or mal-presentation (Figure 2.13). Thus, if not all complications were 'assisted', then the number of women entering St. Mary's with obstetric difficulties could have been higher than 34 per cent of the total. Conversely, if not all assisted cases were as a result of a complication but a doctor's whim, which is

**TABLE 2.9: DIFFICULT (WARD) CASES: MANCHESTER
(SOUTHERN) MATERNITY HOSPITAL 1899-1901 AND 1889-1903**

Difficulty Encountered At Labour...	Register Cases 1899-1901		Annual Rpt Totals 1889-1903 +
	Natural Labour	Doc. Intervened	
Haemorrhaging: Accidental	2		77
Post-Partum	2		
Retained Placenta		1	6
Placenta Praevia		3	43
Contracted Pelvis	7	5	73
Mal-Presentations: Face		1	9
Transverse		2	24
Breech	5	3	31
Occipito-Posterior			10
Other	2	1	13
Pre-Eclampsia\Eclampsia		4	43
Intermittent Disease		1	13
Prolapse of Cord		1	
Hydrominos			12
Spontaneous Delivery	3		9
Premature Labour*	10		18
Weak\Exhausted on Entry		10	
Twins*	4		13
Op. Cases: Unclear Why		4	
Other Difficulties		3	5
Totals	28	39	399
% of Confinement Total	14%	20%	17%

* Twins\Premature Labour figs not noted in Anl Rpts until 1900. + Figs n.a. 1892

Source: Southern Annual Reports 1889-1903 and Case Admissions Register No. 13

**TABLE 2.10: OPERATIVE (WARD) CASES: MANCHESTER
(SOUTHERN) MATERNITY HOSPITAL 1889-1901 AND 1889-1903**

Operations & Reasons For Use*	Register Cases 1889-1901	Annual Rpt Totals 1889-1903 +
Forceps: Mother Exhausted	19 (10%) 10	282 (12%)
Unclear Why	3	
Mal-Presentation	2	
Eclamptic	2	
Premature	1	
Contracted Pelvis	1	
Induced Labour: Pleurisy	7 (3.5%) 1	68 (3%)
Eclamptic	2	
Previously Miscarried	1	
Prolapsed Cord	1	
Mal-Presentation	1	
Unclear Why	1	
Version: Placenta-Praevia	5 (2.5%) 3	32 (1%)
Mal-Presentation	2	
<i>Craniotomy: Contracted Pelvis</i>	3 (1.5%) 1	17 (1%)
Mal-Presentation	2	
Caesarian: Contracted Pelvis	3 (1.5%)	6 (0%)
Adherent Placenta Taken By Hand	1 (0.5%)	
Cut Cord Before Child Born	1 (0.5%)	
Total Number of Operations	39	405
% of Confinement Total	20%	17%

(%) Refers to Respective Confinement Totals. + Figures n.a. for 1892.

* Sub-Headings Relevant to Register Cases Only

Source: Southern Annual Reports 1889-1903 and Case Admissions Register No. 13

highly unlikely during this period, then the number could have been lower. This presentational bias, cataloguing the operative cases rather than the underlying causes, effectively demonstrated to the charitable public that the hospital was actually doing something, even if the reasons were not entirely clear.

Similarly, at the Southern, the first voluntary institution 'to make possible the hospital treatment of serious lying-in cases', by opening the Manchester Maternity Hospital in Upper Brook Street in September 1887, the proportion of 'abnormal cases' averaged 37 per cent of admissions (1891-1903) (Figure 2.14).⁶⁷ Whilst accompanying these returns for the Southern were details of the underlying problems encountered in labour, most notably haemorrhaging, contracted pelvis, mal-presentation or eclampsia, it is not entirely clear whether these figures were in addition to, or part of, the operative case total, which was also listed and included forceps deliveries, induced births, version, craniotomy and caesarean operations (Tables 2.9 and 2.10). For example, a mal-presentation, as reference to the Southern's maternity register indicates, could have been delivered naturally or by intervention, using one of a number of operative measures (Tables 2.9 and 2.10). Thus, if all the mal-presentation cases were listed as such, then the true number of operative cases would be higher than the figure shown, but if listed under the relevant operative categories, then the number of mal-presentations would similarly be underestimated.

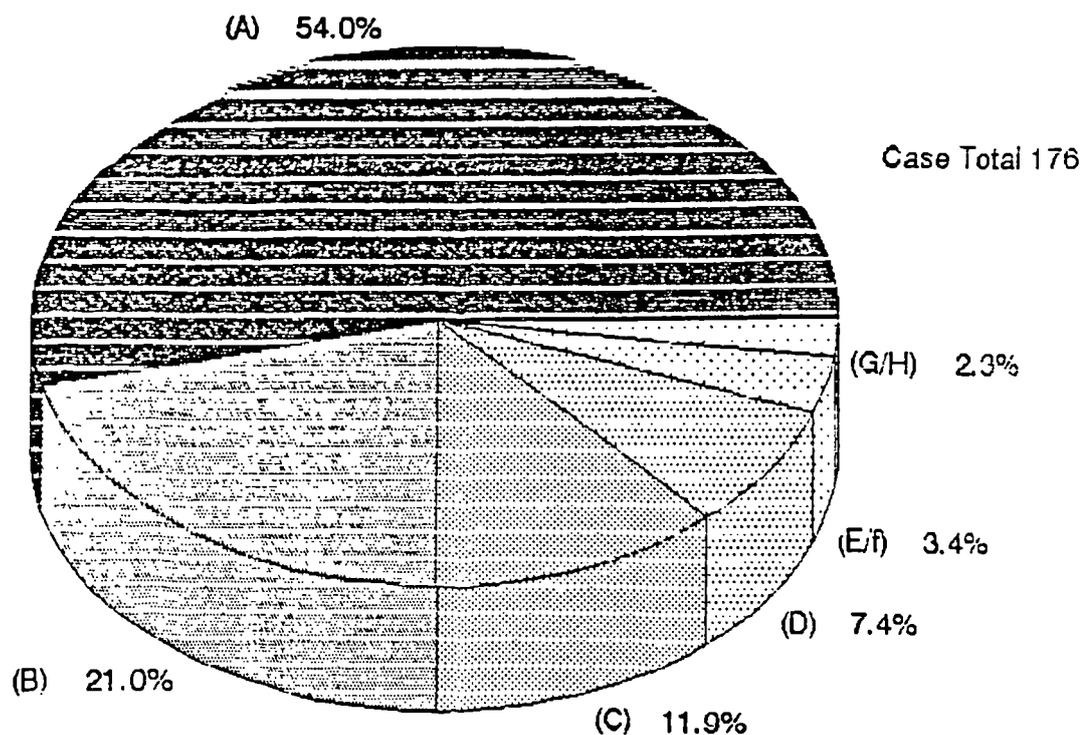
It is therefore hoped that those who compiled the figures in the annual reports, on which analysis depends, categorised each abnormality either as a complication or as an operative case, but not both, thus avoiding duplication. Cross reference with the maternity register, which also listed 34 per cent of cases as complicated, seems to confirm this (Table 2.9 and 2.10). If the 160 to 200 complications (1901-03) attended in St. Mary's and the Southern each year are a true reflection of the number of women confined in hospital with medical difficulties, then the hospitals collectively accounted for up to a fifth of the city's most difficult obstetric cases. On average, there was one complication in 20 labours, which represented between 800 and 900 births in Manchester over the same period.⁶⁸ Therefore, the in-patient service of these two hospitals was as demographically significant to the confinement of difficult cases in Manchester as the district service was in the city's normal confinements.

For further information about the background of these women admitted into hospital, the Southern's only extant maternity register, spanning 14 months, from early December 1899 to late January 1901, provides the most illuminating details. Of the 195 registered names, there are addresses for 176, 130 of which have been located on a street map of Manchester and have formed part of an earlier discussion on the hospital's catchment area (Map 4). All 176 entries were also cross-referenced with Slater's Trade Directory for 1900, which revealed little,

**CASES: MANCHESTER (SOUTHERN) MATERNITY HOSPITAL
1899-1901**

Lived...	Case Totals
(A) In Unlisted Residence	95
(B) In Unlisted Residence\Street	37
(C) Over A Business Premise	21
(D) With a Householder	13
(E) With Husband (householder)	4
(F) With Husband (Occupation Stated)	2
(G) With Relative?	2
(H) In an Apartment Block	2
Total	176

**FIGURE 2.15: A RESIDENTIAL SEARCH OF 176 WARD
CASES: MANCHESTER (SOUTHERN) MATERNITY HOSPITAL
PROPORTIONAL AGGREGATES**



Source: Southern Case Admissions Register No. 13 & Slater's Trade Directory 1900

for 75 per cent of the entries lived in an unlisted residence (Table 2.11). Nonetheless it confirms that the majority of maternity cases were from the labouring as opposed to the trading classes (Figure 2.15). Where an address was located the women generally lived in rented accommodation, either in an apartment block, with a householder as landlord, or over business premises, including a surveyor's office, a chair maker's workshop, a retail beer outlet, a blacksmith's and the Working Men's Conservative Club Chancery Lane, Ardwick (Table 2.11 and Figure 2.15). In two separate instances the patients shared the same surname as the householder, both of whom were females, perhaps their mothers-in-law. In four others, the patient's husband was a householder and in the remaining two examples the husband's occupation was specified (Table 2.11). The husband of case number 1, a 37 year old expecting her sixth child, was a warehouseman, and the other, whose wife gave birth prematurely, was a farrier.⁶⁹

The importance of the register when providing background information, rests not only with the routine entries, but also the chance remarks, which can prove equally illuminating. Thus, for example, case number 24, a 30 year old mother of five, was found to be 'ill-treated' by her husband and to have 'worked at mill until a few days ago'. Such remarks were rarely documented and never before a subscribing public, but case number 24 could have been representative of several other women, for a high proportion of married women were engaged in

some form of paid employment.⁷⁰ Of Manchester's 86,975 working women, 26.2 per cent were married, compared with a national and county average of 21.9 and 24 per cent respectively, and in a city 'of Spinners' and weavers, whose calicos are spread abroad over three parts of the garment-wearing globe', cotton manufacture was inevitably the largest single employer of women, employing 12,502 in 1901, even more than domestic indoor labour which accounted for 12,306 women.⁷¹ Of equal concern, particularly to local health officials, was the tendency of married women 'to continue their work up to the last moment and return to it as soon as they can move about'; case number 24 was apparently not alone in her difficulties.⁷² Similarly, in the example of case number 185, whose home conditions 'were such as to justify her being delivered there [at the hospital]', detrimental housing conditions were, as we saw earlier, a plausible explanation for the admission of many women, where purely medical reasons were not immediately obvious.⁷³

It is the unpublished, usually unrecorded details such as these, that explain a large proportion of admissions where there is no obvious medical reason for their entry into hospital. Other reasons for a woman's admission, though of a medical nature, but which similarly went unpublished, included those women who had formerly lost a child, particularly a still-birth. At least 23 per cent of the 199 admissions had lost one or more children at birth or during its early infancy. A difficult obstetric history could be another reason, as

FIGURE 2.16: AGE AND PARITY DISTRIBUTION OF WARD DELIVERIES: MANCHESTER (SOUTHERN) MATERNITY HOSPITAL 1899-1901

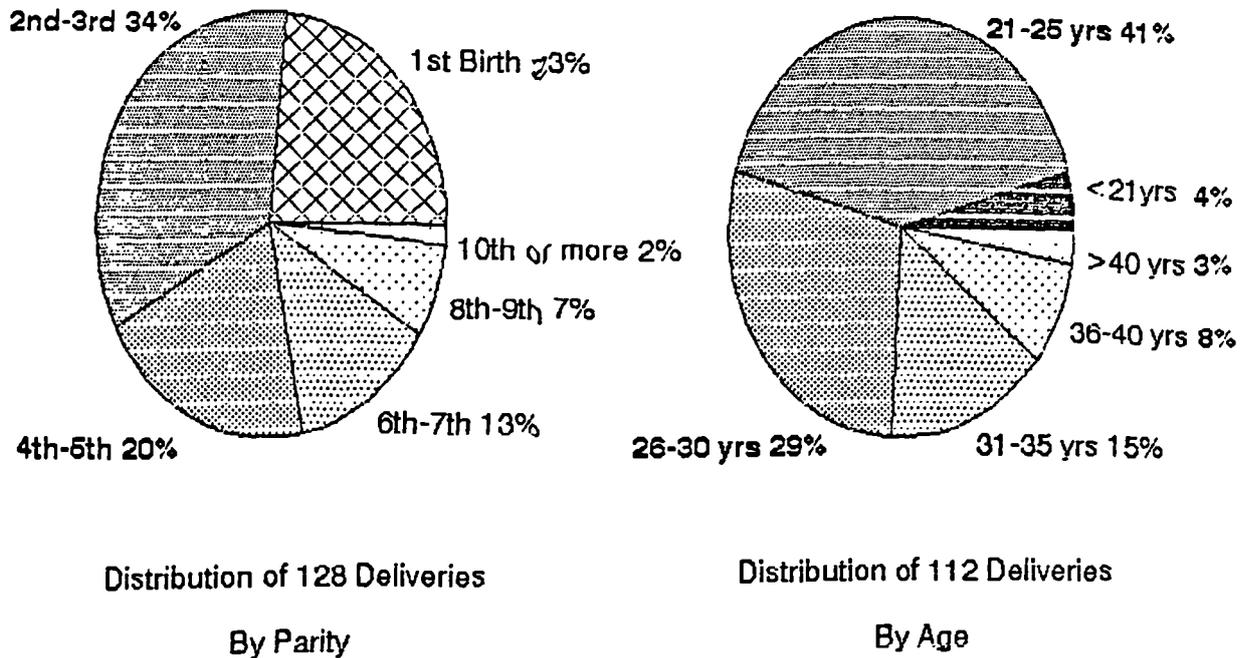


TABLE 2.12: AGE AND PARITY DISTRIBUTION OF 130 NORMAL WARD DELIVERIES: THE SOUTHERN HOSPITAL 1899-1901

	Age Yrs						Age ?	Parity Totals
	<20	21-25	26-30	31-35	36-40	>40		
1st Birth	4	16	8				2	30
2nd Birth	1	13	6				2	22
3rd Birth		12	4	1	1		4	22
4th Birth		3	6	3	1		2	15
5th Birth		1	4	1	1		4	11
6th-10th Birth		1	3	12	6	1	3	26
11th or More						2		2
Parity ?			1				1	2
Age Totals	5	46	32	17	9	3	18	130

Source: The Southern Case Admissions Register No. 13

in the case of the woman whose perineum was 'completely torn' at a previous labour and who feared a repeat occurrence, and in the example of case number 174, whose last child had been delivered at Crumpsall Poor Law Infirmary 'with instruments'. Both women, in the event, delivered naturally and successfully in hospital and gave birth to a 7lb 4oz baby girl and 9lb baby boy respectively.⁷⁴

Parity and age also played an important role. Of the 128 natural labours where the birth parity was known, 56, or 43 per cent of the total, were women delivering their fourth or more child and consequently faced an increased risk of toxæmia, mal-presenting and haemorrhaging. A further 30 women, or 23 per cent of the total, were primiparae, who subsequently faced the possibility of an assisted delivery and infection because a first confinement was generally the most prolonged and exhausting (Figure 2.16 and Table 2.12). Age too was regarded from the time of William Farr as a 'great factor' in the maternal equation because of the strain labour placed on the ageing woman, of whom there were 29 over the age of 30, a quarter of the 112 natural labours where the woman's age was recorded (Figure 2.16 and Table 2.12). Combined with a high parity, the risks of childbirth to an ageing woman could have been manifold.⁷⁵ This explains the admission, even though in the event they were natural labour cases, of case number 17, a 43 year old woman whose last pregnancy, her fourteenth, had ended in a miscarriage after falling down the stairs, and

a woman of the same age, who during 22 years of marriage had delivered 12 children, of whom three had been born prematurely.⁷⁶

The probability of these women surviving their ordeal and the role the hospital played in influencing this outcome will be the subject of discussion in the following chapter. To conclude here, however, Manchester's two maternity hospitals played a far more significant role than previous estimates have allowed. Firstly, with regard to a birth within a woman's own home, the two hospitals were furnishing up to a quarter of the city's parturient women each year with all the resources necessary to conduct a home delivery. Secondly, whilst the total number of ward deliveries was small compared with the city's birth total, the concentration on Manchester's most difficult obstetric cases greatly magnified the hospital's demographic importance to local women. Together with the focus on the economically impoverished, women budgeting on less than 30s a week, often with their husband out of work, and incorporating two of Loudon's essential prerequisites of effective midwifery, namely a 'free' and 'accessible' service, the hospital's potential to influence local maternal mortality rates must have been profound.

Notes to Chapter 2

1. J. Pickstone and S. Butler, 'The Politics of Medicine in Manchester 1788-1792', *Medical History*, 28 (1984), 227-49 (p.229).
2. John Bride, *A Short History of the St. Mary's Hospitals Manchester and The Honorary Medical Staff, from the Foundation in 1790 to 1922* (Manchester, 1922) p.11. John Pickstone, *Medicine and Industrial Society* (Manchester, 1985), p.33.
3. Thomas Radford, *Remarks on the Former and Present Aspects of St. Mary's Hospitals* (Manchester, 1864) p.26.
4. Pickstone, *Medicine and Industrial Society*, p.33.
5. J. H. Young, *St. Mary's Hospitals Manchester 1790-1963* (London, 1964), p.54.
6. As late as 1914 when infant and childhood mortality was a major issue of the day the Children's House Surgeon at St. Mary's, Dr. White, asked to resign his full-time post because of the lack of work. St. Mary's Hospital Archive, Manchester (hereafter, MHA), St. Mary's Annual Reports, 1889-1904. Board Minutes, 5 March 1860; 20 July 1863; 28 May 1914.
7. Manchester Central Reference Library (hereafter CL), 362.1M55, Southern Annual Report, 1867.
8. For Statistical Comparisons with Metropolitan Institutions, see, The Select Committee Report on Midwives' Registration, Reports, Proceedings, Evidence and Index, BPP, 1892 (289), XIV, Appendix No 1, p.141. Return showing the Number of Institutions Approved as Training Schools for Midwives, 1906 (309) XCVIII, p.639. MHA, Manchester, Annual Report 1890.
9. Irvine Loudon, 'Deaths in Childbed from the Eighteenth Century to 1935', *Medical History*, 30 (1986), 1-41 (p.22). Pickstone, *Medicine and Industrial Society*, p.241. *The Break Up of the Poor Law: The Minority Report of the Poor Law Commission*, ed. by Sidney and Beatrice Webb, 2 vols (London, 1909), I, p.113.
10. Loudon, p.22.
11. Manchester CL 362.1M55. Southern Annual Report, 1868. MHA, Annual Report, 1900.

12. Annual Report on the Health of the City of Manchester, 1905.
13. Irvine Loudon, 'Maternal Mortality: 1880-1950, Some Regional and International Comparisons', *Social History of Medicine*, 1 (1988), 183-228 (pp.183, 209, 222). MHA, Annual Reports 1869, 1895-96.
14. *Lancet*, 20 February 1892, p.443. Manchester CL, 362.1M55, Southern Annual Reports, 1890, 1898-1900.
15. MHA, Annual Report 1875, Bye-Laws 1896. Management Minutes 15 October 1860. Medical Committee Minutes, 9 January, 22 February 1906; 26 May 1908.
16. One of the principal reasons for the foundation of the Coombe Maternity Hospital, on the south side of Dublin, was the death of two women from there, who were trying to reach the Rotunda Maternity Hospital on the city's north side. H. W. Hart, 'The Conveyance of Patients to and from Hospital, 1720-1850', *Medical History*, 22 (1978), 397-407 (p.399). MHA, The Manchester (Southern) Maternity Hospital Admissions Register No. 13, case no. 45.
17. *Lancet*, 2 July 1910, p.62.
18. A. Sharrat and Kathleen Farrar, 'Sanitation and Public Health in Nineteenth Century Manchester', *Memoirs and Proceedings of the Manchester Library and Philosophical Society*, 114 (1971-72), 1-20 (p.6). Angus Reach, Correspondent at the *Morning Chronicle*, presented his accounts of Manchester between 1849 and 1851, cited in, *Labour and the Poor in England and Wales 1849-1851*, ed. by Jules Ginswick (London, 1983), pp.18, 46. James Niven, *Observations In the Public Health Effort in Manchester* (London, 1923), p.176. Michael Harrison, 'Housing and Town Planning in Manchester Before 1914', in *British Town Planning: The Formulative Years*, ed. by A. Sutcliffe (Leicester, 1981), pp.106-45 (pp.117). T. R. Marr, *Housing Conditions in Manchester and Salford* (London, 1904), pp. 4, 43, 46.
19. *Lancet*, 6 March 1897, p.699. Harrison, pp.108-09. Fred Scott, 'The Condition and Occupations of the People of Manchester and Salford', *Transactions of the Manchester Statistical Society*, (1888-89), 93-116 (p.105).
20. J. Rowntree and A. Sherwell, *The Temperance Problem and Social Reform* (London, 1900), pp.551-55, Marr, pp.17, 58. Ernest Dewsnap, *The Housing Problem in England* (Manchester, 1907), pp.44-47.

21. Annual Report of the Health of the City of Manchester, 1903, 1926.
22. Marr, pp.17, 42. Reach, pp.18, 21.
23. John Leigh, Medical Officer of Health, quoted in Scott, p.108. See also, Manchester CL, 614 RE 1, Reports on the Sanitary Condition of Manchester, 1886-96, Health Reports by John Leigh for the Years 1884 and 1885, pp.22-24.
24. *Lancet*, 15 October 1892, p.912.
25. Rev. J. E. Mercer, 'The Conditions of Life in Angel Meadow', *Transactions of the Manchester Statistical Society*, (1896-97), 159-80 (pp.161, 164).
26. Reach, pp. 18, 46. *Lancet*, 13 February 1904, p.472.
27. *Lancet*, 12 August 1899, p.421; 23 February 1901, p.582.
28. Loudon, 'Maternal Mortality: 1880-1950', pp.27-34.
29. Of the 11,000 Mancunian Males presenting themselves as recruits for the Boar War, 8,000 were immediately rejected on health grounds, and of those accepted, only 1,000 men, 9 per cent of the initial total were considered fit enough to serve on the front line. Despite the immense popularity of football in Lancashire, the 'stunted and prematurely enfeebled', condition of Lancashire males, meant the teams had to be, 'chiefly composed of imported Scotsmen...whilst the natives look on and shout', and similarly, the local constabulary were forced to recruit from Scotland, Ireland and the County districts due to the prevalence of ill-health. *Lancet*, 24 February 1900, p.572; 18 May 1895, p.1,277, see also: 14 July 1900, p.137; 22 October 1900, p.1167; Robin Martin, 'Sanitary progress and its Obstacles in Manchester', *Transactions of the Manchester Statistical Society*, (1874-75), 87-98 (p.91).
30. Dr. J. Tatham, quoted in Marr, pp.20, 105. *Lancet*, 17 August 1889, p.344.
31. Health Reports by John Leigh, p.22. *Lancet*, 18 May 1895, Jean Towler and Joan Bramall, *Midwives in History and Society* (London, 1986), p.139. Janet Campbell, 'Maternal Mortality', *Reports on Public Health and Medical Subjects*, 25 (London, 1924), p.36.
32. MHA, Admission Register, No. 13.

33. Manchester CL, 362.1M55, Southern Annual Reports, MHA, Annual Reports, 1867, 1869, 1900.
34. Manchester CL, 362.1M55, Southern Annual Reports, 1895, 1900. MHA, Annual Report 1900, Board Minutes, 22 February 1906.
35. MHA, Correspondence from T. Radford to St. Mary's Board of Management, 6 December 1862.
36. MHA, Correspondence from St. Mary's Board of Management to the City's Medical Officer of Health, Dr. James Niven, October 1907. Annual Report 1907.
37. For a realistic account of travelling from door to door encountering difficulties securing a patron, see, George Moore, *Esther Waters* a fascimile of the 1st edn. London, 1894 (Chicago, 1977), p.110.
38. MHA, John Leigh quoted in, Thomas Radford, *Remarks on the Former and Present Aspects of St. Mary's*, p.38.
39. MHA, Board Minutes, 2 February 1863.
40. Census of England and Wales 1901, Summary Tables (London, 1902), pp.223-29, 234-35. A. Kidd, 'Charity Organisation and the Unemployed in Manchester c1870-1914', *Social History*, 9 (1984), 45-66 (p.55).
41. David Owen, *English Philanthropy 1660-1960* (London, 1964), p.53.
42. W. Barnett Tracy, *Manchester and Salford* (Manchester, 1899), p.53.
43. MHA, Annual Reports, 1890-1900.
44. See, with particular reference to Manchester: Michael Rose, 'Culture, Philanthropy and Manchester's Middle Classes', in *City, Class and Culture*, ed. by Alan Kidd and K. W. Roberts (Manchester, 1985), pp.103-17 (pp.104-05); Alan Kidd, 'Outcast Manchester: The Voluntary Charity, Poor Relief and The Casual Poor', in Kidd and Roberts, pp.48-78 (pp.49, 52). Also, F. Prochaska, *The Voluntary Impulse: Philanthropy in Modern Britain* (London, 1988), p.22; K. Woodroffe, *From Charity to Social Work in England and the USA* (London, 1962), p.12. Roy Porter, 'The Gift Relation: Philanthropy and Provincial Hospitals in Eighteenth Century England', in *The Hospital in History*, ed. by Lindsay Granshaw and Roy Porter (London, 1989), pp.149-78 (p.152).
45. Porter, p.177.

46. William O'Hanlon, 'Our Medical Charities and their Abuses: With Some Suggestions for their Reform', *Transactions of the Manchester Statistical Society*, (1872-73), 40-72 (p.52).
47. For history of the DPS in Manchester, see H. C. Irvine, *A Short History of the Old DPS 1833-1933* (Manchester, 1933), Alan Kidd, 'Charity Organisation and the Unemployed in Manchester 1870-1914', *Social History*, 9 (1984), 45-66 (p.47). For contemporary reports, see, Manchester CL, 361 M20, Manchester and Salford Provident and Charity Organisation Society Annual Reports.
48. Kidd, 'Charity Organisation and the Unemployed in Manchester', pp.47, 51, 'Outcast Manchester', pp.52, 53. Irvine, p.14. Manchester CL, 361 M20, Manchester and Salford Provident and Charity Organisation Society Annual Report, 1871.
49. Kidd, 'Outcast Manchester', p.52. 'Charity Organisation and the Unemployed in Manchester', pp.46, 52, 55-56.
50. MHA, Board Minutes, 18 October 1875. Manchester CL, 361 M20, Manchester and Salford Provident and Charity Organisation Society Annual Reports, 1875, 1877-78, 1882.
51. MHA, Board Minutes, 25 October, 1 November 1875, 24 January 1887. Annual report, 1878. Rules of St. Mary's Hospital, 1896. Manchester CL, 361 M20, Southern Annual Reports, Annual Report, 1889. O'Hanlon, p.52.
52. MHA, Annual Reports, 1871-78.
53. MHA, Board Minutes, 24 January 1887.
54. MHA, Board Minutes, 2 July, 2, 16 August, 1875.
55. F. Nightingale, *Introductory Notes on Lying-In Institutions* (London, 1871), p.89.
56. MHA, Annual Report 1869. Lawson Tait, *An Essay on Hospital Mortality Based on the Statistics of the Hospitals of Great Britain for Fifteen Years* (London, 1877), p.78. Coghlan, 'Deaths in Childbirth in New South Wales' *Royal Statistical Society*, 61 (1898), 518-28 (pp.519, 524-25).
57. St. Mary's Management Board, openly admitted in 1879 that single women were 'sometimes' confined by hospital staff albeit 'by deceitful strategy' on the part of the mother. At the Southern, which never officially stated its position towards single women, the decision of admission into the hospital and acceptance of district cases was very

much left to the medical staff, which perhaps accounts for the 5 per cent of maternity admissions, a minimum estimate, (December 1899-January 1901) who had only been married between four and eight months; an impropriety of which the staff appear to have been fully aware. MHA, Annual Report 1879, Admissions Register, No. 13. Manchester CL, 361 M20 Southern Annual Report, 1869. For further evidence of medical staff sympathy towards the admission of single women, see Chapter 4.

58. MHA, Annual Report 1878.
59. Manchester CL, 361 M20, Southern Annual Reports, 1867, 1877. 'Manchester Southern and Maternity Hospital For Women and Children', *Manchester Faces and Places*, 9 (1898), 144-49.
60. Marr, p.13. W. Elkin, 'Manchester', in *Married Women's Work*, ed. by C. Black (London, 1915), pp.161-67. Scott, p.93.
61. MHA, Board Minutes, 29 December 1862, 5 January 1863.
62. Irvine, p.13. *Lancet*, 8 March 1879, p.354.
63. Janet Campbell, 'The Protection of Motherhood', *Reports on Public Health and Medical Subjects*, 48 (London, 1929), p.33. Loudon, 'Maternal Mortality: 1880-1950', p.227.
64. MHA, Annual Report 1877, Board Minutes, 3 February 1879. The Select Committee Report on Midwives' Registration, 1892, p.145. F. B. Smith, *The People's Health 1890-1910* (London, 1979), p.46.
65. M. C. Versluysen, 'Midwives, Medical Men and "Poor Women Labouring of Child": Lying-in Hospitals in Eighteenth Century London', in *Women, Health and Reproduction* ed. by Helen Roberts (London, 1981), pp.18-49 (pp.19-20). MHA, Annual Report 1872, Bye-Laws, 1896. Manchester CL, 362.1M55, Southern Annual Report, 1867, 1889, 1896.
66. see note 57.
67. 'Manchester Southern and Maternity Hospitals', p.145.
68. Figures based on estimation by Arthur Newsholme, *Supplement Containing a Report on Maternal Mortality in Connection with Childbearing*, 44th Annual Report of the Local Government Board 1914-15 (London, 1915), pp.31, 84.

69. MHA, Admissions Register No. 13. Case Nos. 1, 139. Slater's Trade Directory For Manchester, 1900.
70. MHA, Admissions Register No. 13, case no. 24.
71. In Manchester's central districts, the areas in which the maternity hospitals did most of their work, the proportion of mothers engaged in salaried employment was as high as 40 per cent. Annual report on the Health of the City of Manchester, 1908. Census of England and Wales, Summary of Tables, 1901, pp.234-35, Reach, p.4.
72. *Lancet*, 13 February 1904, p.473; 28 January 1905, p.267.
73. MHA, Admissions Register No. 13, case no. 85.
74. MHA, Admissions Register No. 13, case nos. 62, 174.
75. For contemporary and historical references on the effects of parity and age on parturition, see: W. Farr, 30th Annual Report of the Registrar General, 1867, pp.223, 226; Coghlan, pp.520-21; P. Branca, *Silent Sisterhood: Middle Class Women in the Victorian Home* (London, 1975), p.75. Kerr, *Historical Review of British Obstetrics and Gynaecology 1800-1950* (London, 1954), p.269; R. Schofield, 'Did the Mothers really Die?' in *The World We Have Gained*, ed. by L. Bonfield, R. Smith and K. Wrightson (Oxford, 1986), pp.231-60 (pp.255). See also Chapter 5 for further references.
76. MHA, Admissions Register No. 13, case nos. 17, 57.

Chapter Three

The Manchester Maternity Hospitals:

A Case Study in Clinical Practice

1860-1905

...a careful midwife and a skilful doctor
rarely lose a patient¹

In the last chapter, it was found that Manchester's two Victorian maternity hospitals attended sufficiently large numbers of the economically impoverished and abnormal cases to play a far more demographically significant role than previous estimates allowed. It is the purpose of the following section to extend this line of investigation and establish by whom these women were delivered, by what means and to what effect. This approach has been taken, firstly, to ascertain the quality of obstetrical attendance, which has been regarded as the all-important determinant of low maternal mortality and secondly, to highlight ways in which hospitalization enhanced the character of such attendance.

Having already shown that hospital midwifery met two of the three important determinants of low maternal mortality, namely a 'free' and 'accessible' service, it will be claimed that the third and arguably the most important determinant 'obstetric care of a high standard', was equally assured under the auspices of the maternity hospital.² This was primarily achieved by effective use of a well-trained and regulated midwife at all normal confinements, but with the support, in moments of complication, of highly experienced and skilled medical assistance. The provision of maternity wards

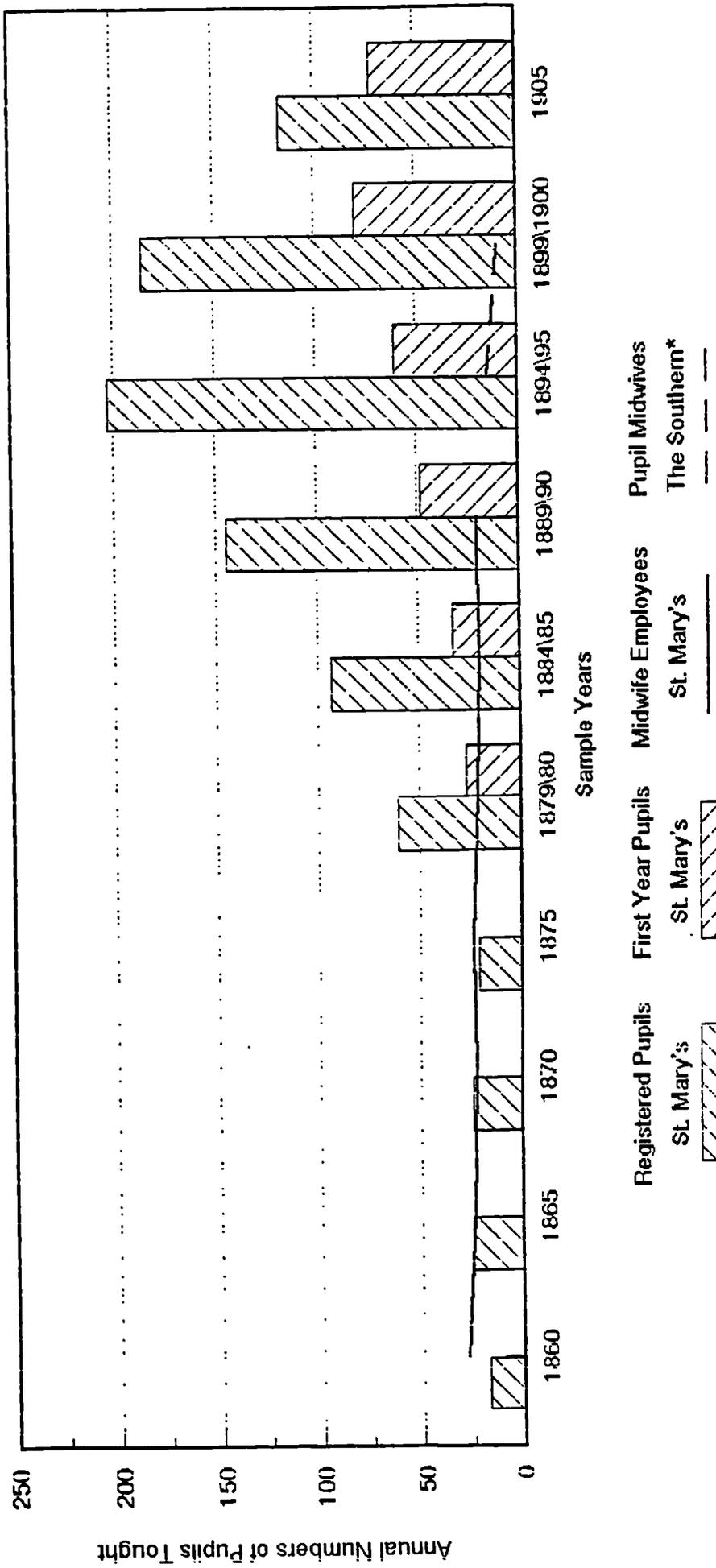
from the late 1880s, it will be further argued, augmented the hospital's position, not only by guaranteeing attention regular nourishment, and isolation from domestic strife, but also by providing a range of clinical services (an aseptic environment, a central reserve of staff and resources alongside the latest improvements in obstetric methods), long before general practitioners were aware of such advances or were inclined to follow them.

Hospital Practitioners: 'A Careful Midwife...'

For a number of historians the 'quality of care' has been judged solely in terms of midwives, who if they 'had received some training or at least took reasonable precautions against infection' and 'interfered as little as possible', provided the safest and most effective means of delivering a woman.³ Whilst the argument cannot be taken so narrowly and has to take account of skilled medical assistance, particularly in cases of complicated labour, there is, as explained in the Introductory Chapter, little doubt of the trained midwife's crucial role in improving the maternal mortality rates in any given locality.

For a maternity organisation to have received any credibility, therefore, the trained midwife would have had to have played an integral role in its work. Maternity hospitals not only offered, but fostered such a role, by constantly supplying themselves and other

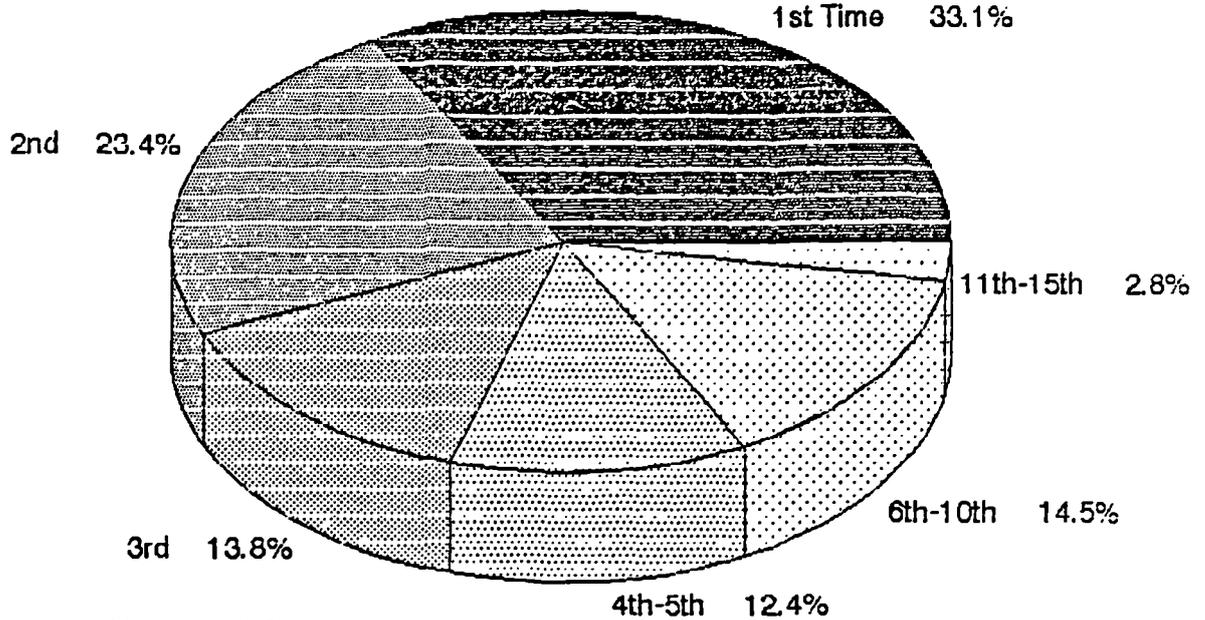
**FIGURE 3.1: THE TOTAL NUMBER OF PUPIL MIDWIVES
ST. MARY'S AND THE SOUTHERN (SAMPLE YEARS) 1860-1905**



* At the Southern, midwife nos. (1889-1903) varied between 15 (1893) & 7 (1901)
Source: Registers of Pupil Attendance, St. Mary's, 1853-1892\3 & 1893\4-1909
Southern Annual Reports 1889-1903

FIGURE 3.2: FREQUENCY OF COURSE ATTENDANCE BY PUPIL MIDWIVES: ST. MARY'S 1889-1890

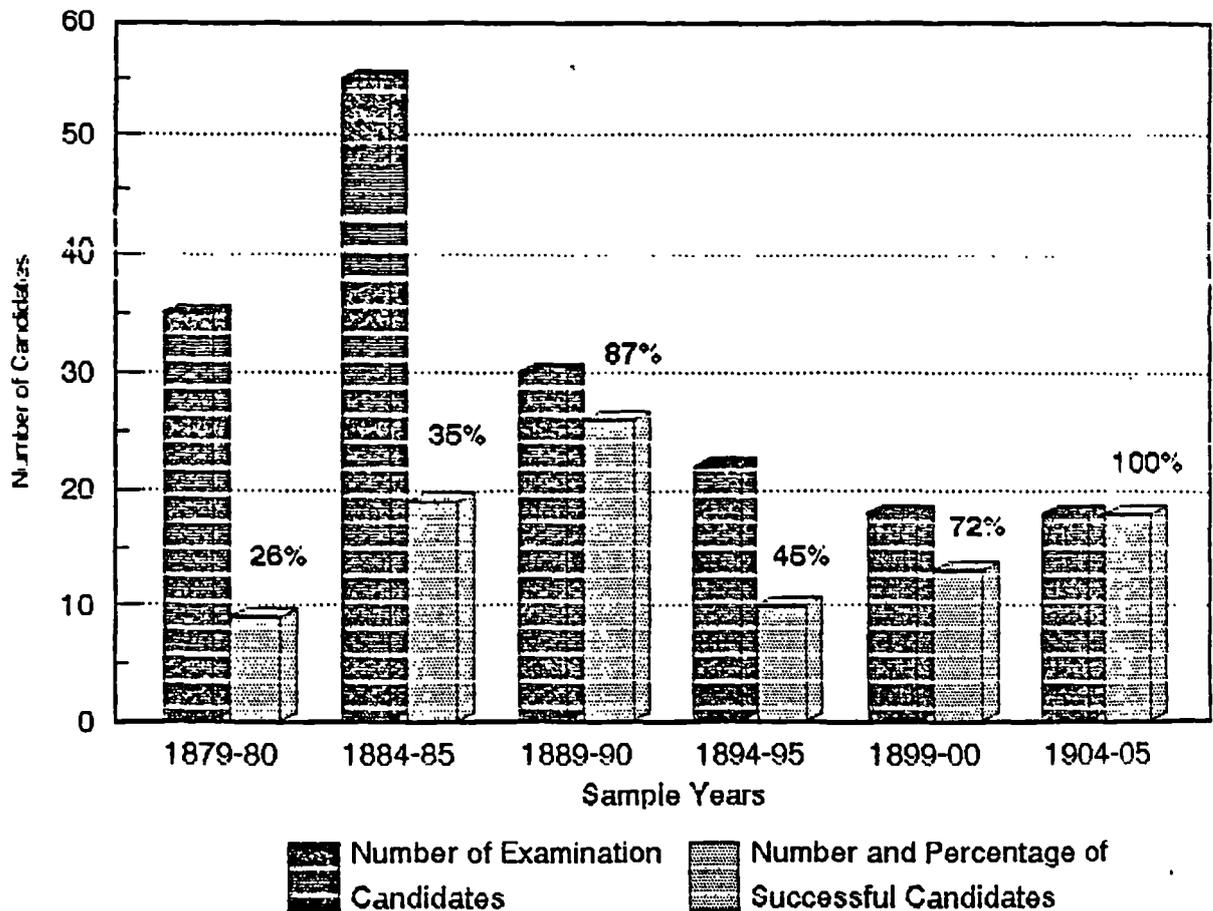
Frequency of Course Attendance:



Total Number of Pupils Attending the Course (145)

FIGURE 3.3: EXAMINATION PASS RATES

BY PUPIL MIDWIVES: ST. MARY'S 1879\80-1904\5



Source: St. Mary's Registers of Pupil Attendance 1853-1892\3 & 1893\4-1909

maternity charities with trained midwives. St. Mary's had, since its foundation, instructed pupil midwives and the Southern taught midwives from 1881. However, enrolling no more than 15 pupils a year, the latter could hardly compete with St. Mary's which had, by the 1890s, 200 or more pupils annually on its books (Figure 3.1). Rarely, though, were St. Mary's pupils attending the course for the first time (Figure 3.1). During the year 1889 to 1890, when 33 per cent of the 145 registered pupils attended the course for the first time, a further 23 per cent attended for the second time, 41 per cent for the third to the tenth time and others from the twelfth to the fifteenth time respectively (Figure 3.2).

Course repetition in this fashion perhaps says something about the calibre of the pupils recruited. It may be that a number of pupils were genuinely second and third year pupils, but this would not excuse those attending for the fifth or more time, or those who failed either to attend or to pass the examination at the end of the course and had to repeat it again. During the academic year, 1894 to 1895, only 22 pupils sat the examination, which would have accounted for a third of the pupils attending the course for the first time (Figures 3.1 and 3.3). Of the 22, over half failed and were either refunded two of their three guinea course fee, encouraging them to attend the course again, or were offered a certificate in monthly nursing, despite examination marks as low as 24 per cent; seven of the 12 failures (1894-95) opted for this latter route (Figure

3.3).⁴ The high failure rate and the transfer to monthly nursing was perhaps indicative of their poor theoretical competence and confirmation of Campbell's conclusions about pupil midwives of the 1920s, that they were 'women of limited education, who learn with difficulty...'. Yet it could hardly have been otherwise, since women were recruited not so much for their academic abilities, as their 'irreproachable moral character' 'and fitness for the office'.⁵

However, this ought not to invalidate Thomas Radford's claims, on behalf of St. Mary's, that 'every means is taken to make the midwives sound and good practitioners, as far as their province extends'.⁶ The repeated attendance at lecture courses indicates that certain standards of competence had to be met before the midwife could qualify. This included midwives already in the hospital's employ who had to attend refresher courses on an annual basis. If they hoped to be awarded a Diploma they had, like the pupil midwives, to achieve at least 50 per cent in the viva voce examination but were exempt from any written test.⁷ Here the emphasis lay not so much with theoretical instruction as a practical, working knowledge of the subject.

The Diploma, devised by St. Mary's medical staff in 1885, was 'similar in character and value to that of the Obstetrical Society of London [Diploma]' and in fact many of St. Mary's graduate midwives joined those trained at the Southern and entered 'the highest examination open to a midwife, namely that of the Obstetrical Society of

London'. This Diploma was based on three months of lectures which included instruction on elementary anatomy, the principles of hygiene, the management of a natural labour and the lying-in period and recognition of abnormalities. The pupil midwives were also made fully aware of the necessity of calling a doctor at moments of uncertainty or abnormality. Throughout the training, classroom instruction was supplemented with practical work, including delivering a minimum of 25 domiciliary cases.⁸ This accustomed pupils to the physical demands of the job and the unfavourable working conditions and if nothing else, ensured that they soon grasped the rudiments of hygiene management.⁹

Once trained, those midwives who remained with the hospital joined a team of about 20 midwives at St. Mary's and one of about ten at the Southern, to become part of an organised and disciplined group, where regulations were adhered to 'in every respect ... on pain of suspension or expulsion' (Map 4, Chapter 2, for their location). Though restrictive, the system simultaneously offered a safety net, presenting midwives with a number of informed options, practical solutions and most significantly, the reassurance of medical support. If unable to attend a case, a hospital midwife from a neighbouring district would be sent to deputize and in all cases of potential danger and difficulty, she was to complete 'one of the "Difficult Case Cards", and send it by trustworthy messenger to the Resident Obstetric Assistant Surgeon at the Hospital', free of charge to the

mother (Sample Text 3.1). These written procedures also ensured that the mother and her newborn received a uniform standard of care during her lying-in period, for the mother had to be regularly visited and her condition constantly monitored. If her child displayed 'a deformity, malformation or monstrosity', or any disease of the eye, she was to be immediately referred to the hospital.¹⁰ Thus, what the newly-formed Midwifery Supervisory Committees were striving for in the wake of the 1902 Midwives Act, namely a regulated body of trained and competent midwives, had been accomplished by the voluntary maternity hospitals a quarter of a century earlier.

The demands on the hospital midwife, the high standard required of her and the sense of professionalism that it instilled, appear to be reflected in the relatively high salaries derived from both hospital and private case work. Although it is not entirely clear how much a midwife earned a year, for she never received a fixed salary, she was known to be paid 3s 6d for each hospital case she delivered and between 7s 6d and 10s for each private case, ensuring the 3 guinea Diploma fee was soon recouped.¹¹ Whilst hospital work seems poorly paid in comparison with private practice, it was her affiliation to a reputable hospital, to which her clientèle might well have subscribed, that enabled the midwife to demand high, private fees.¹² Also, as private midwifery practice was heavily competitive, because of rivalry from general practitioners and untutored

midwives, a hospital appointment at least ensured regular employment.

One St. Mary's midwife, a sample of whose case work was recorded when she was accompanied by a medical student in March 1883, conducted 20 labours within 15 days, with as many as three deliveries on the same day.¹³ For the fortnight's work, at 3s 6d a case, the midwife would have received £3 10s, a most acceptable income for any wage earner, male or female. The 15 day case load of 20 labours was, however, far from representative, for if logically followed through, the woman would have delivered 480 cases a year and earned £84. With assistance from a medical student or a pupil midwife the midwife may have conducted 400, or perhaps 500 labours a year, but this would have been most unusual and not common practice. In addition post-confinement nursing for a patient involved an average of 1¹/₂ hours a day for 14 days, excluding travel time. Thus a midwife, working alone, often conducted between 120 and 150 labours per annum, 'and even this means hard and continuous work'.¹⁴ If the midwifery fee of £514 and district case total of 2,691 labours at St. Mary's in 1900, for example, were evenly distributed amongst the 16 midwives on its pay roll, each would have delivered about 168 women and earned £32, excluding any income from private cases. This would seem to be a more realistic figure and one equivalent to the wage of an upper servant or governess.¹⁵

As a result of the training, employment, supervision and financial incentives, a number of highly motivated and competent midwives emerged. As early as January 1858, Agnes Cheetham, for instance, on her resignation from St. Mary's midwifery staff due to ill-health, wrote a most literate composition of gratitude to her employers, thanking them for her midwifery tuition which she believed was the reason she never lost a case. Yet the following month a midwife was summoned before the same hospital board for falsification of papers, recording a twin birth when only a single had occurred. It transpired that the midwife's daughter writing on behalf of her mother, who could neither read nor write, had filled the forms in error. Following a month's suspension, pending further enquiries, the midwife was eventually dismissed.¹⁶

Although standards undoubtedly improved as training and employment requirements became more formalized, disciplinary problems continued to emerge which were invariably alcohol-related. Reported by a maternity patient, confirmed by witnesses and 'feebly' denied by the accused, one midwife was found intoxicated whilst actually attending a birth. As the midwife had served the hospital for several faultless years, she received a three month suspension rather than an outright dismissal. In another case, the fate of the attendant midwife was less favourable, for after being found at the patient's home 'lying half drunk on the bed', incapable of delivering the child and unable to offer a plausible

explanation, the midwife was referred to a lunatic asylum for 'special treatment'.¹⁷

Alcohol-related problems, though not excusable, were not unusual, given the particular set of circumstances in which midwives found themselves. The midwives were, after all, residents in a city which accommodated almost 3,000 licensed premises by 1900, or one for every 180 inhabitants. There was also a recognised alcohol problem amongst women, who accounted for 36 per cent of all drink offences in Manchester in 1894.¹⁸ The birthing room itself was frequently uncondusive to sobriety, for alcohol was often used as an anaesthetic and freely supplied to the midwife and onlookers who turned the occasion into something of a social celebration. This reverts to eighteenth century childbirth practices, when childbirth was regarded as 'an occasion for an often lively and somewhat alcoholic gathering of female neighbours and kin' and where the mother and midwife were offered a thin gruel mixed with wine or ale.¹⁹ This was not without its problems, as one surgeon claimed in the spring of 1864 when he accused a midwife from St. Mary's of inducing birth with drugs, then returning a day later, inebriated, and toppling over the woman who later died. Several other, former patients also attested to being confined by the same midwife whilst she was drunk, but the Hospital Board of Enquiry set up to investigate the allegations found them to be unfounded.²⁰

Moreover, even with the benefits of a hospital training, which emphasised, above anything else, personal

hygiene and antiseptic precautions, it did not necessarily follow that a hospital trained midwife adhered to classroom instruction and clinical observation. During a routine inspection in 1905, Manchester's newly appointed Inspector of Midwives, Dr Merry Smith, found one midwife, a recipient of a hospital training and who ran a 'fairly large practice', used a maternity bag which was

blood-stained and filthy...soiled throughout. The scissors were blood stained. The thermometer was broken, and she had no vaginal douche or catheter. She was personally dirty and untidy, and the home was in the same condition.

A later, impromptu inspection, found the midwife personally neat and tidy, her appliances were complete and in excellent order and the care taken of the lying-in women very satisfactory.²¹ The woman obviously knew how and what was required of her, but until the appointment of the Inspector and the introduction of regulations, she had neither the incentive nor compulsion to apply even to the basic principles of midwifery. In contrast, the institutional midwives, well rewarded but regulated, were both motivated and closely supervised to adhere to regulations and hygiene principles, no matter how tedious they seemed.

The maternity hospital had begun to address central issues concerning the ignorance and incompetent practices of midwives and their quest for professional recognition, long before the State involved itself with such problems. The public statements made by Manchester's first

Inspector of Midwives, Dr Merry Smith, bear testimony to this. Referring to those midwives in the hospital's employ, Smith found that 'backed up directly by the authority of the Hospital', it was 'much easier for the midwives...to cope with the problems incidental to midwifery among the very poor than it is for the isolated midwife to do so'. As a result, the hospital midwives were doing 'excellent work' and 'the very poor in the central districts of the city are now sure of skilled care and attendance from the midwives working directly in connection with St. Mary's Hospital'.²²

'...and a Skilful Doctor'

The overall success of a midwife-based organisation, like St. Mary's or the Southern, was equally dependent on assistance, at moments of complication, from a second birth attendant, 'a skilful doctor'. Unlike general surgery, where procedures were well-defined, in obstetrics the emphasis lay not only on the skill of the operation, but also on the judgement over which one of several options was taken and at what point it was carried out, if at all, during the course of labour. The 'technical skill, judgement and experience', demanded at a difficult confinement, meant a thorough grounding in obstetric instruction. An awareness of changes in clinical thought and methods as well as a considerable amount of obstetric experience, were essential if the risk of infection and injury at a complicated birth were

to be minimised.²³ It is against such criteria that 'a skilful doctor' must be judged.

However, the doctor's physical presence at a district or even a ward confinement must not be overstated, for although historians have been quick to regard a hospital labour and a birth conducted by the doctor as one and the same, they clearly were not.²⁴ Governed by the hospital's bye-laws, the doctor's role was restricted to only those women where there was 'any likelihood of difficulty and danger'. It was the midwife who attended to all normal confinements and took the decision whether to call a doctor. Although influenced by written regulations defining a complication, the midwife had the final word and thus a certain amount of discretion in the labour room. Indeed, midwives were given every encouragement to remain in charge of their cases, for it was neither in their interests, as William Sinclair at the Southern explained, to be 'seen to lose their heads and send too frequently for medical assistance', nor in the interests of the hospital to pay the doctor extra for an unnecessary house call. As a result, no more than between 5 and 10 per cent of the women who were confined in their own home ever saw a hospital doctor which meant, in absolute terms, no more than 150-300 cases a year.²⁵

A further distinction also needs to be made between the hospital doctor and the general practitioner. Unlike America, where general practitioners not only admitted their own cases to a maternity hospital but also

personally attended them there, Manchester's maternity hospitals used their own appointed doctors.²⁶ At St. Mary's, for example, when the midwife,

requires assistance, [unless the patient was in immediate danger] she is not to send for any other doctor than the Resident Obstetric Assistant-Surgeon; and in the event of any one else being called in by the friends of the patient, is to give up the case.²⁷

At the Southern too, depending on the location, the district midwife had to call for assistance from one of between 10 (1900) and 15 (1890) district obstetric physicians; men selected and appointed by the Southern Hospital to the exclusion and anger of many general practitioners (Map 4, Chapter 2, for their location).²⁸

Yet even these hospital appointees, who were only expected to diagnose and perform minor obstetrical tasks, were restricted as to what they could and could not attempt to do at the birth. St. Mary's resident obstetrician and his assistant, appointed in 1898, had in all cases of labour requiring operative treatment, 'except ordinary forceps and turning cases' and whenever a consultation was required, 'as in grave cases of placenta praevia, puerperal convulsions & C.' to call for the Honorary Medical Officer of the District in which the patient resided. Similarly, in all ward confinements, 'unless the case to be one of normal labour', the presence of an honorary medical officer was mandatory.²⁹

Whilst a regulated and collaborative approach to problem births was more characteristic of institutional midwifery than private practice, it was largely led by

TABLE 3.1: A PROFILE OF HONORARY MEDICAL STAFF

ST. MARY'S AND THE SOUTHERN 1900

	Graduated	Honorary Service	Royal College Membership	Other Honorary Posts	Lecture Posts	Obstetric Society Membership	Other Society Membership	Made a Contribution To Research...
Southern Hospital:								
William Sinclair*	1873	1876-1912	M.R.C.P.		Professor Owen's Cllege	N.E.O.S. L.O.S.	M/C.M.S.	C. Sect. Promoter of Ob. & Gny Soc
John Scott	1873							
John Stallard	1881					N.E.O.S.	M/C.M.S. S.O.A.	
Arnold Lea*	1890		F.R.C.P.	Gyne Surgeon Clinical Hosp.	Lecturer Owen's Cllege	N.E.O.S. L.O.S.	M/C.M.S.	Puerperal Sepsis
St. Mary's:								
Lloyd Roberts*	1857	1868-1920	M.C.R.S.	Csllt Gyne Surg	Lecturer	N.E.O.S.	M/C.M.S.	Midwifery Text
William Walter	1875	1880-1908	F.R.C.P. F.R.C.S.	Royal Infirmary	Owen's Cllege	L.O.S. N.E.O.S. L.O.S.		C. Sect.
Stephen Nesfield	1854	1858-1909	M.R.C.S.					
Archibald Donald*	1883	1888-1937	M.R.C.S. M.R.C.P.	Hon Gyne Surg Royal Infirmary				Prolapse Uterus Antisepsis Midwifery Text

F/M Fellow/Member R C P /S Royal College of Physicians/Surgeons
 N.E.O.S N of Eng Obstc Soc. L.O.S London Obstc Soc S O.A Soc. of Anesthetists
 Source Medical Directory/Registrar 1900 *Obituaries & Bibliographies (see text)

honorary practitioners, a small body of men at the peak of their profession and at the very hub of obstetric activity. As an honorary position provided a unique opportunity to pursue research interests and tuition privileges, offering an introduction to an affluent and distinguished panel of patrons, governors and subscribers, all potential clients, it was considered 'the key to fame and fortune', much sought after and therefore, by its very nature, highly exclusive.³⁰ Honorary appointments were for only the most aspiring and experienced doctors.

Selected from the survey of 1900, William Japp Sinclair, for example, was one such figure (Table 3.1). Graduating 'with highest academical honours', he held residential appointments at Aberdeen's Royal Infirmary and Manchester's St. Mary's and Clinical Hospitals. After a short study period in Vienna for obstetrics and gynaecology, Sinclair was appointed an Honorary Physician at the Southern in 1876. There he spent the first six years attending difficult confinements, but soon emerged as the hospital's 'professional mainstay' and retained his honorary position, even on amalgamation with St. Mary's, until his death in 1912.³¹

Sinclair's 36 years service was not unusual. His counterparts at St. Mary's had by 1900 each held their honorary appointments for an average of 27 years, including the Honorary Physician, Lloyd Roberts, who was eventually to serve for 52 years, and Honorary Surgeons, Stephen Nesfield and Archibald Donald, who were similarly

to hold their posts for 51 and 52 years, respectively (Table 3.1). In each of these cases, only death seems to have terminated their association with the hospital. Their commitment to St. Mary's can therefore be left in little doubt and clearly qualification by experience was one of the hospital's practitioners' key qualities.

These long periods in office, permitted until amalgamation in 1905, when a retiring age of 65 was imposed on all new honorary appointments, made it difficult for the young and ambitious to acquire honorary status. Individuals intent on securing an honorary post had to undergo a lengthy traineeship, subservient to, and exploited by the current office holders.³² William Walls, for example, the Obstetric Assistant Surgeon at St. Mary's in 1900, had been employed by the hospital since he qualified in 1888 and had held every full-time post possible, before eventually receiving an honorary post in 1905. From the patient's perspective, it meant that these new honorary medical officers were being appointed to posts 'with a fund of experience', with well established reputations as skilled operators and regular contributors to obstetric debates. William Walls, for one, whose 'chief reputation was as a bold and skilful operator and one of very sound judgement', was also a member of the principal obstetrical societies and a regular contributor to the debates and publications of the North of England Obstetrical and Gynaecological Society, including a valuable paper on the treatment of accidental haemorrhaging in 1899. Similarly, William

Fothergill, a graduate of Edinburgh University in 1893, received an honorary post at St. Mary's at the same time as Walls in 1905. He had, nine years earlier, already 'exercised a profound influence on British Obstetrics', by publishing The Golden Rules of Obstetrical Practice and a Manual of Midwifery, which had run into its fifth edition by 1922, and was one of the standard textbooks of the day.³³

Membership of an obstetrical society, a publishing contract, regular contributions to a recognised journal and tutorial duties, the principal characteristics of most of the honorary staff, provided the basis from which institutional practitioners dominated the obstetrical profession. The Southern's Japp Sinclair, for example, the first General Secretary of The North of England Obstetrical and Gynaecology Society 'upon whose individual effort the success of the enterprise had so much depended', was also responsible for founding the Society in 1889, the first obstetrical society in England and Wales that was active outside London. Co-founder and editor of the Medical Chronicle in 1884, which furnished Manchester's practitioners with a regular synopsis of medical progress, Sinclair also established, together with Doctors Fothergill and Arnold Lea, The Journal of Obstetrics and Gynaecology of the British Empire in 1897, which was soon heralded as one of the most important international journals of its kind.³⁴

Though perhaps not as accomplished in the dissemination of ideas as Sinclair, who contributed a

large number of his own abstracts to such journals, the experience of his colleagues was no different. Most were Members, Fellows and even former Presidents of two of the country's foremost obstetrical societies, The Obstetrical Society of London and The North of England Obstetrics and Gynaecological Society, as well as Manchester's own medical society, reputedly the foremost medical society in provincial England and a major venue for obstetrical and gynaecological debates (Table 3.1).³⁵ Lloyd Roberts, for example, Honorary Surgeon to St. Mary's for 52 years and the Chairman of St. Mary's Medical Committee for a considerable part of that period, was Vice-President of the Obstetrical Society of London, former President of the Manchester Medical Society and three times President of the North of England Obstetrical Society.³⁶ His junior colleague, Archibald Donald, similarly went on to preside over all three societies before 'whom he read many papers' and in the case of the North of England Obstetric Society, 'rarely missed a meeting'. Their contemporary, an honorary medical officer first at the Southern, then on amalgamation, at St. Mary's, Arnold Lea, was for seven years President elect of the Northern Obstetrical Society, to which he had 'contributed several papers of high merit'.³⁷ Regularly in conference with the nation's obstetric élites with whom they could exchange new ideas, hospital medical staff, more than most in their profession, were in a commanding position not only to become fully conversant with current obstetrical practice

but also to devise a number of their own methods and techniques.

Building on the original work of Charles White and John Hall, Donald and Lea, at St. Mary's and the Southern respectively, became established authorities on puerperal sepsis in their own time. Donald, who on his appointment to St. Mary's experimented with various methods of sterilization, soon developed original views on the most effective antiseptic and aseptic procedures to employ and took his lectures on 'Antiseptics and Aseptics', 'beyond the classroom setting to much wider audiences and venues nationwide'. His command of the subject was duly recognised and rewarded by appointment in the 1920s to the Departmental Committee of the Ministry of Health on the Causes and Prevention of Puerperal Sepsis.³⁸ Had Lea not died prematurely in 1916, he too may have been invited to join the committee, following his publication of Puerperal Infection in 1910, which soon became the standard work of reference on the subject.³⁹

Similarly, in the field of caesarean section, a pioneering tradition existed at St. Mary's long before Sanger's classic caesarean operation in 1882. As early as 1798, John Hull wrote in defence of the caesarean section and outlined the circumstances under which it should be carried out and correctly observed that a number of fatalities arose as a result of its being performed too late in labour. Thomas Radcliffe, a male midwife contemporary of Hull and later a consulting physician to St. Mary's (1818-1881), gave the first

address to the British Medical Association on Caesarean Section in 1854 and 11 years later followed this with his publication, Observations on Caesarean Section which, re-published in 1880, launched a scathing attack on craniotomy as an elective operation, one conducted by choice, whilst calling for the greater use of caesarean section.⁴⁰ Once Sanger's suturing technique was perfected in 1882 and the mortality from the operation considerably reduced, Sinclair pursued this method with considerable enthusiasm and vigour. By 1901 he had successfully conducted ten caesarean sections, soon followed by an account of performing the operation for the fourth time on the same woman.⁴¹ This was then a leading record in multiple caesarean sections. It is upon such innovations that reputations were founded and fortunes made; honorary posts had brought untold rewards.⁴²

Though highly acclaimed in their own speciality, it was in the lecture theatre and the drafting of the student-midwife syllabuses that institutional practitioners best illustrated their extensive knowledge and command of midwifery. It has already been seen that until 1905 Manchester's hospitals were independent schools for midwives, and what they taught to midwives, the methods and assessments used, were at the total discretion of the respective medical committees. Similarly, once the local medical school, Owens' College, established formal links with both the city's maternity hospitals during the 1880s and offered a number of lectureships, as well as the chair in Obstetrics and

Gynaecology at Owens', the hospital staff were able to make an equally significant contribution to medical education. As soon as Sinclair, for example, was appointed to the Chair at Owens' (1888-1912), the midwifery syllabus underwent its first major review since the appearance of the prospectus and for the first time focused upon female anatomy, the conception and development of the ovum and the anatomy of the foetus. It also directed far more attention to the pathology of pregnancy and to such neglected topics as breast disorders, injuries to the uterus, vagina and perineum, mental disorders and the appearance of phlagmasia dolens. Sinclair was also the first professor to insist on students having a compulsory, three month residential stay in the maternity hospital.⁴³ Impressive though the influence of individuals like Sinclair was, it was the weekly lectures in obstetrics and midwifery, delivered at some time or other by most of the hospital staff, and the publication of popular midwifery textbooks, that most readily confirms the medical staff's competence.⁴⁴

Such activities ensured that their patients, both charity and private, were the recipients of the most modern obstetric practices, as administered by highly renowned, experienced and informed practitioners. With certain qualifications, which will be discussed later, this was of undoubted benefit to the woman encountering a complication at birth. In the presence of Donald or Lea, for example, women were assured of the most hygienic environment possible. Others, suffering perhaps from

contracted pelvis, common amongst malnourished Mancunian women, were able to receive the most up-to-date treatment, saving themselves and their child, by submitting to a caesarean section, conducted by one of the country's earliest and most successful modern caesareanists, Japp Sinclair at the Southern and William Walters at St. Mary's.⁴⁵ Similarly, Donald carried out some pioneering work in the summer of 1888 when he devised a surgical technique for a prolapsed uterus, again a common problem amongst Manchester women who returned too soon to housework and paid employment. Until Donald's work, the problem had been treated only palliatively by the insertion of a rubber pessary which most women found to be a great source of irritation, infection and the cause of an offensive discharge.⁴⁶ Whilst not a life-saving procedure, Donald's surgical technique greatly improved women's lives. Thus, hospital care was a great social leveller, because it ensured that the poorest received the latest treatments and the attention of the country's leading specialists, for which the affluent generally paid large fees.⁴⁷

At a more fundamental level, because the medical staff attended only complications and were part of a regulated, collective body, women were offered a certain amount of protection from the inconsistencies and flaws of general practice, for amongst this latter group 'all grades of competence are found...from the keen and careful...to the overworked doctor in an industrial community who was himself inadequately trained in

midwifery'. From the hospital's junior doctor upwards, all were instructed, supervised and regulated by senior colleagues, qualified not only by experience but by original research into such key areas of midwifery, as antiseptic-aseptic practice and the ill-effects of 'meddlesome and mischievous' obstetrics, to which Sinclair drew attention in the 1890s:

It is a pathetic and humiliating sight to see healthy young women dying in childbed, with her little wedding presents as yet untarnished around her, because the medical attendant had thought it right to risk the production of injuries in a first and normal labour under the mistaken impression that he can prevent bacterial infection by some weak solution...which he calls antiseptic.

The 'three things - interference, undue haste and sepsis', from which it was considered in the late 1920s to be 'in the vital interest of the normal patient to be saved', were on Sinclair's agenda 30 years earlier.⁴⁸

Hospitalised Childbirth: Advantages and Drawbacks

Before 1940, neither equipment nor expertise in the hospital was good enough to make for noticeably greater safety in childbirth...⁴⁹

The question of 'expertise', whether it be taken to mean the body of honorary medical staff who had overall responsibility for patient care and took personal charge of major complications, or the body of trained midwives who conducted the majority of the hospital's births, cannot, in view of the preceding evidence, be seriously doubted. It also seems equally dubious to argue, on the premise of 'equipment', that as there appeared to be no

clinical advantages to delivering a child in hospital as opposed to the home, there were no advantages to a hospitalised birth at all. 'Safety' at birth meant far more than drugs and equipment. For the weak and anaemic, the overworked and impoverished, it was regular nourishment, clean surroundings, the opportunity for rest and the assurance of constant attention, which made for a safer birth. The hospital encompassed all these features in an environment arguably less oppressive than a woman's own home.

Recalling evidence before St. Mary's Board of Management in April 1858, on death in a domiciliary confinement, the doctor commented at length upon what in hindsight was a poignant illustration of the 'oppressiveness' of home life and the threat it posed to a safe birth. He found the woman, severely haemorrhaging after delivery, in a weak, pale and dying condition, but attempts to revive her were thwarted by the woman's family who were resolved to observe the religious sanctity of Passover Week, during which time the confinement had occurred. The doctor's requests to check the bleeding by administering cold drinks and sustaining the woman's strength by placing her on a milk diet were staunchly refused by her family, including, to the doctor's surprise, his offer of reviving doses of sherry wine. Her condition was further aggravated by her retention in 'a close and oppressive room', filled with people and excessively heated, which was highly reminiscent of sixteenth and seventeenth century

childbirth rituals. The doctor ordered the fire to be extinguished, the room to be vacated and cold applications to be applied to the woman, after which the bleeding successfully stopped. These palliative measures, however, had little effect, for the woman died four days after the doctor had first been called. Although her death was attributed by the coroner to an organic disease of the liver, her subjection to almost medieval childbirth rituals, forcing women to act in culturally prescribed ways arguably no less rigorous in their application than those later imposed by hospitals, could only have served to exacerbate the problems.⁵⁰

The oppressiveness of home life on pregnancy and childbirth took many forms, and whilst views towards the actual confinement were changing as the need for spacious, cool and clean surroundings was realised, views towards women themselves remained steadfast. 'Considered the very prop and mainstay of the household', 'the mother of a home and upbringer and trainer of a family', women were custom-bound to perform these highly demanding roles without any due regard to the personal sacrifices they made, particularly where their health and physical well-being were concerned. Governed, for example, by the practical need and convention of feeding a husband and children first, before taking what remained, which may have been little more than 'bread, weak tea and scraps', often left pregnant women 'in a very low, weak condition' at a time when they could least afford to be.⁵¹

Waging a continual battle with household dirt, feeding their husbands and raising their children 'with wholly inadequate equipment and in depressing surroundings', was an equally debilitating task and one that did not suddenly slacken as labour became imminent and the lying-in period followed. Frequently the sole breadwinner or chief wage-earner, more from economic necessity than choice, a mother's plight was exacerbated by being frequently employed right up to the last moment of pregnancy, the strain of which often resulted in a difficult labour and inflicted permanent injuries on the unborn child.⁵²

The Southern's 'Case Number 24', already referred to, epitomised these very problems. The thirty year old mother of five, until a few days prior to her admission, had worked in a local mill and in all previous confinements had nursed her newborn for only two weeks, before returning to work. Attention was also drawn in the woman's case notes to the fact that she had been 'ill-treated' by her husband, which might have been a reference to physical abuse or to nutritional and material deprivation which was common amongst working-class women. Whatever the form such 'ill-treatment' took, the result was the same, the increased probability of a difficult labour. Confined within minutes of her admission under the supervision of Dr Japp Sinclair, the woman gave birth to twins, the first of whom, a girl of 6lb 4oz was delivered alive and well, whilst the second, the subject of an operative delivery, because of a

retained placenta, was dead on delivery. Soon after labour, a 'sub-involution of the uterus' was diagnosed and a three-week residential stay followed, during which time the mother 'improved in health' and her baby daughter, breast-fed throughout, was discharged 'in very good condition'.⁵³

Whilst it would be pure speculation to suggest that the outcome would have been different had the woman been delivered at home, a number of conclusions may be drawn. Firstly, the hospital served as a welcome haven for a woman whose home environment did not provide the rest and attention she obviously needed. Secondly, the constant observation and her long term residence, twice the normal stay, physically prevented the woman from performing household chores and responding to employment commitments, which could have aggravated her condition and caused a whole list of other ills, including burst veins and a prolapsed uterus.⁵⁴ Thirdly, from the viewpoint of her newborn, she did the best possible thing, that of breastfeeding her, which was not, as had been the case with her previous children, suddenly interrupted by a return to work.⁵⁵ Fourthly, the doctor had to remove, by hand, the woman's lacerated placenta, which incurred a tremendous risk of infection, and had the removal not been conducted in an aseptic environment and after the attendant's hands had been thoroughly scrubbed and disinfected, there was every possibility of the woman dying from infection. Whilst the physical surroundings *per se*, tend to be dismissed as having no

appreciable effect on the outcome of the birth, it was generally accepted that where operative interference was necessary, such as the removal of a retained placenta, the hospital was the safest possible place.⁵⁶ Finally, the woman, throughout her labour difficulties, was attended by a highly experienced and competent obstetrician free of charge and regularly at hand. Again, it is doubtful whether a general practitioner, depending on experience and competence, could have removed the placenta without further injury to the woman, prevented sepsis and made a correct diagnosis of her subsequent condition. This is presuming, of course, that a doctor would have been called, which, if the woman was paying for the confinement herself, would not necessarily have been the case.⁵⁷

Despite the material advantages that a hospitalised birth bestowed on the ignorant, impoverished and overworked, an institutional confinement was not always appreciated or welcomed by women themselves. One notable example was during the Lancashire Cotton Famine (1861-63) when the Local Relief Boards paid St. Mary's 1s 3d a day to accept maternity cases referred to them. As St. Mary's was not normally open for maternity admissions, this underlines the importance attached to a hospitalised birth, serving, amongst other things, as a haven at moments of financial hardship; but the offer was still refused by a number of local women. One such woman was a mother of four, Sarah Ann, whose sponsors, the Salford Relief Committee, secured her a bed at St. Mary's and

Sample Text 3.2

'I wish, mother, you was going to the hospital with me: it would save a lot of expense, and you'd be better cared for'.

'I,d like to be with you, dearie, but I can't leave my'ome, all these young children about and no one to give an order'.

(The mother was pregnant too, the daughter was encouraging her to give birth in the hospital (Q. Charlottes) at the same time.)

Excerpt from George Moors, Esther Waters
(London, 1894), p.110.

agreed to pay her ward fees. She was so reluctant, however, to leave her family and enter the hospital, that she refused the free offer and went through the whole tedious and very uncertain process of applying for relief again, in attempt to secure the services of a district midwife and home delivery.⁵⁸

As late as 1925, when Manchester's Maternity and Child-Welfare Sub-Committee subsidised six beds at Crumpsall's Auxiliary Hospital, paying half the cost of a woman's maternity fees, public demand fell far below expectations and only 15 applications for the Auxiliary Hospital were received that year. In this instance, the additional stigma of pauperism was apparent because it was a Poor Law Institution, but nonetheless, there was a general fear of entering an institution whatever its affiliation.⁵⁹ Locked in a self-sacrificial mode of duty to her husband and children and eager to avoid the domestic disorganisation that followed even a brief absence, most women succumbed 'to illness only when they literally can no longer keep on their feet' (Sample Text 3.2). To have entered hospital would, in the minds of a number of women, only have exacerbated their problems, for as Councillor Mary Rothwell later remarked, 'some women with families took their problems with them [to hospital], and wondered what their children were doing'. 'Moreover', she added, 'father shelved some of the responsibility when mother went to hospital', hence the several women who requested an early discharge from the

Southern (1899-1901) to return, in one instance, to a family of eight children.⁶⁰

Moreover, the hospital itself was hardly an enticing place to be, and though to some a stay in hospital was both physically and psychologically rejuvenating, to others it caused further anxiety at an already stressful period in their lives. There was, as the Manchester correspondent for the Lancet observed, a strong reluctance amongst a section of the working-class towards hospitalisation in general.⁶¹ In the same way, a number of women quickly dismissed the idea of being confined in hospital, for a variety of reasons, not the least of which was,

fear of loneliness, reluctance to be amongst strangers at such time and dread of hospital surrounds; above all from anxiety for the welfare of their young.⁶²

This aversion to a hospitalised birth was more than just a reaction to alien surroundings and the loss of family contact, it was also a defiant act against the stringent, almost regimental approach to childbirth that was adopted by the maternity hospitals and perhaps to the overbearing and condescending manner of doctors to which Wohl refers.⁶³ This would explain, for example, the popularity, in some quarters of Manchester, of unregulated and untrained 'handy women', who were 'easy going both as regards payment and cleanliness', but at the cost of 'the more competent and highly trained woman who insists on the provision of clean garments and

requires the recognised fee for her attendance'. The result was, in one district of Manchester, the loss of a 'well-trained midwife' because she was 'literally starved out after residing there two years'.⁶⁴ Whilst the presence of a 'well-trained midwife' may well be regarded as an important determinant of local maternity mortality profiles, there was no guarantee that they would have been either popular or, more to the point, employed by working-class mothers. If on the other hand, these mothers were recipients of institutional relief, as were many women in the central districts, they had little option but to be confined by a trained and regulated midwife.

As for being hospitalised, before the National Insurance Act of 1911, very few of the hospital's maternity cases were actually admitted into hospital. Immediately prior to amalgamation (1901-05) only 10 and 12 per cent of St. Mary's and the Southern's maternity cases, respectively, were delivered in hospital and even after amalgamation, the proportion of women that was hospitalised remained as low as 12 per cent of the case total (1906-10). By their very admission to hospital these women were highly selected cases, some of whom by simply being taken away from their own home benefited from the advantages outlined. Others, 'the exceptional and difficult' labours, required more than a regular diet, rest and comfortable surroundings if they were to survive childbirth. It is to the latter category, abnormal births, that the chapter now addresses itself.

Hospital Treatment: Scope and Limitations

Ideally, if the relevant source material were available, it would be possible, firstly to identify from the admissions, the true number and range of abnormal cases and secondly, to assess the quality of their treatment and survival prospects. If a similar approach were then taken for the hospital's district service, noting the nature and outcome of each home confinement, comparisons could be drawn and the most important features of a hospitalised delivery more readily illustrated. Whilst no relevant data exist to pursue this latter objective or indeed the former in the case of St. Mary's, the Southern's sole surviving maternity register, based on the case histories of 197 ward confinements, does provide more detailed evidence. It has already been possible, for example, using the register, to present socio-economic as well as medical profiles of the types of cases admitted into a maternity ward, and from the individual entries it will also be possible to glean information about a woman's treatment in hospital, including many aspects of her care that would, on the basis of published material alone, have been omitted.

One essential aspect was the point at which pregnant women were admitted and the importance, for a number of women, of residing in the hospital prior to labour. A indicates that the Southern admitted women throughout the

FIGURE: 3.4: DISTRIBUTION OF ADMISSIONS OVER DAYS OF THE WEEK AND MONTHS OF THE YEAR: MANCHESTER (SOUTHERN) MATERNITY HOSPITAL 1899-1901

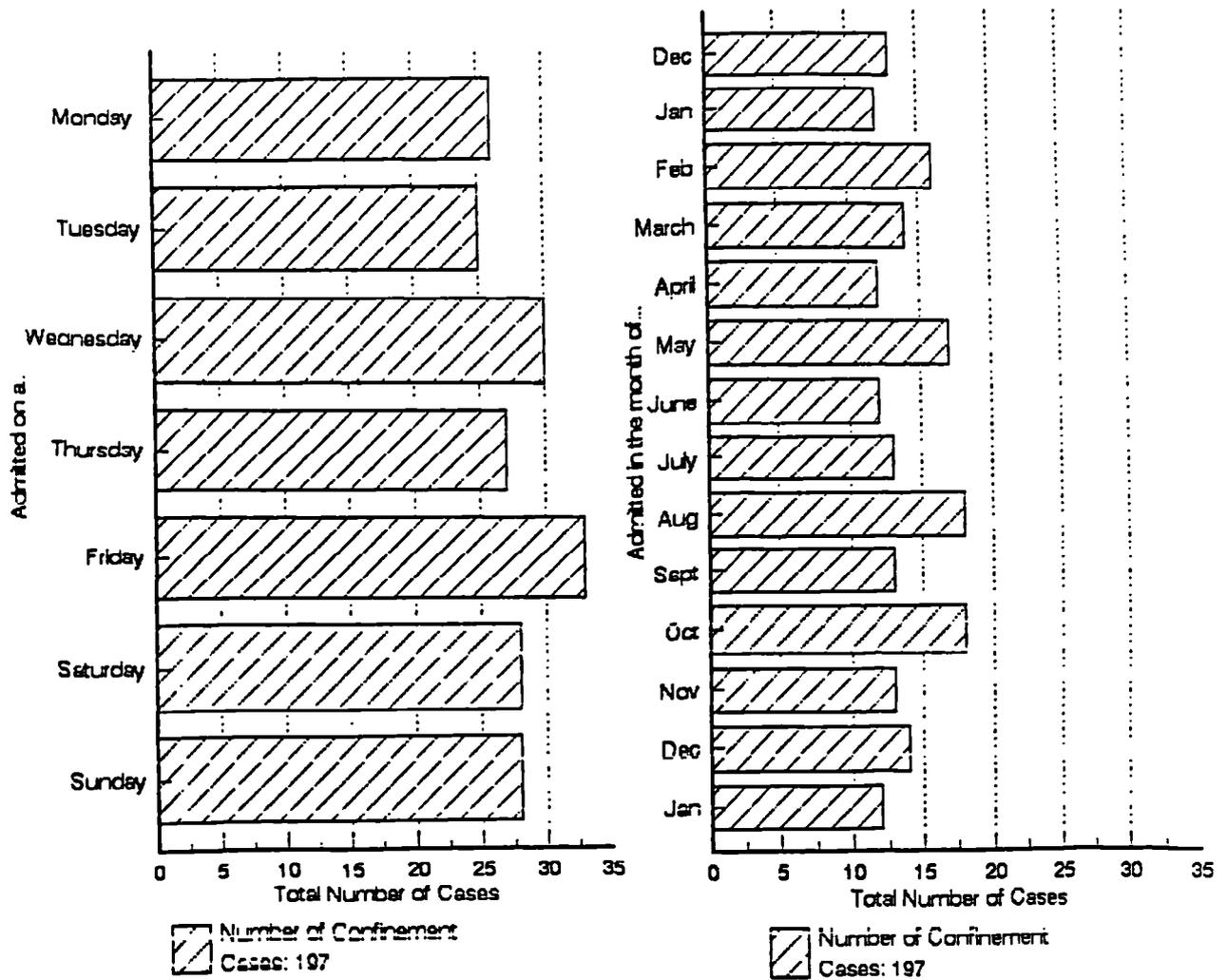


TABLE 3.2: LENGTH OF STAY PRIOR TO CONFINEMENT MANCHESTER (SOUTHERN) MATERNITY HOSPITAL 1899-1901

Women Admitted & Delivered...	Ward Deliveries:		Totals
	Normal	Assisted/Complicated	
The Same Day	102 (23)	40 (7)	142 (30)
A Day Later	25 (7)	18 (6)	43 (13)
Two or More Days Later	3 (1)	9 (3)	12 (4)
Totals	130 (31)	67 (16)	197 (47)

() Refers Primiparae Cases

Source: The Southern Case Admissions Register No. 13

review of the register's admission and delivery dates year, with no apparent concentration of cases on any one day or month, oblivious to teaching demands and Holy Days (Figure 3.4). This reflects the widespread practice, in 72 per cent of cases, to admit and confine a woman on the same day, sometimes within minutes of entering the hospital (Table 3.2). In one instance, for example, the feet were already presenting and in another, the child was born en route, in a cab from Openshaw.⁶⁶ For these women, the skill and judgement of the doctor on the day was all-important.

For the remaining 28 per cent of cases admitted a day or more before delivery, there appear to have been genuine grounds for their early admission and real scope for the hospital staff to do something positive, even life saving, for the women in their charge. Described as 'pale and sickly', 'unwell in pregnancy' and 'rather delicate', many of these early admissions had poor obstetric histories, had experienced complications during pregnancy or were facing their first confinement; 36 and 40 per cent of primiparae and complicated cases respectively, were admitted a day or more before delivery (Table 3.2). For all these women, predisposed to exhaustion and prolonged labour, the opportunity, though brief, to adjust to their new surrounds, rest and prepare themselves psychologically, for their ordeal, was an important one. This was particularly the case for 'the very neurotic' 'Mrs W', who was admitted 16 days prior to her confinement 'because at a previous labour the

perineum was completely torn. She had it repaired, but her labours were so rapid that she feared a similar incident'. In the event, the tear was not repeated and the woman gave birth to a 9lb living male, quite naturally and unhindered, but her case demonstrates the psychological importance many women attached to delivering their child in hospital.⁶⁷

From a clinical perspective, an early admission also gave the doctor time to observe, reflect and prepare, which helped him to anticipate, if not eliminate, a foreseen complication. Thus, 32 year old mother of two, 'Mrs H', who had been pregnant nine times in twelve years, enduring three miscarriages, two still-births and three premature deliveries, was admitted on 26 February 1900. Two bougies were inserted over a two day period, 3-4 March, to dilate the cervix and induce delivery, which took place quite naturally and without any unusual difficulty on 7 March. Though one month premature, weighing 5lbs 12oz, a baby girl was born alive and well and was, 12 days later, discharged with her mother, both of whom were said to be 'in good condition'.⁶⁸ Similarly, 'Mrs R', a 39 year old expecting her first child, displayed all the signs of pre-eclampsia, including swollen hands, legs and feet, and albumen in her urine. Dr Scott, one of the Southern's district physicians, referred her to the maternity hospital where she remained 30 days prior to delivery. The early admission, subsequent rest, milk diet and ultimately an induced labour to terminate pregnancy and avoid the development

of full eclampsia, a major killer of women in child bed, was the safest course that could have been taken from the mother's perspective. Her newborn, on the other hand, weighing 4lb 12oz, died within 23 hours of birth.⁶⁹

There is also every reason to believe that early admission procedures and treatment were an equally important element of St. Mary's maternity practices, long before it became a national phenomenon and formally conceptualized as ante-natal care. Two of St. Mary's Honorary Medical Officers, Archibald Donald and Fletcher Shaw, independently pointed out to the readership of the British Medical Journal in July and October 1916, respectively, that it was quite wrong to believe that ante-natal care was of twentieth century origin, the idea of J. W. Ballantyne in Edinburgh in 1901. Ballantyne's notions of ante-natal care were, they claimed, 'the sort of thing that has been going on everyday for years in the out-patient department of St. Mary's Hospital'. Donald recalled, that even at the time of his appointment to St. Mary's in the mid-1880s, as soon as a woman applied for a ticket and was accepted, notes were taken of her obstetric history and state of health, and if deemed necessary, an examination was carried out and ante-natal care prescribed. Regarded by the 1920s as an essential pre-requisite of childbirth and the most effective means of preventing a maternal death, ante-natal care was one important safety feature that was practically unique to Victorian Manchester and its two maternity hospitals.⁷⁰

Such ante-natal care that there was, however, was far from systematic and for every woman admitted for early treatment, there was one whose difficulties in labour, despite a problematic pregnancy or a poor obstetric history, were not recognised before full term and who was the subject of emergency treatment. A case in point was 'Mrs B' who had been confined six times before delivering five still births and a child who survived only ten months. It was the conclusion of Honorary Medical Officer, Arnold Lea, that she should never have been delivered full term, but as it was, she entered hospital at the end of her term, weak, anaemic and with a contracted pelvis, and the only way to deliver the 8lb 8oz foetus and preserve the mother's life, was to perforate the foetal skull (a craniotomy) and remove the body by hand (version). Similarly, Mrs T, who had had 15 children, seven of whom were still-born, including a set of twins, one of which weighed 15lb 15oz, was a prime candidate for early admission. Admitted, however, at full term, suffering from chronic bronchitis, poor health and insomnia, and described as 'very fat', the woman attempted to deliver an 11lb 4oz foetus which caused her a tremendous amount of pain, distress and exhaustion. The only way to relieve her and ensure no permanent damage was to remove the child by forceps. Resident for 11 days after delivery 'Mrs T' made an 'uninterrupted recovery' and left at her own request, no doubt anxious to return to her eight surviving children.⁷¹

Albeit in some instances avoidable, the last-minute medical attendance of women in a severe, if not moribund condition, was, as Jalland points out in her case study of upper class women, not unusual, and certainly not in the experience of hospital staff in Manchester whose maternity wards existed for these very women, hence the unusually high rate of intervention. It would be wrong to assume, however, that obstetric intervention was a 'prominent feature' for its own sake, and conducted on lines similar to those in American maternity hospitals where 'The medical posture became one of manipulation, intervention and active combat'.⁷² As Sinclair outlined in a paper in 1897, 'denouncing in no uncertain terms the interference with nature's processes by the practitioner in a hurry', the forceps rate at the Southern was relatively high (12 per cent of the ward total, 1889-1903) because the maternity wards were retained primarily for cases of 'difficult and dangerous labour' and victims of the 'meddlesome and mischievous' medical practices against which he was campaigning. The forceps rate of 1.4 per cent amongst 2,049 of the Southern's home deliveries was, Sinclair argued, more reflective of what community rates ought to be and not the 25 to 30 per cent rate that he alleged it was.⁷³

In the light of such high community rates, the prudent and restrained approach, which characterized a hospitalised confinement in Victorian Manchester, was an indispensable safety feature in itself. This cautious approach is most clearly supported by reference to the

TABLE 3.3: OBSTETRIC INTERVENTION AND THE DURATION OF LABOUR: MANCHESTER (SOUTHERN) MATERNITY HOSPITAL 1899-1901

	Normal Deliveries			Complicated Deliveries		Totals
	Multiparae	Primiparae	Forceps Cases	No-Interference	Other Operative Cases	
< 4hrs	7	2				9
4-7hrs	15	5	1	2	4	27
8-11hrs	10	6		1		17
12-15hrs	10	2			1	13
16-19hrs	6	1	1			8
20-23hrs	2	1				3
> 23hrs	4	3	4	1		12
Totals	54	20	6	4	5	89

Source: Southern Maternity Hospital Case Admissions Register No. 13

duration of a woman's labour, which was, in 89 of the Southern's 197 register cases recorded for each of the three stages of her confinement (Table 3.3). Excluding the three women whose contractions lasted from two to seven days, the average duration of labour, from the moment the contractions began and the membranes were ruptured (stage 1), through to the delivery of the foetus (stage 2) and the expulsion of the placenta (stage 3), was 13 hours. Given today's average of '12 hours or so' this was neither long nor excessive, but where a woman was in labour longer than this, there would be cause for concern and justification for a hospitalised birth.⁷⁴ Moreover, these times must be regarded as the minimal readings, for women, even today, are not always sure when they entered into labour, so that the accuracy with which a labour was timed was highly suspect and more than probably underestimated.

Given, therefore, that these times were the minimal readings, it is a surprise to find that amongst the 77 labours which were under 24 hours duration, the forceps were only applied twice, once on a woman who had been very ill during pregnancy and with a history of forceps deliveries and once on 'Mrs T' whose difficult case history has already been cited (Table 3.3). This implies that a woman was given every opportunity to deliver naturally without undue haste or interference on the part of the attendant. In other instances of intervention, where the labour was terminated within 24 hours, generally by inducing the birth, there were further

complications to be considered, including breech deliveries, eclampsia, prematurity and in one instance, an umbilical cord wrapped twice around the neck of the foetus which had to be cut before the child could be born. Even after 24 hours, which today is considered the danger zone and point of intervention, there were far more women who were allowed to continue their labours naturally, including primiparae and in one instance, a breech birth, than there were subject to forceps, which were used only when the woman was deemed too exhausted to continue and no longer able to make use of her labour pains (Table 3.3). Until this latter stage, when labour exceeded 24 hours, there appears to have been no discrimination between primiparae and multiparae cases. The former, though subject to a much longer labour were given an equal opportunity to effect a natural delivery (Table 3.3). This is significant, for in the United States and increasingly in inter-war Britain, primiparae cases were regarded as an abnormal category and often subject to intervention, whether it was required or not.⁷⁵

Intervention was clearly a measure of last resort. Not to have intervened with forceps in instances where a woman was too weak and too exhausted to continue labour, could, as she became increasingly tired, dehydrated and feverish, have caused her a great deal of distress and deprived the foetus of oxygen (Table 2.10). Similarly, when there was a mal-presentation, accounting for one in 14 of the Southern's admissions (1899-1901), intervention

was avoided where possible (Table 2.9).⁷⁶ In most breech deliveries, as the medical attendant was at pains to point out in the case notes, natural labour was generally the norm (Table 2.9). When intervention was necessary, as for example in cases where the labour was protracted and the foetus making little progress, a hand may have been inserted and a foot brought down (podalic version) after which the 'rest of labour - was left to nature'.⁷⁷ Assistance when called upon, was minimal but deliberate.

This cautionary stance against intervention, even to the point of delivering an asphyxial child, which runs contrary to claims that a hospitalised birth was a 'medicalized', 'dehumanized' and 'controlled' process, can be explained on two counts.⁷⁸ Firstly, Japp Sinclair, Senior Medical Officer at the Southern, was very alert to the dangers of meddlesome midwifery and highly critical that midwifery had become 'largely surgical - too surgical', which ensured all admissions to the Southern enjoyed natural births where possible. Secondly, as centres for gynaecology as well as childbirth the hospital staff, at both St. Mary's and the Southern, would have had to deal with the after-effects of a general practitioner's mal-practice and abuse of forceps,

at the Manchester Southern Hospital it is by no means a rare thing to find a young woman suffering from dislocation of the uterus and the lacerations of the cervix and of the perineum whose first labour was terminated by forceps within four to six hours of the onset of labour.⁷⁹

Admitting such cases, which in part accounted for the continued use of craniotomy, could not but impress on medical staff at both St. Mary's and the Southern the dangers caused by unnecessary intervention, a hasty delivery and the abuse of forceps.

Once intervention was agreed, the form it took was influenced more by the survival prospects of the mother than her unborn. Unlike continental Catholics, who in deference to Rome's doctrines on the sanctity of human life were passionately opposed to foetal destruction, the English, free from such religious constraints and more concerned about the legal implications of chancing the mother's life to save her unborn, had a much lower regard for the survival of the foetus.⁸⁰ 'In this country', as Galabin explained when justifying the use of craniotomy (the crushing of the foetal head to aid delivery), 'the interest of the mother has always been considered paramount' and because of the lack of safe alternatives, 'we were driven', added one fellow of the British Gynaecology Society, 'to fall back upon the long recognised claim of the mother to be considered first'.⁸¹ This would account for the persistence of craniotomy in the Southern's operative case figures (1889-1903) and its elective use by Donald at St. Mary's in instances where: forceps and version had been applied without effect, where there was every possibility of the child already being dead and where rapid delivery was necessary to save the mother's life, as in a case of eclampsia or severe haemorrhaging (Table 2.10).⁸²

In light of such continental practices as forcibly dilating the cervix and removing the child by forceps (accouchement forcé) and enlarging a contracted pelvis by separating the pubic bones (symphiotomy) to ensure a living child for baptism, the English view of the mother first was often to her advantage.⁸³ Whilst, for example, a symphiotomy was widely practised on the Continent and in America, after enjoying a period of revival in the 1890s, it was only used five times at St. Mary's (1894-97) and never once at the Southern; Japp Sinclair, the Southern's leading obstetrician, was renowned for having 'had no great opinion of symphiotomy'.⁸⁴ It was not just a simple case of inertia that the operation was not widely practised at the two institutions, as Patricia Branca would be quick to argue, but because symphiotomy, whilst short, lasting only three minutes and thereby reducing the risk of shock, haemorrhaging and infection, led to permanent disablement. Following the operation, the patient had to be bandaged, remain in bed for six weeks and face the possibility, as a result of a severe tear of the perineum, of a prolapsed vagina or extreme bladder injury, of being in a wheelchair for life or suffering chronic incontinence.⁸⁵ The cost to maternal welfare was considered by Honorary Medical Officers of the respective institutions to be too high and there appears to be some merit in the powers of discrimination displayed here, sheltering women from obstetrical 'advances' which did little to improve their condition.

Concern for the mother also partially explains the hospital's cautious response to the use of caesarean section which, for the majority of women with a contracted pelvis, assured the birth of a living and viable child. Yet despite its advantages for the unborn, the operation still failed to displace the more traditional methods of delivery in cases of contracted pelvis, namely version and induction, whose foetal and neonatal mortality rates were 'considerable' (Table 2.10). Though Sanger's caesarean technique (1882), compared with former methods, substantially improved the mother's chances of survival, preserved her genitalia and was immediately popular on the continent, the operation was not attempted at the Southern or St. Mary's until 1890 and even then, the number of operations only rose by multiples of four and nine respectively (1890-1900). Branca cites this comparatively slow response towards the application of new caesarean methods, which was no different from the situation at the Glasgow Royal Maternity Hospital (18 caesareans in 12 years, 1888-1900), the country's leading centre in caesarean section, as a reflection of the medical profession's conservatism, female prejudices and inability 'to recognise the real needs of women'. On the contrary, given the operation's high maternal death rate compared with say, induction, the maternal mortality and morbidity rates of which were 'practically nil' and the real danger of rupturing the uterus at a subsequent delivery, it could be argued that it was precisely with the woman's needs in mind, that the

profession's use of caesarean section was slow and cautious.⁸⁶

Yet no matter how cautious and how discriminating the hospital was towards new techniques and procedures, it was, by its very nature, a research centre with all the connotations of trials, tests and experimentation, that this suggests. The Honorary Doctor's reputation as a 'bold and skilful operator', 'a pioneer', with 'a profound influence on British Obstetrics', may well have enhanced the hospital's standing in the community, but it all sounded somewhat ominous from a woman's perspective, for inevitably it was on her body that this bold and pioneering work was performed.⁸⁷ Thus, for every successful series of experiments, such as Sinclair's caesarean section trials and Donald's operative cure for prolapsed uterus, there was an equal number of disabling if not fatal mistakes. Sinclair, for example, claimed to be the first to use normal saline solution for flushing out the peritoneal cavity after abdominal section in 1884, but his method was never published and was later found to have 'undesirable results'.⁸⁸ Similarly, Donald's symphiotomy trials at St. Mary's, though involving only a handful of women and restricted to a three year period, left the women permanently disabled and with little hope of leading full lives again.

Beholden to the hospital for gratuitous aid and 'liable to instant dismissal' if they failed to abide by the requirements of the medical and nursing staff, the women who were hospitalised were hardly in a position to

object to such bold experimentation or to routine examinations of their bodies, access to which 'would not normally be permitted to any other person, even perhaps to a sexual partner'.⁸⁹ 'Mrs M' who remained in hospital for over three months illustrates these points.

Suffering from a contracted pelvis which had resulted in the death of her first child, the woman was admitted to the Southern two months prior to delivery to prepare for a caesarean section, the hospital being the only place where such an operation could be conducted because of technical and hygiene considerations. This was still a pioneering operation in Britain and one that would have secured a mention in the national medical journals, so attention would be very much focused on 'Mrs M' as a test case. This is readily illustrated by the 27 year old's two month residence prior to the operation, for other than an 'undersized but not deformed pelvis', the woman was 'in good health' and 'very well during pregnancy'. There was no real justification for her to be retained in bed for so long other than perhaps for the convenience of her medical keepers, as demonstration material for visiting doctors and students; two other successful caesareans that year were performed on women within zero and 13 days of their respective admissions. That said, 'Mrs M' may well have considered her temporary loss of liberty was a small price to pay to secure the birth of her first living child, an 8½ lb boy, and to leave the hospital herself, alive and well.⁹⁰

Hospital Mortality Profiles: In and Out-Patients

Although the merits or otherwise of an individual case are important, the only real means of assessing a hospital's success rate is to analyse its mortality returns which served, as 'a kind of profit and loss account showing the progress and the result of the work from year to year'. Yet even this approach is not without its critics, including F. B. Smith, who regards the hospitals' handling of the statistics, which at best were described as 'slippery', to be sly and underhanded. In doing so, he echoes the opinions of such contemporaries as Robert Rentoul, who claimed, amongst other things, that the maternity hospital's mortality returns were 'cooked'. This was achieved, Rentoul alleged, by rejecting 'risky patients' (single women, primiparous cases, mothers who had endured a still-birth or difficult labour) and once admitted, by transferring potentially fatal cases, particularly those suffering from puerperal sepsis, to fever hospitals. Maternity hospital deaths, it was also maintained, were only recorded if they occurred within the first five to ten days of confinement, when under the hospital's direct care, and not for the whole of the thirty day lying-in period, as stipulated by the Registrar General.⁹¹

Rentoul, renowned for his 'contradictory and sometimes defamatory statements' and a fervent opponent of the proposal to train and register midwives, gave a totally wrong impression of these institutions and his

views cannot, despite Smith's endorsement of them, be taken seriously. It was, for example, with the notable exception of single women who were rejected for moral rather than clinical reasons, Rentoul's categories of 'risky patients' who constituted the very group of women admitted to the Southern and St. Mary's. By offering women, throughout the period, 'medicine and medical assistance for one month before and one month after confinement' and assuring subscribers that the causes of maternal deaths were 'strictly analysed' up to the month after delivery, the hospital authorities also appear to have respected the 30 day rule.⁹² By even emphasising this particular point to subscribers, the Board of Management appears to have felt genuinely accountable to their sponsors, for no doubt the fear of public exposure for deliberately manipulating the statistics, was as powerful a deterrent as any from actually doing so. This would then explain the lack of evidence of women being purposefully transferred to another institution to avoid inflating the mortality returns. Where a woman did leave hospital immediately prior to dying (1899-1901), was in the case of 'Mrs Y' who specifically requested that she be allowed to return home on the sixth day of her lying-in period to die in her own bed. The request was respected and the true reasons for her discharge duly recorded.⁹³

The statistical difficulties that arise with this data tend to prejudice rather than favour the maternity hospital as Smith would argue. At first sight, for

example, the Southern's maternal death toll of 37 (1889-1903), accounting for one woman in every 63 delivered in the hospital, would appear high, compared with a national average of one woman in every 200 deliveries, after 'excluding such cases as smallpox, phthisis and other fatal diseases not connected with childbirth'. However, all deaths, whatever the cause, were included in the Southern's figures, even where childbirth may not have been the direct cause of death and where, for many women, death was inevitable. In 18 of the 37 cases, the women were 'almost moribund on admission', even comatosed, owing to a difficult pregnancy, or more commonly, multiple attempts at delivery at home, giving the hospital little scope to effect a successful delivery. Take, for example, the four deaths from eclampsia: all four women enduring the obstetric complication, which even today is not fully understood, were comatosed on admission and never regained consciousness. With no cases of puerperal fever, except perhaps for an indirect reference to an 'extensive laceration', which may or may not have been caused by obstetric intervention and may or may not have been a source of puerperal fever, there is also no suggestion from the Southern's mortality returns that the hospital promoted any unnecessary deaths.⁹⁴

Within the woman's own home, under the command of a hospital midwife, the mortality figures were particularly favourable. In 1876, when Farr addressed the maternal mortality issue at some length, he pointed to 'two remarkable institutions' as proof of the preventable

nature of maternal deaths. They were the Birmingham Lying-In Charity (formerly, the Lying-In Hospital) and the Royal Maternity Charity, London, whose maternity patient profiles, characterized by the admission of the 'lamentable and destitute', were similar in character to those of the Southern and St. Mary's Hospital's. The maternal mortality rate for Birmingham (1867-77) and Royal Maternity Charity (1875-77) was one death in every 430 women confined in their own home, compared with a rate of one in 375 home deliveries at the Southern (1867-70) and one in 1,333 at St. Mary's (1869-77). Although St. Mary's figures, the earliest on record for this period, are perhaps questionable, appearing too remarkable to be credible in their entirety, the possible inaccuracies ought not to detract from the overall picture. Between 1881 and 1885, when it is possible to relate the maternal deaths at St. Mary's to live births, there were 1.3 maternal deaths per 1,000 live births amongst the hospital's district case total, of which more than 95 per cent were solely midwife conducted labours.⁹⁵ This rate, before the advent of the maternity wards, which may have admitted from the district all the potentially fatal cases, compared most favourably with the county and national maternal mortality figures of 5.59 (1882-85) and 4.94 (1881-85) deaths per 1,000 live births respectively.⁹⁶ Highlighting the clinical and demographic importance of the Victorian maternity hospital to the local community, it was exactly this type of institutional-district success that was used to

justify the necessity of a regulated and trained body of midwives, as embodied in the Midwives Act of 1902.✓

Notes to Chapter 3

1. J. M. Campbell, 'Maternal Mortality', *Reports on Public Health and Medical Subjects*, 25 (London, 1924), p.95.
2. Irvine Loudon, 'Maternal Mortality: 1880-1950. Some Regional and International Comparisons', *Social History of Medicine*, 1 (1988), 183-228 (p.222).
3. Mary Chamberlain, *Old Wives' Tales* (London, 1981), pp.113-14. Loudon, p.222.
4. John Ryland's University Library, Manchester (hereafter JRUL). Manchester Medical Collection, Register of Pupil Attendance, St. Mary's, 1853-1892/3.
5. J. M. Campbell, 'The Training of Midwives', *Reports on Public Health and Medical Subjects* 21 (1923), p.8. T. Radford, *Remarks on the Former and Present Aspects of St. Mary's Hospital* (Manchester, 1864), p.43. JRUL, Manchester Medical Collection, Jb6, Rules of St. Mary's Hospitals, 1905.
6. T. Radford, p.43.
7. St. Mary's Hospital Archive (hereafter, MHA), Board Minutes, 11 April 1885. JRUL, Manchester Medical Collection, Register of Pupil Attendance, 1853-1892/3.
8. MHA, Board Minutes, 30 March 1885, Annual Report 1885. Manchester, Central Library (hereafter, CL), 362.1M55, Southern Hospital Annual Report, 1893. *Transactions of the Obstetrical Society*, 14 (1872), p.22.
9. Report on the Health of the City of Manchester, 1905, p.227.
10. There were very specific rules about when assistance had to be called for. The Resident Obstetric Surgeon at St. Mary's, had to be called in all cases of retained placenta, mal-presentations, flooding, convulsions, pelvic tumour, protracted labour 'and in any other case in which any unusual condition or circumstance threatens or indicates danger'. MHA, Bye-Laws of St. Mary's Hospital, 1896.
11. One maternity case claimed that the midwife arrived three hours after labour because she held a recommendation ticket rather than paid cash, in the region of 7s 6d and 10s. The midwife was

- reprimanded and reminded that all hospital midwifery cases were entitled to the best attention and skill available. MHA, Board Minutes, 9, 16 August 1886; 2 September 1889.
12. A hospital midwife would have placed an engraved plate outside her home advertising her connection with the local maternity hospital.
 13. JRUL, Manchester Medical Collection, FA.F4t. Student's Midwifery Card, 28 February-14 March 1883.
 14. Only 23 of the 174 registered midwives in Manchester in 1905 conducted an average of more than 100 deliveries a year, and only seven conducted 200 or more. Report on The Health of the City of Manchester, 1905, pp.259, 261. J. M. Campbell, *Report of the Physical Welfare of Mothers and Children, England and Wales*, 2 vols (Liverpool, 1917), II, p.33.
 15. Pay for a governess was 'notoriously low', between £15 and £100 a year, but generally averaging £20 to £45 a year. Jean Peterson 'The Victorian Governess: States Incongruance in Family and Society', in *Suffer and Be Still: Women in the Victorian Age*, (Indiana, 1972) pp.7,8. Jean Donnison, *Midwives and Medical Men* (London, 1977), p.59. MHA, Annual Report 1900.
 16. MHA, Board Minutes, 11 January, 5 February, 29 March 1858.
 17. MHA, Board Minutes, 9 July, 20 October 1888; 11 November, 16 December 1889.
 18. T. R. Marr, *Housing Conditions in Manchester and Salford* (London, 1904), p.27. J. Rowntree and A. Sherwell, *The Temperance Problem and Social Reform* (London, 1900), pp.85, 678.
 19. Donnison, p.34. Jacques Gélis, *History of Childbirth: Fertility, Pregnancy and Birth in Early Modern Europe*, trans. by Rosemary Morris (Cambridge, 1991), p.100. Adrian Wilson, 'The Ceremony of Childbirth and its Interpretation', in *Women as Mothers in Pre-Industrial England*, ed. by Valerie Fildes (London, 1990), pp. 68-102. A. McLaren, *Reproductive Rituals* (London, 1984), Young, p.2.
 20. MHA, Board Minutes, 21 March, 7 April 1864.
 21. Report on the Health of the City of Manchester, 1905, p.247.

22. Report on the Health of the City of Manchester, 1908, p.254; 1909, p.240; 1916, p.49.
23. J. M. Munro Kerr, *Maternal Mortality and Morbidity: A Study of Their Problems* (Edinburgh, 1933), p.109. Henry Jellett, *The Causes and Prevention of Maternal Mortality* (London, 1929), p.9.
24. Loudon, p.222.
25. In a survey of 3,948 district cases conducted by the newly amalgamated St. Mary's and Southern Hospitals in October 1907, only 202 women, or 5.1 per cent of the case total, were attended, at the midwives' request by the doctor. MHA, Bye-Laws of St. Mary's Hospital, 1896. Annual Reports, 1880-1900. Correspondence from St. Mary's Board of Management to the Medical Officer of Health, Manchester, October 1907. Japp Sinclair, 'The Injuries of Parturition: The Old and the New', *British Medical Journal*, 4 September 1897, p.589.
26. See for example, Richard and Dorothy Wertz, *A History of Childbirth in America* (New York, 1979), p.147.
27. MHA, Bye-Laws of St. Mary's, 1896.
28. The principal reason for the dissolution of the district physician scheme in February 1907, was the hostility from local doctors who felt the scheme presented unfair competition, excluding them from an opportunity to receive payments for attending a complication, which, if instigated by a midwife, could be claimed from the Council who guaranteed remuneration in such cases. MHA, Medical Committee Minutes, 22 January, 19 February 1907.
29. MHA, Bye-Laws of St. Mary's, 1896.
30. For an assessment of the significance of hospital appointments see: Noel and Jose Parry, *The Rise of the Medical Profession* (London, 1976), pp.137-139; Brian Abel-Smith, *The Hospitals 1800-1948* (London, 1964), pp.19-20; Lindsay Granshaw, 'Fame and Fortune By Means of Bricks and Mortar: The Medical Profession and Specialist Hospitals in Britain 1800-1948' in *The Hospital in History*, ed. by Lindsay Granshaw and Roy Porter (London, 1989), pp.199-200 (pp.201-02).
31. JRUL, Manchester Medical Collection, Author Files (Sinclair). John Bride, *A Short History of the St. Mary's Hospitals Manchester* (Manchester, 1922), pp.106-9.
32. See for example, Abel-Smith, p.20.

33. Bride, pp.102-03; idem, 'Some Manchester Pioneers in Obstetrics and Gynaecology', *Journal of Obstetrics and Gynaecology*, 54 (1954), 69-79, pp.76-77. W. E. Fothergill, *Manual of Midwifery*, 1st-5th edn. (Edinburgh, 1896, 1900, 1903, 1906, 1922).
34. JRUL, Manchester Medical Collection, Author Files (Sinclair). Holland, Eardley, 'Obstetrical Societies and Clubs', in *Historical Review of British Obstetrics and Gynaecology 1800-1950*, ed. by J. Munro Kerr, R. W. Johnstone and M. H. Phillips (London, 1954), pp.305-22 (p.317). Bride, 'Some Manchester Pioneers', p.78.
35. Holland, pp.307, 309.
36. JRUL, Manchester Medical Collection, Author Files (Roberts), Bride, 'Some Manchester Pioneers', p.73.
37. Archibald Donald, Obituary, *British Medical Journal*, 24 April, 1937, pp.892-93. Arnold Lea, Obituary, *British Medical Journal*, 20 May, 1916, p.742.
38. Bride, 'Some Manchester Pioneers', p.70, 76. Willis Elwood and Félicité Tuxford, *Some Manchester Doctors* (Manchester, 1984), p.117.
39. Arnold Lea, *Puerperal Infections* (London, 1910).
40. J. H. Young, *St. Mary's Hospitals, Manchester 1790-1963* (London, 1964) p.113. Bride, 'Some Manchester Pioneers', p.71.
41. Max Sanger's suturing technique (1882) refers to the classic caesarean operation by suturing the uterus as well as the abdominal wall, thereby greatly reducing the risks of infection. Japp Sinclair, 'A Series of 10 Successful Cases of Caesarean Section', *Lancet*, 19 January 1901, p.158, *Journal of Obstetrics and Gynaecology*, 12 (1907), 65-66.
42. In the obituaries of both Lea and Donald, it was a point of remark that each had 'a large consultancy practice', see note 37.
43. Formal links were established with St. Mary's in May 1884, when, in exchange for teaching students practical midwifery, Owens offered the hospital's medical staff, three lecturers' posts in clinical midwifery and diseases of women. Four years later, soon after Sinclair was appointed to the chair at Owens, the Southern similarly agreed to accept medical students to attend cases both in the district and in the hospital. MHA, Board Minutes, 12 May 1884. Manchester CL, 362.1M65, Southern Annual Report, 1889. JRUL, Manchester Medical

Collection F4Lvii, Owens College Prospectus, 1890-91. Bride, 'Some Manchester Pioneers, p.75.

44. Fothergill, A. Donald, *An Introduction to Midwifery: A Handbook for Medical Students and Midwives*, 1st edition, 8th edition (London, 1894, 1920). Lloyd Roberts, *The Student's Guide to the Practice of Midwifery*, 1st edition (London, 1876).
45. As late as 1920 rickets accounted for 10 per cent of the Children's Hospitals' out-patient total which amongst young females alone accounted for 1,000 cases a year. John Bride, 'Caesarean Section in Manchester', *Journal of Obstetrics and Gynaecology*, 28 (1920), 463-68 (p.464).
46. The problem with women having to resume domestic duties and waged employment too soon after labour was so extensive a problem, that it became the focal point of the discussion of the local Ladies Health Society as early as 1905 and directly led to the foundation of the Society of Home Helps in Manchester, 1916. *Lancet*, 21 January, p.193, 28 January 1905, p.267. Report on the Health of the City of Manchester, 1916, p.49. A. J. Wrigley, 'Prolapse', *British Medical Journal*, 4 April 1953, p.778. JRUL, Manchester Medical Collection, Author Files (Donald).
47. Similarly, in the United States, 'Some of the finest obstetricians of the nineteenth century attended [via the maternity hospital] the poorest and most desperate of women', Judith Leavitt, *Brought to Bed: Childbearing in America 1750 to 1950* (New York, 1986), pp.75-82.
48. Campbell, 'Maternal Mortality', p.73. Japp Sinclair, 'The Injuries of Parturition' p.589. Jellett, p.15.
49. Jenni Carter and Thérèse Duriez, *With Child: Birth Through the Ages* (Edinburgh, 1986), p.154.
50. For references to childbirth practices reminiscent of the sixteenth and seventeenth centuries see note 19. MHA, Board Minutes, 6 April 1858. Edward Shorter, *A History of Women's Bodies* (New York, 1982). p.149.
51. Ministry of Health, *Interim Report on the Departmental Committee on Maternal Mortality and Morbidity* (London, 1930), p.103. *Married Women's Work*, ed. by Clementa Black (London, 1915), p.2. *Maternity: Letters From Working Women Collected By the Women's Co-Operative Guild*, ed. by Margaret Llewelyn Davies (London, 1915), pp.40-41, 151, 181, see also Anthony Wohl, *Endangered Lives: Public Health in Victorian Britain* (London, 1983)

- pp.12-13. John Hawkins Miller, 'Temple and Sewer: Childbirth, Prudery and Victorian Regina', in *The Victorian Family: Structure and Stresses*, ed. by Anthony Wohl (London, 1978), pp.23-43 (p.27). Robert Roberts, *The Classic Slum* (Middlesex, 1986), p.110.
52. Jane Lewis, *Women in England 1870-1950* (Brighton, 1984), pp.28, 57. Llewelyn-Davies, pp.134,144, 179.
53. MHA, Manchester (Southern) Maternity Hospital, Case Admissions Register No. 13, case no. 24.
54. The 1891 Factory Act prohibited an employer from 'knowingly' employing a woman, 'within four weeks after she had given birth to a child', but as Wohl explains, 'The Act seems to have been drafted and passed with little commitment or enthusiasm; there was no machinery for making it effective and since no doctors, letters were required giving the date of birth and there was no legal precision to the phrase 'knowingly' it remained a 'dead-letter'. Wohl, p.31. Sylvia Pankhurst, *Save The Mothers* (London, 1930), p.30. Llewelyn-Davies, pp.100, 118, 177, 181.
55. It is generally agreed, that, at a time of poor artificial alternatives and unpasteurised cows milk, even breast feeding for the first few days only, was very beneficial, because this initial supply of milk (colostrum) provided antibodies to protect the child against bacterial infections, particularly against thrush and gastro-intestinal infections, a major cause of infant mortality in the nineteenth century. Valerie Fildes, *Breasts, Bottles and Babies* (Edinburgh, 1986), p.81. Wohl, p.21.
56. Kerr, *Maternal Mortality and Morbidity*, pp.119, 212, 238. Campbell, 'Maternal Mortality', p.53. Ministry of Health, *Final Report of the Departmental Committee on Maternal Mortality and Morbidity* (London, 1932), pp.38,39.
57. It was not until 1905 that Manchester, along with Liverpool and Cardiff Councils, took the initiative and paid the doctors' fees 'in respect of the poorest members of the community' in cases where a midwife felt a doctor was necessary. Report on the Health of the City of Manchester 1905, p.221.
58. MHA, Board Minutes, 5 January, 2 February 1863.
59. At the Rotunda Maternity Hospital, Dublin, the situation was no different; 'it was with the greatest difficulty patients could be prevailed

- upon to remain in hospital even so long as the eighth day, and numbers, to our own knowledge, have insisted upon being discharged before the ordinary time'. O'Donel T. D. Browne, *The Rotunda 1745-1945* (London, 1947), p.50. Report of the Health of the City of Manchester 1925, p.168.
60. Black, p.10. MHA, Case Admissions Register No. 13, case nos. 82, 85, 167.
 61. So adamant was one father, that his two small-pox-infected sons would not be admitted to hospital that he isolated them himself, in a shed on Ashton Moss, 'a desolate looking spot'. *Lancet*, 4 August 1906, p.325.
 62. Pankhurst, p.39.
 63. Wohl, p.18.
 64. Report on the Health of the City of Manchester, 1907. pp.297-98.
 65. MHA, Annual Reports 1901-10. Manchester CL, 362.1M65 Southern Hospital Annual reports, 1901-04.
 66. MHA, Case Admissions Register No. 13, case nos., 145, 150.
 67. MHA, Case Admissions Register No. 13, case no. 62.
 68. A bougie was a slender, semiflexible instrument which was passed through the cervix and up one side of the uterus and left in situ between the membranes and muscular wall whilst the lower end was left in the vagina. Once uterine contractions began, the bougie could be removed and the labour allowed to proceed naturally. William Fothergill, *Manual of Midwifery*, 1st ed. (Edinburgh 1896), p.423. MHA, Case Admissions Register No. 13, case no. 41.
 69. MHA, Case Admissions Register No. 13, case no. 55.
 70. A. Donald, *British Medical Journal*, 8 July 1916, p.33. 7 October 1916, pp.506-7. W. Fletcher Shaw, *British Medical Journal*, 14 October 1916, p.540.
 71. MHA, Case Admissions Register No. 13, case nos. 3, 167.
 72. Pat Jalland, *Women, Marriage and Politics 1860-1914* (Oxford, 1936), pp.143-44. Wertz, p.137.
 73. Sinclair, *British Medical Journal*, 4 September 1897, p.589.

74. M. Myles, *Textbook for Midwives*, 8th ed (London, 1975), p.362.
75. See Chapter 7. Wertz, p.137.
76. 'Had a breech presentation no artificial interference' was a common remark recorded against such cases. See for example, MHA, Case Admissions Register No. 13, case no. 13 and 17.
77. Version referred to the turning of the uterus to facilitate delivery and podalic version involved turning the foetus to bring the legs down first as opposed to cephalic version where the head was brought down first. Fothergill, p.390. MHA, Case Admissions Register No. 13, case no. 130.
78. Carter and Duriez, p.11. Wertz, p.137.
79. Sinclair, *Lancet*, 18 September 1897, p.760. *British Medical Journal*, 4 September 1897, p.595.
80. J. H. Young, *Caesarean Section: The History and Development of the Operation from Earliest Times* (London, 1944), p.73. Alfred Meadows, 'Meadows on Craniotomy' *The British Gynaecological Journal*, 2 (1886), 309-331 (pp.313, 315, 319).
81. A. L. Galabin, *A Manual of Midwifery* (London, 1900), p.54. Dr Roberts Barnes, cited in Alfred Meadows, p.315.
82. Archibald Donald, 'Methods of Craniotomy', *Transactions of the Obstetrical Society of London*, 31 (1889), 28-49 (p.28).
83. For an historical reference to accouchement forcé, see Janet Ashford, 'A History of Accouchement Forcé:1550 - 1985' *Birth*, 13 (1986), 241-49.
84. *Lancet*, 31 March 1891, p.309-11, 18 February 1893, 370-71. MHA, Annual reports, 1894-96.
85. Patricia Branca, *Silent Sisterhood* (London, 1975), pp.64, 82, *Women in Europe Before 1750*, (London, 1978) pp.118, 129. Armand Routh, 'On Caesarean Section in the United Kingdom', *The Journal of Obstetrics and Gynaecology of the British Empire*, 19 (1911), 1-55 (p.9).
86. Routh, pp.3,6. MHA, Annual Reports, 1890-190, Japp Sinclair, 'A Series of 10 successful cases of Caesarean Section', *Lancet*, 19 January 1901, p.153. J. Willcocks and A. A. Colder; *The Glasgow Royal Maternity Hospital, 1834-1934, 150 Years of Service in a Changing Obstetric World*, *Scottish Medical Journal*, 30 (1985), 247-54, p.251. Branca, *Silent Sisterhood*, pp.84, 89.

87. For a more general review of this issue, see I. Waddington, 'The Role of the Hospital in the Development of Modern Medicine: A Sociological Analysis', *Sociology*, 7 (1973), 211-54.
88. JRUL, Manchester Medical collection, Sinclair's Obituary Note, Author files (Sinclair).
89. Waddington, pp.214, 219, MHA, St. Mary's Bye-Laws 1896.
90. MHA, Case Admissions Register No. 13, case nos. 89, 90, 122.
91. C. J. Cullingworth, 'A Review of Some Recent Statistical Reports of In-door and Out-door Maternity Charities', *Journal of Obstetrics and Gynaecology*, 12 (1907), 293-312 (p.293). F. B. Smith, *The People's Health* (London, 1979), p.37. Rentoul, Select Committee on Midwives' registration, BPP, 1892 (239) XIV, p.28. *Lancet*, 16 January 1895, p.155.
92. MHA, Annual reports, 1863, 1878.
93. MHA, Case Admissions Register No. 13, case no. 114.
94. Manchester CL, 362.1 M55, Southern Hospital Annual Reports, 1889-1903.
95. William Farr, Annual Report of the Registrar General 1876, pp.243-44. Manchester CL, 362.1 M55, Southern Annual reports, 1869-77. MHA, Annual Reports, 1881-85.
96. Annual Reports of the Registrar General, 1881-85.

The Voluntary Maternity Hospital:
a social history of provincial institutions,
with special reference to maternal mortality, 1860-1930

Two Volumes

Volumes Two

Craig Stephenson

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Chapter Four

A Lay Affair

(A Lesson in Female Management)

Part One

Liverpool Lying-in Hospital 1869-1896

The Politics of Hospital Management - An Introduction

It was the desire to establish male control rather than therapeutic advances in medicine that provided the impetus for the creation of maternity hospitals.¹

The purpose of using the Liverpool Lying-in Hospital as a case example is to present a fourth dimension to the institutional material already discussed. Whereas Chapters 2 and 3 concentrated on the mechanics of maternity hospital care, in terms of what was provided, in what numbers and by what means, the aim will now be to address the underlying factor that determined all of these, the politics of hospital management, asking by whom and for what reasons such provision was made. The following chapter will concentrate on the key participants in institutional practice, namely the Board of Management, the Ladies' Committee and the Medical Board. This is unusual because it constitutes a tripartite, as opposed to the more conventional bipartite system of hospital administration, for Liverpool Lying-in Hospital was also managed by a female contingent of supporters as well as the traditional all-male Management and Medical Boards.²

Each of these groups will be reviewed separately, paying particular attention to their respective areas of interest in hospital management and policy, and the extent of their influence on the course of its development. The interaction of these groups, especially at times of controversy, will be another area of

concern, particularly when considering how the various groups defined the hospital's role and measured its effectiveness. Whilst remaining constantly aware of specific group interests and their ability to promote or indeed colour initial objectives, it will be important to consider whether any one group ideology dominated proceedings or contributed to a melting-pot of policies and ideas.

One of the principal lines of investigation, the relationship between professional and lay volunteers in charitable work, has rarely been considered. Perhaps this is because it is readily assumed by Granshaw, Versluyen, Checkland and others, that the specialist hospital, 'the profession's training ground...the workplace of the medical elite', was governed by its professional staff in all but name.³ Checkland attributed this to the philanthropists' inability to challenge the hierarchy and authority inherent in the medical profession, arguing that 'very few of them would think resistance to this to be proper' for 'by and large they did not and could not, challenge professional authority'.⁴ Referring to the development of eighteenth century maternity hospitals, Versluyen argued that these institutions were not only under the control of their respective Medical Boards, but were the very product of doctors' desires to dominate the field of female midwifery and establish their authority over female midwives and patients; in such an interpretative

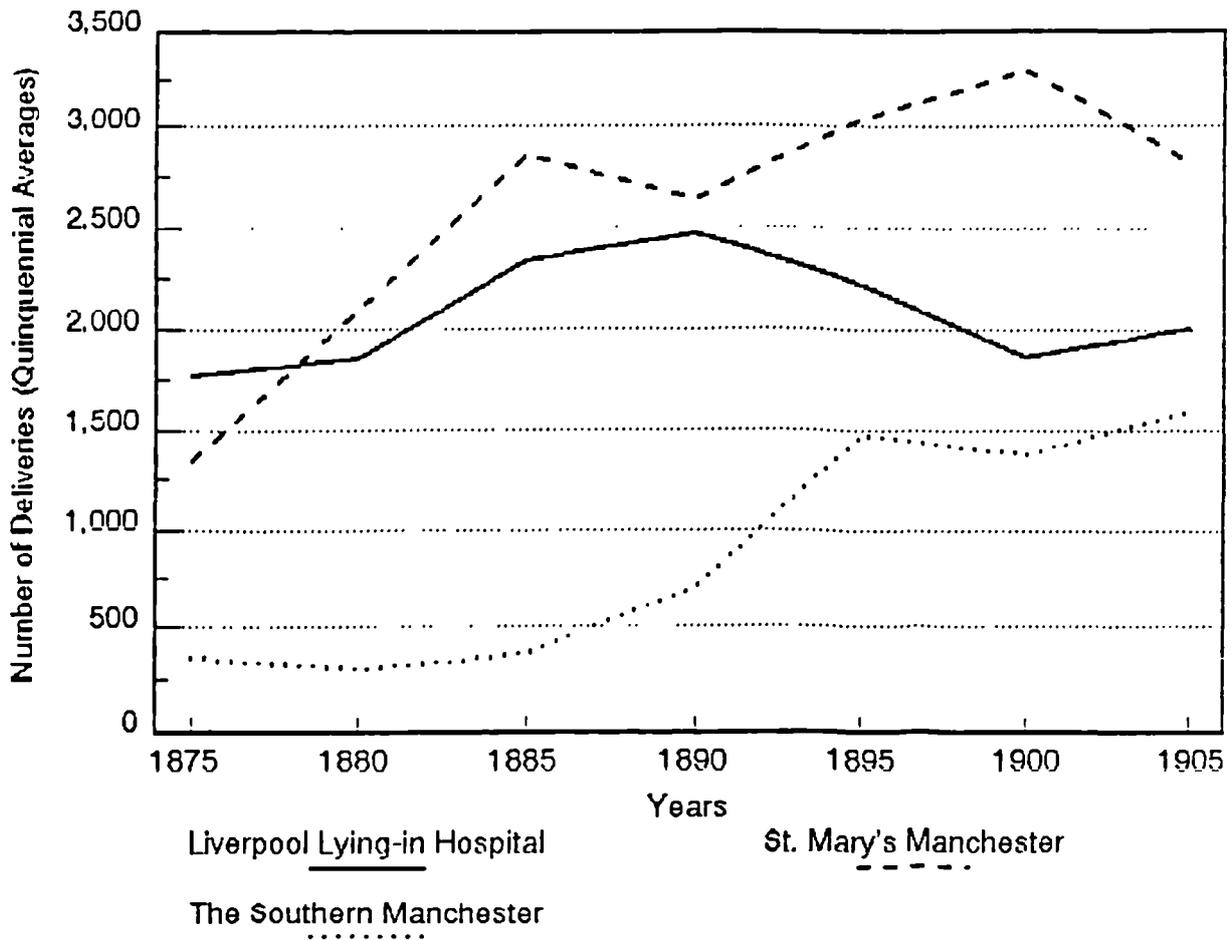
framework there was clearly little scope for lay involvement.⁵

Focusing on the period beginning with the amalgamation of the Ladies' Charity and Lying-in Hospital (1869) and ending with the lay-medical dispute (1896), it will be argued that there was a strong lay influence which successfully tempered and restricted the more blatant aspirations of the medical staff. An important reason for this was the contribution of the hospital's female supporters to the decision process on all manner of issues, major as well as minor, lay as well as professional. This female perspective is in itself an important line of historical investigation, for the role of Victorian women in charitable works is considered by many to be subordinate and amateur, if considered at all.⁶

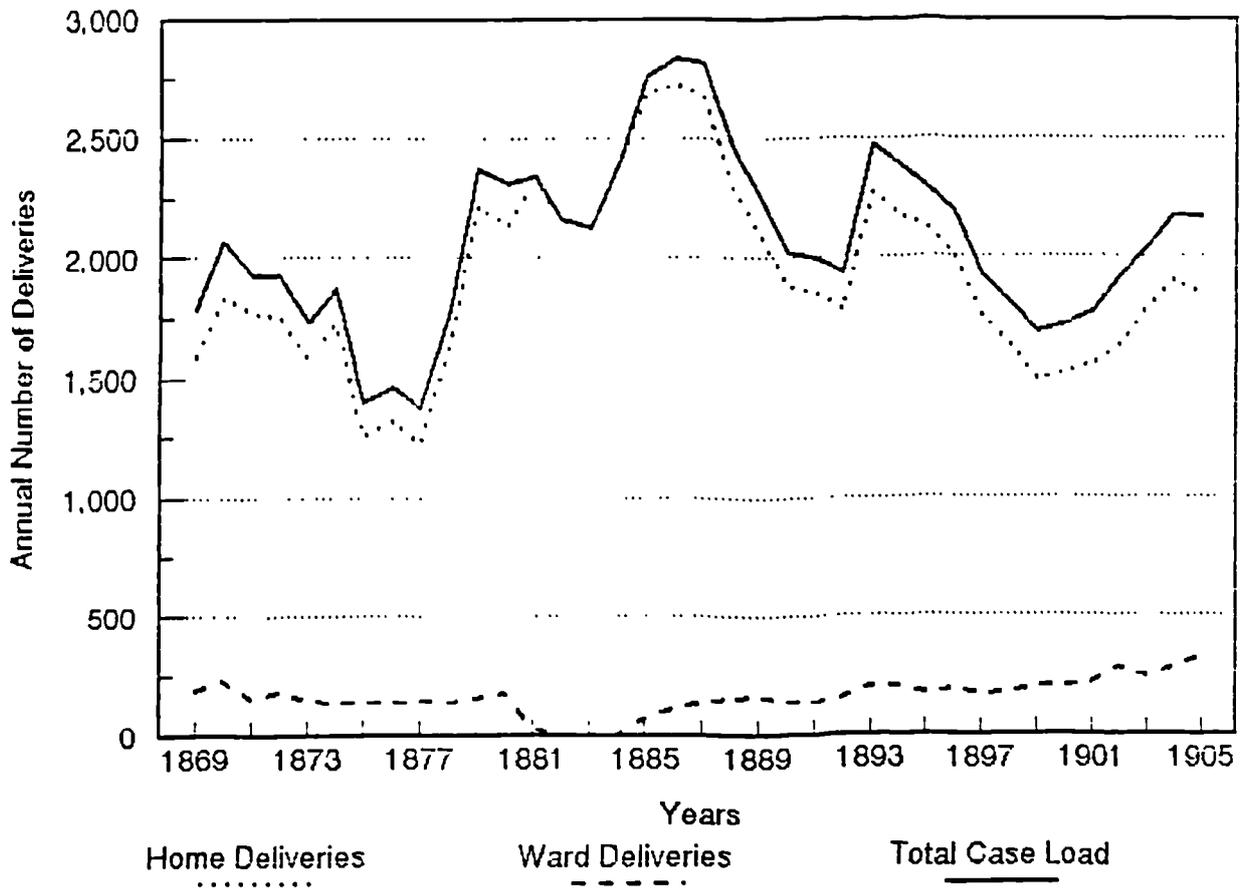
An Institutional Synopsis: The Nature and Scope of the Work of the Liverpool Lying-in Hospital

Although as noted in Chapter 2, Liverpool's maternity hospital did survive the hostile publicity that was directed against maternity institutions in general and its own in particular, it clearly lacked the dynamism and enterprise that characterized the work of Manchester's maternity hospitals during the late nineteenth century. Not only did St Mary's and the Southern Hospitals virtually double and quadruple their

**FIGURE 4.3: AVERAGE NUMBER OF DELIVERIES
MANCHESTER AND LIVERPOOL MATERNITY HOSPITALS
1871\5-1901\5**

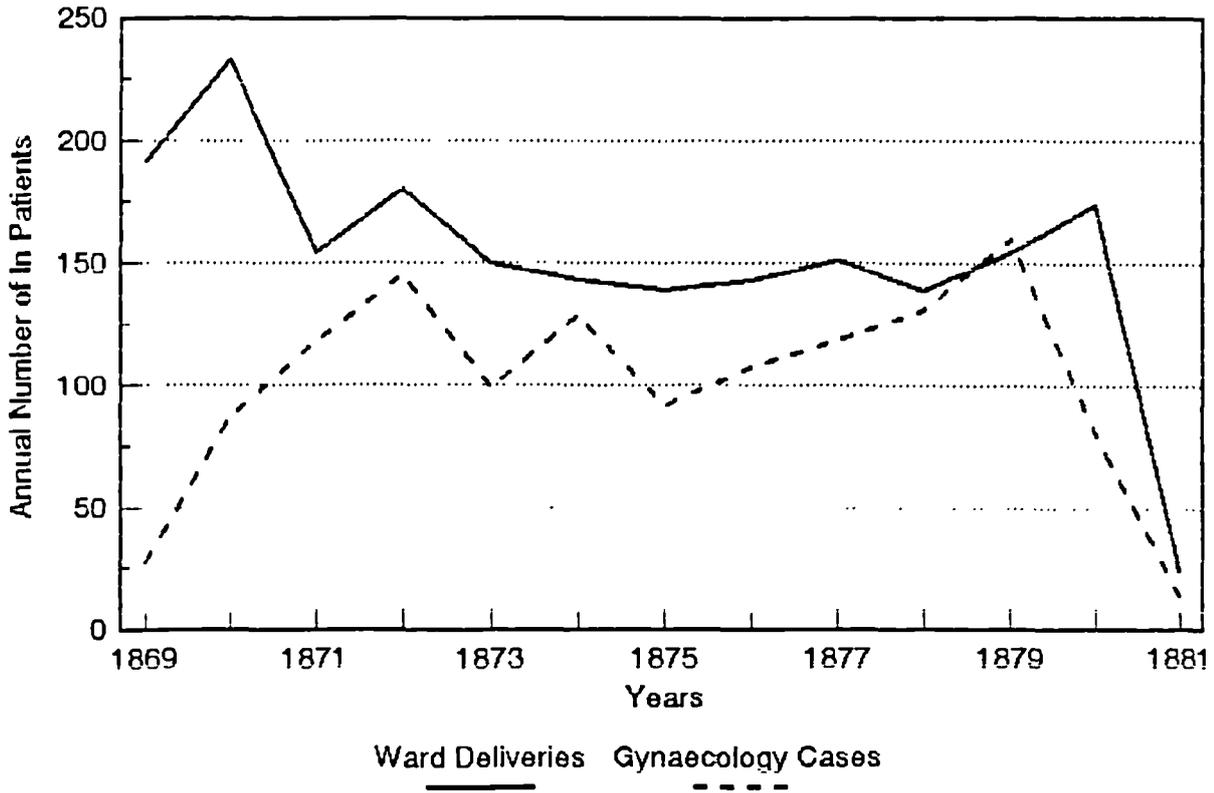


**FIGURE 4.4: ANNUAL NUMBER OF DELIVERIES
LIVERPOOL LYING-IN HOSPITAL 1869-1905**

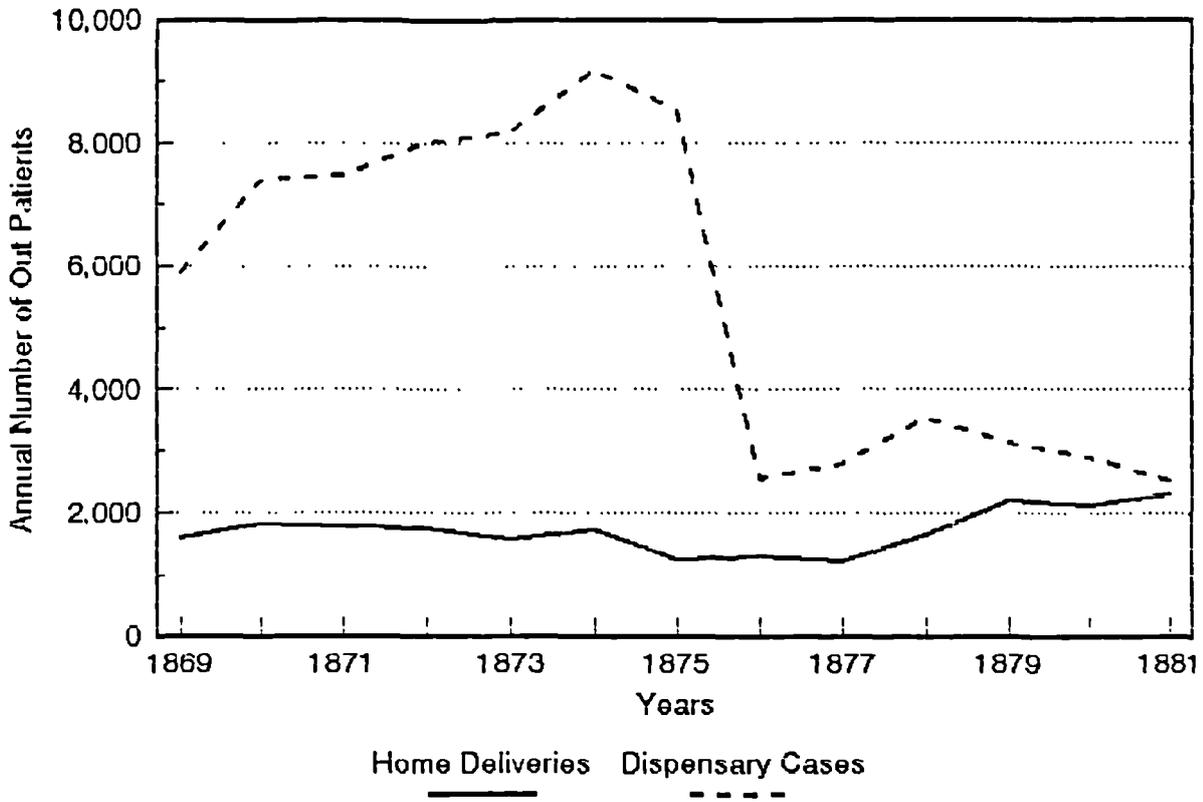


Source: Liverpool Lying-In Hospital, St. Mary's & The Southern Annual Reports 1869-1905

**FIGURE 4.5: ANNUAL NUMBER OF IN-PATIENTS
LIVERPOOL LYING-IN HOSPITAL 1869-1881**



**FIGURE 4.6: ANNUAL NUMBER OF OUT-PATIENTS
LIVERPOOL LYING-IN HOSPITAL 1869-1881**

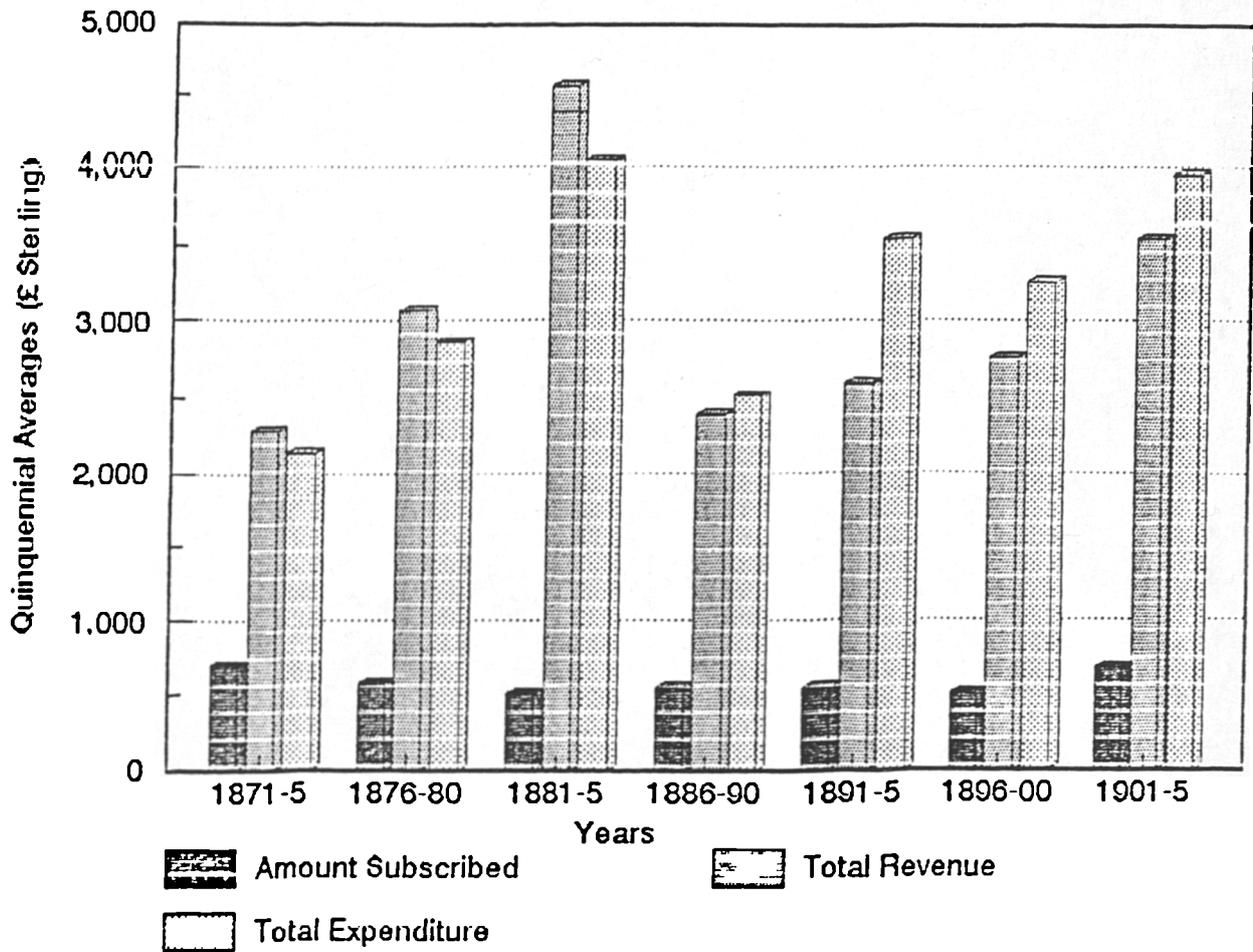


Source: Liverpool Lying-in Hospital Annual Reports 1869-1881

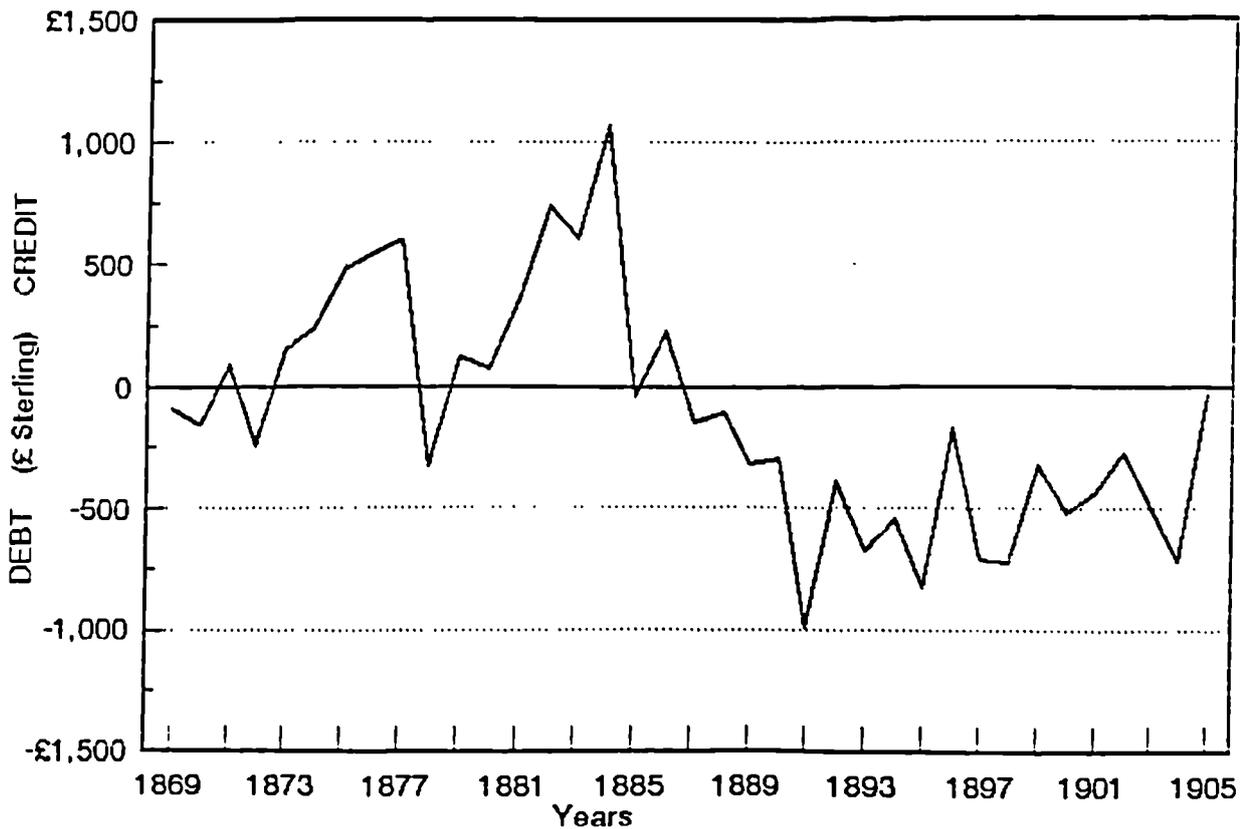
annual district case loads (1871-1905) to over 3,000 and 1,300 confinements respectively, they also opened maternity wards in the late 1880s which were soon accommodating up to 200 maternity cases a year, a figure comparable with their more established counterpart in Liverpool (Figures 4.1 and 4.2). Such was the inertia of the Liverpool Lying-in Hospital that it barely increased its case total (1871/5-1901/5), delivering, on average, only 241 more women a year during the latter period than the former (Figure 4.3). Moreover, when the new hospital premises was opened in February 1885 and the charity concentrated solely on confining women, it never came close to duplicating the 10,000 or more cases a year that it dealt with during the 1870s, when, in addition to the midwifery facilities, it had run a popular dispensary for women and children, as well as a fee-paying gynaecology department that accounted for half the hospital's ward capacity (Figures 4.5 and 4.6).⁷

A principal reason for this inertia was the loss in 1881 of the dispensary and gynaecology wards, for it was, as will be explained, the plight of the sick child and the emergent interest in female disorders that attracted the necessary funding, not maternity work *per se*. Whereas Liverpool Lying-in Hospital between 1871 and 1875, for example, attracted £700 a year in subscriptions, accounting for a third of the hospital's expenditure, including the finance for its dispensary and gynaecology services, between 1886 and 1890 (after their closure) the hospital had difficulty raising £500 a year

**FIGURE 4.7: AVERAGE VALUE OF SUBSCRIPTIONS
LIVERPOOL LYING-IN HOSPITAL 1871\5-1901\5**



**FIGURE 4.8: ANNUAL CREDIT-DEBT ACCOUNT
LIVERPOOL LYING-IN HOSPITAL 1869-1905**



Source: Liverpool Lying-in Hospital Annual Reports 1869-1905

by subscriptions and meeting a fifth of the hospital's annual running costs by this means (Figure 4.7). The loss of popular appeal and the puerperal fever scares that had precipitated the fall in subscriptions from the 1870s, resulted in persistent debt problems from the mid 1880s and a period of 'great anxiety' over 'the serious condition of the finances' which severely curbed the hospital's ability to maintain existing case levels, let alone expand them (Figure 4.3).⁸ In the first 15 years that the hospital concentrated purely on delivering women, during which time the annual surplus of £227 was converted into an annual deficit of £518 and the amount subscribed stagnated at £500 a year, the hospital's annual number of deliveries fell from 2,838 in 1886, to 1,727 by the end of the century (Figures 4.4 and 4.8). Without the support of other specialist services the maternity hospital was unable to repel the fears and prejudices that it had engendered during its pre-antiseptic days and attract sponsors in any substantial numbers.⁹

Albeit limited, the Liverpool Lying-in Hospital was nonetheless able to offer a service similar in scope to its counterpart in Manchester, which was,

To provide poor married women of good character and widows whose husbands have died during their pregnancy with the assistance of trained midwives during their confinement, and, when requisite, of Surgeon Accoucheurs...¹⁰

As in Manchester, applicants who had been recommended by a half guinea or more subscriber to the hospital, lived

within a prescribed boundary, extending 'from Bootle in the North to Aigburth-vale in the South', and presented 'certificates or other satisfactory proof of marriage', were eligible for maternity relief (Map 5).¹¹ Whether they actually received relief, was dependent upon whether they were approved by a visitor from the Ladies' Committee or more usually a member of the Liverpool Central Relief Society, who paid 'great attention...to the moral character of the objects, and...their inability to provide for themselves or to obtain relief from other sources'. Women who were then admitted into hospital were accepted 'on account of the distress of their social surroundings, or the expectation of some of the more unusual and serious obstetric difficulties'.¹² With the emphasis upon extreme poverty and unsuitable domestic circumstances, 'and such are 86 per cent of the cases attended to in the hospital', the hospital was just as receptive to social needs as clinical considerations.¹³

Once accepted, the expectant mother, as in Manchester, was delivered by one of the hospital midwives who 'carefully revised, and their conduct and efficiency ...strictly superintended', were central to the work of the charity, attending all normal confinements, including those in the hospital.¹⁴ The 'Nurses Companion', purchased by the hospital for 12s 6d each and containing all the midwife's implements: nail brush, soap, Vaseline, perchloride of mercury, ergot, Hyginson's syringe, catheter, castor oil, temperature and relief books, and in the douche tin, powder, scissors, cotton thread, linen

and a thimble, illustrates both the scope and the limitations of the midwife's work.¹⁵ Equipped with soap and nail brush, it is evident that cleanliness was a major priority for the midwife who had to follow strict Listerian practices of hygiene in stark contrast to the uncertificated and unregulated neighbouring midwife whose 'pockets' and 'Dorothy' bags, on inspection, were often found to contain 'rusty scissors, dirty bottles and unsuitable appliances'.¹⁶ In possession of a needle and thread, midwives were also expected to stitch a woman's perineum if it were torn during delivery or perhaps, more mundanely, to carry out some clothing or linen repairs on behalf of the patient. Douche tins, though standard issue with all midwives' bags, could only be used in the presence of the doctor and the only medicine the midwife could prescribe, 'at, during or after labour without the sanction of the medical officer', was castor oil, and after 1886, ergot, but only when the placenta had been expelled. Long before it had become the statutory practice of registered midwives, hospital midwives, as a means of detecting an irregularity, namely puerperal fever, were responsible for recording a woman's temperature and pulse and reporting any case where the temperature rose beyond 100°F, as well as cases of flooding or a suspected complication. As an assurance that midwives were abiding by regulations and carrying out their duties they were expected to submit monthly reports on the cases they had delivered. Also if necessary, they were brought before the Medical Board,

and towards the end of the period, the Ladies Committee, to face a disciplinary hearing.¹⁷

In the same way that the hospital's midwives were regulated and restricted in what they could and could not do, so the medical staff were similarly bound by rules and procedures drafted by the Board of Management. As the Medical Board, when the occasion arose, inquired into a midwife's conduct, addressing allegations of neglect, drunkenness and general incompetence, so the Ladies' Committee reprimanded, and even instigated the dismissal of, those house surgeons who had failed to comply with the rules and regulations governing their terms of office. Exactly as the Medical Board went to great lengths to frame the rules and regulations governing the midwife, ensuring that she attended only normal confinements, adhered to hygiene procedures and refrained from dispensing medicines, so the House Surgeon, who had to record every clinical decision that he took, and similarly follow written procedures, could never use instruments, even forceps, without consulting an Honorary Medical Officer.¹⁸ By the 1890s, when obstetric operations were more frequently performed, the Board of Management even attempted to dictate to the Medical Staff what operations they could and could not do in the hospital and upon whom they could and could not perform an operation, but, as it will be seen in Chapter 6, the attempt was short lived and ultimately contributed to the Board's downfall.

The Gentlemen's Committee: Their Purpose, Policies and Objectives

On amalgamation, the intention was for 'The Ladies' Charity and the Lying-in Hospital...so far as practicable ...', to 'be worked jointly under the management of the same Committees and Officers'. In reality, the officers of the Management Committee of the Lying-in Hospital, an all-male body, including a President, Vice-President, Secretary, Treasurer and a professional accountant, were 'to all intents and purposes the Officers of each charity, as well as the two charities jointly'. It was they, the Gentlemen's Committee, and not the ruling body of the Ladies' Committee, an all-female group, who assumed the Board of Management role and overall authority for the Charity. Annually elected by a body of subscribers, of whom over three-quarters were female, the Gentlemen's Committee took responsibility for all major policy decisions, with the power to appoint, suspend or dismiss, all stipendiary officers and servants, make by-laws which were consistent with the existing regulations and 'regulate the financial and general business of the Institution'; 'professional subjects', in theory, were the province of the Honorary Medical Officers who were collectively known as the Medical Board.¹⁹

As Victorian social thought emphasised the separation of the spheres of influence between the sexes and rigid sexual division of labour, so in charity work, women formed a quite separate body of volunteers, whose

role was intended to be distinct from and subservient to their male counterparts.²⁰ Identified as the Ladies' Committee of some 30 members with its own executive body, including a Lady President, a Sub-Treasurer and Secretary, the hospital's female volunteers, 'in tune with the conventional expectations of the day', were responsible for the 'detailed work of management', particularly the hospital's domestic arrangements, including the appointment of nursing and ancillary staff.²¹ The appointments they made and the decisions they took were also subject to the approval of the Gentlemen's Committee. Only when it was deemed 'needful' did the Ladies' and Gentlemen's Committees ever meet together and at no point until the spring of 1903 were female volunteers represented on the Management Board.²²

The Ladies' Committee: The Voiceless, Powerless Body of Housekeepers Portrayed ?

Thus, like any other female philanthropic body of the period, the Ladies' Committee had the appearance of a voiceless, powerless body of housekeepers. Yet it would be wrong to assume, as so many have, that these women consequently lacked the opportunity, desire and encouragement, to effect any real change and merely 'dabbled' in charity.²³ The very fact that members of the Ladies' Executive assembled weekly, as opposed to their male counterparts who met monthly, and actually spent

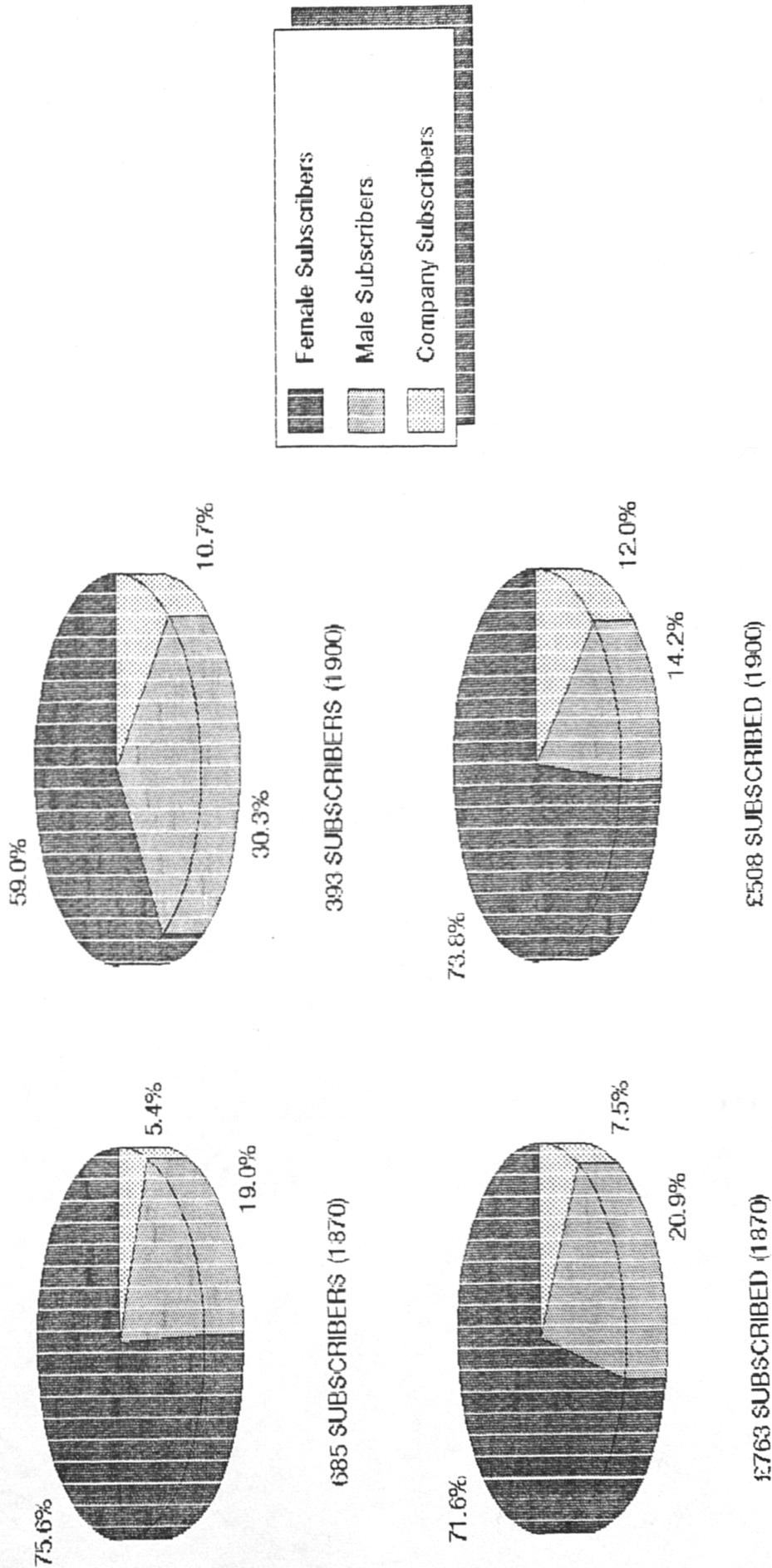
time at the hospital with equal regularity, suggests more of a personal involvement and familiarity with the day-to-day running of the hospital than the Board of Management ever hoped or intended to achieve. Meeting as infrequently as they did and with business commitments elsewhere, the Gentlemen's Committee was content to make the overall management decisions on the basis of information, views and proposals, supplied by those connected with the hospital on a daily basis, namely the hospital's doctors and the female volunteers.

As one of the two bodies looked upon as a source of information, respected for their opinions and turned to for their ideas, the female contingent quickly rose to the occasion, volunteering advice and submitting recommendations on all kinds of issues which went well beyond the scope of their original brief. It was the Ladies' Committee who ultimately instructed the Board of Management on the nature and scope of ward extensions, which charitable cases to accept and which to reject, whom amongst the midwifery applicants to appoint and on what terms, what gynaecology fees to charge in the pay wards and when and where the hospital's district boundaries were to be extended.²⁴ On matters of midwifery appointments and training, patient selection and administrative reforms, the women's ideas and views were sought, their feelings respected and their proposals adopted; the female contribution to charitable work can no longer be regarded as subservient and amateur.

So influential were the Ladies' Committee's views in the formation of hospital policy and so regular were their probings into every facet of institutional business, of both professional and lay concern, that not surprisingly the medical staff were often left frustrated and angered at their exclusion from even the most professional of subjects. When, for example, the matron-midwife failed to call the duty medical officer to a complicated labour, the medical staff lost no time in pointing out to their 'surprise and extreme regret', that this was the second time that the Ladies' Committee had selected a matron who had proved 'highly incompetent for the situation'. The Medical Board demanded the matron's immediate dismissal and argued that they be consulted in all future midwifery appointments; their requests went unheeded.²⁵ Similarly, when the Ladies' Committee independently decided to close the hospital during a sepsis outbreak and organise the cleaning of the hospital themselves, forcing the medical staff to cancel a cleaning operation that they had also organised, the Medical Board could do little but express their dismay at not being consulted.²⁶

Members of the Ladies' Committee were, on the whole, more successful than the professional staff in influencing the Board of Management, not least because a number of their husbands served on the Management Board and because Board members were annually elected by a board of subscribers of whom the majority were women (Figure 4.9).²⁷ As one female subscriber observed, 'as

**FIGURE 4.9: TOTAL VALUE AND NUMBER OF SUBSCRIPTIONS
LIVERPOOL LYING-IN HOSPITAL 1870 AND 1900**



Source: Liverpool Lying-in Hospital Annual Reports 1870 & 1900

Ladies form a very important part of the supporters of this combined institution, their feelings must be respected'.²⁸ Moreover, the Ladies' Committee often sponsored their own proposals which would have won over the most cost-conscious of the Management Board. When, for example, extra nursing was provided for critical cases and when a number of women and children were sent to a convalescent home, the cost, like the £110 needed to extend the hospital's district facilities to out-lying areas, was met by the women themselves, from their own fund raising events.²⁹ Yet this ought not to belittle the point that the female volunteers had already proved themselves as able managers when they ran their own maternity charity (1796-1869), supervising up to a third of the city's annual confinements.³⁰ On amalgamation with the Lying-in Hospital in 1869, the Ladies' Charity was, in theory, supposed to retain its integrity and be accepted to run the newly formed, 'Ladies Charity and Lying-in Hospital ...jointly, under the management of the same committees and officers'.³¹ Thus, historical circumstance ensured that women had a voice in the running of the hospital, but the fact that it continued to be heard was, in addition to their money, because of their practical working knowledge of the institution, their daily running of affairs and their sheer strength of character and determination in the way they broached their demands.

The Female Legacy: Midwifery Instruction, Patient Admissions and Lay Leadership

Given such an unusual situation where women had a voice in hospital management and were able to use it to some effect and in the absence of any extensive local studies on female philanthropy, it is important to be fully aware of the issues arising from this rare occurrence. It is necessary to determine, for example, if the women's contribution to institutional management were much more substantial than the beautifying of hospital wards or the organising of a garden fete, which is what many women were restricted to doing in organisations of this nature.³² If the answer is in the affirmative and the evidence to date seems to confirm this, then it is important to assess whether this made any real difference to hospital practice, particularly with regard to matters relevant to their own sex, such as the training and employment of midwives and the relief of impoverished women. Underlying this particular line of enquiry is a more fundamental one about motives, discovering why women became involved in such work and what influenced the way they managed affairs.

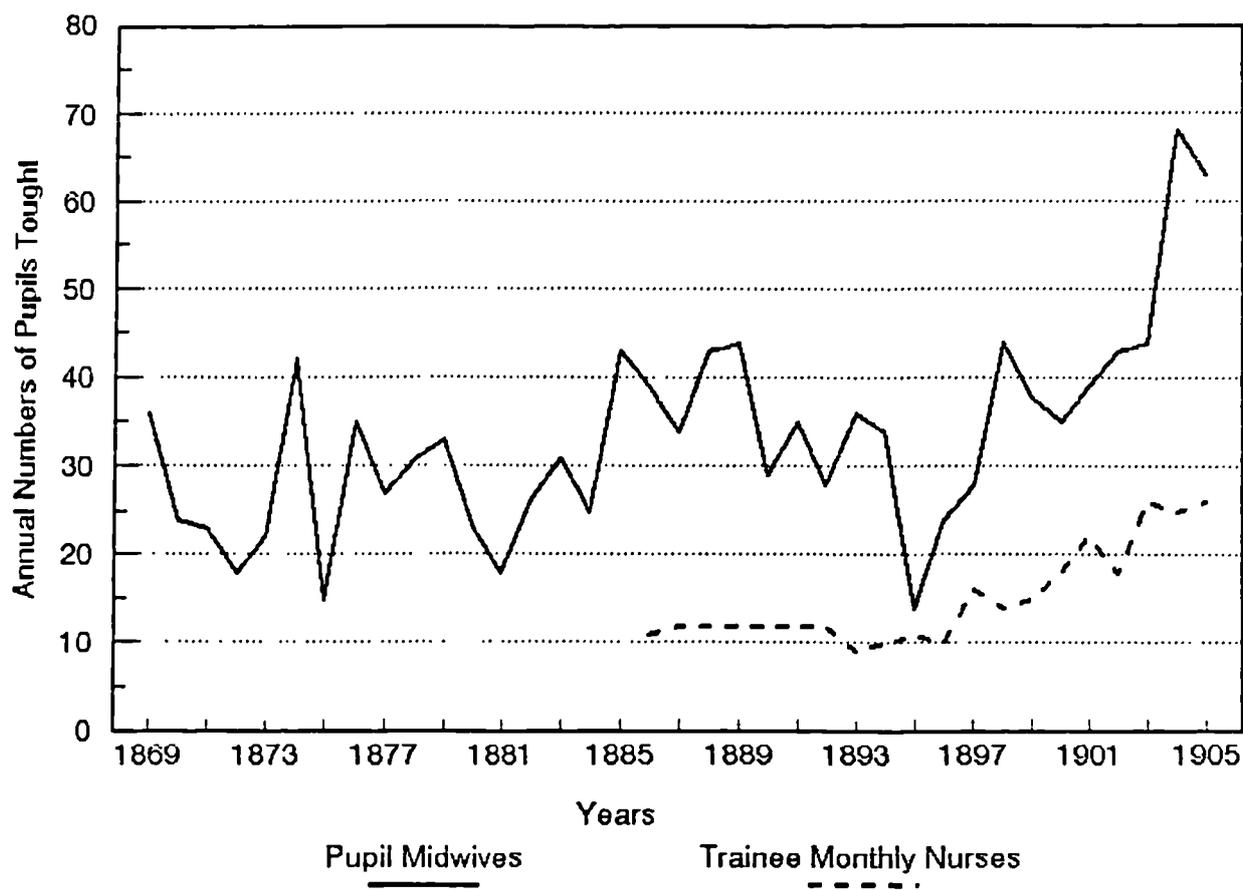
In the case of recruiting, training and employing midwives, the women's objective was very clear, to improve the occupation radically, not so much for the benefit of the charity's recipients, but for the benefit of their contemporaries who were in search of respectable and lucrative employment other than that of a

governess.³³ As soon as the two charities merged in 1869, the Ladies' Committee was proposing the immediate substitution of the hospital's midwives with 'younger', 'better educated' women which the Medical Board successfully thwarted; the midwives had been in the hospital's employ for several years and had never been found to be neglectful or incompetent. Unrelenting, the Committee's second resolution 'that no [midwifery] candidate should be deemed eligible unless her qualifications as to character, education, respectability, general fitness for the post are unquestionable', was more successful. As this was followed in October 1875 by proposals to charge ten guineas for a three months residential course, which went far beyond the means and requirements of most 'working, common-sense women', it was quite evident that the Ladies' Committee envisaged a completely new class of midwife pupil, the educated women of 'impeccable character' and 'acceptable social status'.³⁴ The Committee in pursuit of this ideal was no doubt influenced by the Ladies' Medical College, London, established in 1865, which set demanding midwifery courses and charged ten guineas, not only in the hope of rehabilitating midwifery as an occupation worthy of gentlewomen but also with the intention of providing the very same class of women with competent birth attendants of their own gender.³⁵

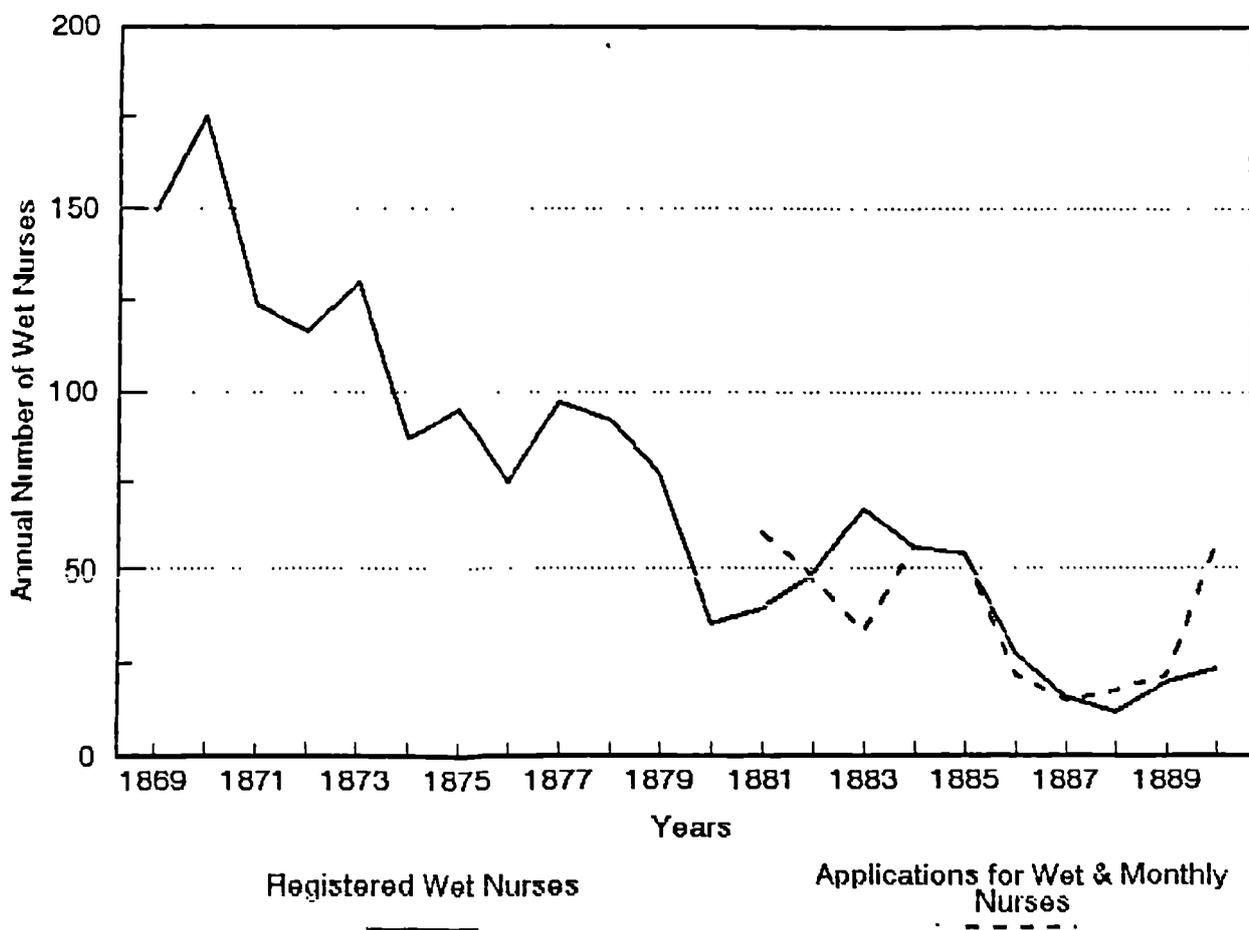
The women's vigorous pursuit of this ideal raises a number of points. Firstly, it must have been more than

just deep-seated religious beliefs, as suggested by Prochaska and Jalland, that inspired women's participation in philanthropy and more than just the strong sense of social obligation supposed by Simey.³⁶ Their participation was also inspired and directed by personal motives, which in this instance, was the opportunity to provide female kin with 'honourable and lucrative employment' and the option of being attended at their confinement by a competent and socially acceptable member of their own sex.³⁷ Whether these aims were comparable with those of the hospital raises a second point, for the scope of midwifery instruction was so highly exclusive, once rigorous qualifications were imposed, high fees set and lengthy courses endured, that it failed to cater for those midwives intending to work in Liverpool's working-class districts. As the medical staff pointed out, 'it [is] most desirable that every inducement should be held out to midwives and nurses to receive instruction, for whether instructed or not they will still continue to practise'. Though, as a result of their intervention, the medical staff managed to avert the introduction of the ten guinea fee until the end of the century, the Ladies' Committee still secured a rise in the tuition fee from five to seven guineas in 1879, which, coupled with the long duration of the course and the fact that the Committee selected its own pupil midwives, might well have accounted for the stability in the numbers of midwives taught before 1901, when midwifery instruction became compulsory (Figure 4.10).³⁸

**FIGURE 4.10: ANNUAL NUMBER OF MIDWIFERY PUPILS
LIVERPOOL LYING-IN HOSPITAL 1869-1905**



**FIGURE 4.11: ANNUAL REGISTER OF WET NURSES
LIVERPOOL LYING-IN HOSPITAL 1869-1890**



Source: Liverpool Lying-in Hospital Annual Reports 1869-1905

Yet not only did the Ladies' Committee effectively limit the supply of trained midwives, they also encouraged those they trained, to serve, not amongst the poor and the impoverished where the real demand was, but amongst their own social set who were eager to dispense with male doctors and where the quickest returns on the training fees could be made.³⁹ This may partially explain why opposition to midwife registration was at its most ferocious in Liverpool.⁴⁰

Another example where Liverpool's lying-in hospital catered exclusively to the needs of the middle and upper-class households, was its registration of wet-nurses, whereby the hospital introduced young women to the mothers of these households to suckle their young for anything up to 12 months.⁴¹ In return, the nurse received free board and lodgings and earnings of up to £1 a week, whilst the hospital had 1s from each nurse who registered with them and a 2s 6d enquiry fee from those seeking to hire a nurse. The hospital's earnings from this trade were minimal, accounting for no more than £4 a year (1871-75), yet it was providing a very popular service which at its peak (1870) totalled 175 registered wet nurses (Figure 4.11).⁴² Such demand was partially due to the lack of intimacy between some mothers and their young, where women were only mothers 'at set times of the day, even of the year', abandoning their children to nannies, governesses and servants, and partially due to the genuine difficulties some mothers encountered in suckling their young.⁴³

Sample Text 4.1

By what right, by what law was she separated from her child ? She was tired of hearing Mrs Rivers speak of my child, my child, my child and of seeing this fine lady turn up her nose when she spoke of her own beautiful boy ... yesterday the housemaid had told her that that little thing in the cradle had had two wet-nurses before Esther, and that both had died ...

"two innocent children murdered so that a rich woman's child may be brought up. I'm not afraid of saying it, it's the truth; I'd like everyone to know it."

At the word "murdered" a strange look passed over Mrs Rivers face. She knew of course, that she stood well within the law, that she was doing no than more a hundred other fashionable women were doing at the same moment; but this plain girl had a plain way of putting things, and she did not care for it to be publicly known that the life of her child had been bought with the lives of two poor children.

Excerpt from, George Moore, Esther Waters
(London, 1894), p.142.

Though wet nurses were heavily criticized in the 1860s for neglecting their own child in preference for another, even abandoning them to notorious baby farmers, and though many of them were unmarried mothers who under normal circumstances would have been automatically refused help of any form by the Ladies' Committee, the lying-in hospital continued to encourage their presence (Text Sample 4.1).⁴⁴ From 1872, when fee-paying foster homes of two or more children had to be registered, the hospital undertook to obtain homes for the infants of wet nurses during their period of employment. From 1882 it required that wet nurses, before registering, showed a certificate of health confirming they were free of contagious diseases.⁴⁵ This latter request was a fruitless attempt to arrest the rapid fall in the demand for wet nurses from the late 1870s, by reassuring their clients about the health condition of the women they were to employ.⁴⁶ The reduced numbers of wet nurses and the eventual closure of the register in 1892 could not have been prevented, however, for their demise was nationwide, not least because wet nurses were increasingly proving uneconomical and because Victorian mothers were believed to have felt threatened by such nurses and the mystique that surrounded them, fearing, for example, that the nurse's milk would produce some of the physical characteristics of the nurse into the child.⁴⁷

Once the demand for wet-nurses had disintegrated the emphasis merely shifted to registering and training monthly nurses who were sent to a prospective mother ten

days prior to her confinement, not to deliver the child, but to remain with her for the subsequent month in order to attend to her needs and those of her new born. The hiring of such nurses, which was recommended by all the popular child care manuals of the day, was very fashionable amongst middle and upper-class households and once again it was the hospital who indulged them (Figures 4.10 and 4.11).⁴⁸ Indeed, the lying-in hospital made the monthly nurse an even more attractive proposition from 1885, when it trained its nurses in midwifery as well as general nursing skills. This not only reassured mothers, who now had a qualified midwife at hand, but also reduced the cost of pregnancy since a doctor's attendance at the birth was no longer required. Indeed, so popular was the service, that the Board of Management decided in 1894 to hire out its own monthly nurses to private patients rather than just serve as an employment agency and to provide a residential home for those nurses who were in between engagements. The investment was soon recouped for by 1900 the hospital was receiving well over £200 a year in private nursing fees alone.⁴⁹

Although tuition fees, training and subsequent employment of monthly nurses and midwives, was largely the responsibility of the Ladies' Committee, it was with the patient herself that the Committee's principal interests lay. From the moment a woman applied for maternity relief the Ladies' Committee was involved, for it was members from this body who had the final say in determining who was 'deserving and worthy' of

institutional care and who was not.⁵⁰ The task fell to the Ladies' Committee for they had a well-established tradition in this kind of work and as Prochaska suggests, a female visitor may well have been considered preferable to a male visitor because of the relative ease with which they could enter a woman's home and acquire the necessary information.⁵¹ Hence the appointment, at a salary of £35 a year, of Mrs Eaton as 'Outdoor Inspector' in March 1869, to review, in full consultation with the Ladies' Committee, each woman's application for maternity relief.⁵²

Tradition, however, and even an affinity with the plight of the prospective mother, were not necessarily the only reasons for female, middle-class participation in philanthropy of this nature, nor for that matter was the great sense of personal achievement and gratification women were believed to have derived from their work amongst the poor.⁵³ Important though these factors were, the question was not one of gender but class. Contrary to Prochaska's belief that 'class guilt, does not appear to have been a very powerful motive...in the charitable work of women generally', that they were 'more likely to be inspired by Eve and not class advantage', female residents of middle-class suburbia felt just as threatened by the idea of social conflict with the urban poor, from whom they were increasingly distancing themselves, as their husbands, and were just as aware of philanthropy's capacity, by means of material endorsements and moral instruction, to bridge the gulf

**TABLE 4.1: RELIEF DISTRIBUTION AMONGST DISTRICT CASES
LIVERPOOL LYING-IN HOSPITAL 1876\80-1901\5**

Nature of Relief	1876\80	1881\85	1886\90	1891\95	1896\00	1901\05
	pa	pa	pa	pa	pa	pa
1lb Soap 1lb Sugar	All District Cases Eligible For This Relief					
1/4lb Tea 2s6d C19th						
No of Maternity Bags Received By 1 Woman in Every:		160	246	287	315	295
		15	9	7	5	6
Articles of Clothing Received By 1 Woman in Every:	82	339	707	1,103	1,180	1,095
	5	7	3	2	2	2
Beds Loaned Out 1879-		5	7	21		
Night Nurses 1898-						

Source: Liverpool Lying-in Hospital Annual Reports 1869-1905

**TABLE 4.2: CENTRAL RELIEF SOCIETY EXECUTIVE
LIVERPOOL 1874-1875**

Executive Member	Association With The Hospital	Executive Member	Association With The Hospital
Mayor Ex-Officio		Charles Inman	Subscriber
Charles Banning		George Johnson	
H.C. Beloe	Wf Subscriber	William Langton	Wf Subscriber
Thomas Bushby	Hosp President	Edward Lawrence	Wf Subscriber
C. Bushell	Subscriber	Charles Melly	Wf Subscriber
Thomas Chilton	Wf Subscriber	W M Rathbone MP	Wf Subscriber
Henry Cox		Samuel Smith	Wf Subscriber
Elliot Davidson		John Stitt	Wf Subscriber
R C Gardner		John Torr MP	Subscriber
Major Greig		Edward Whittley	
George Horsfall	Wf Subscriber	William Grisewood	
Joseph Hubback			

Source: Liverpool Lying-in Hospital Annual Report 1874, CRS Annual Report 1873-4

between the social orders.⁵⁴ After all, it was the Ladies' Charity, with its emphasis upon the material well-being of their maternity cases and on regular house calls, that first attempted to close the socio-political gulf that had begun to emerge between themselves and the working classes at the beginning of the nineteenth century.⁵⁵ This the women continued to do after the Charity's amalgamation with the Lying-in Hospital, so that along with the 2s 6d cash benefit, baby clothes, parcels of tea, sugar and soap, and even the temporary loan of a bed, came the 'kindly helpful counsel' and the speeches about the virtues of temperance, self-reliance and thrift (Table 4.1).⁵⁶

Their approach was similar to that of the Central Relief Society, whose calls for 'strict enquiry and knowledge' of all relief applicants and desire 'to repress mendacity and expose imposture' by restricting relief to only the 'distressed and deserving', secured them Mrs Eaton's post in August 1874. For the remainder of the period, the Relief Society was responsible for inspecting all the hospital's maternity-relief applicants and presenting it with only the 'most deserving and worthy' cases.⁵⁷

Often unresponsive to the major periods of distress and known to have neglected the intemperate and long-term unemployed, whilst considering female applicants, not in their own right, but in light of their husband's moral and financial position, the Relief Society's willingness to assist the most necessitous cases was highly questionable. The Liverpool Lantern, which ran a series

of articles on the Relief Society's work, felt it was a public scandal that the society refused to recognise, let alone help, the most necessitous cases:

We have given instances (and hundreds more to give) to show that this mistaken Society never touches, but absolutely avoids, the most heart rendering and urgent cases of distress. To the cry of the widow it is deaf; to the appeal of those who have been longest in a state of semi-starvation and who are physically weakened by long-continued hunger and desperation, it is heartily impervious...it rarely if ever touches the most extreme and urgent cases of distress.⁵⁸

Though the achievements of the Central Relief Society in making the first real attempt to infuse order and method into the city's chaotic charity affairs should not be underestimated, its selection procedures severely impeded the hospital's capacity to deal with those most in need of gratuitous assistance and left it with only the 'handpicked members of the labouring classes'.⁵⁹

In the first year (1874-75) the hospital employed the Relief Society to investigate all its maternity applicants, the number of women refused relief multiplied six-fold, from 40 to 251 a year and the total number of women attended by hospital staff simultaneously fell by 25 per cent, from 1,874 to 1,398 confinements a year (Figure 4.4). The total number of annual confinements remained at this reduced level for a further two years until the Lord Mayor unprecedentedly spoke out at a subscribers' annual meeting, declaring that 'the work of the charity should be carried into the lowest part of the town, where objects for relief should be found rather

than amongst the better-to-do working class'. This was followed the next month, by a request from the Management Board to the Relief Society, 'that it was the wish of the Committee that the benefits of the Charity should be conferred upon all poor married women'. Consequently, the total numbers confined and assisted did increase beyond the pre-1875 figure, but twice the proportion of women, 10 as opposed to 5 per cent of the total number of applicants, were still being refused relief (Figure 4.4).⁶⁰

Whatever the total number of women annually refused, the figures could never convey the emotional trauma and humiliation that the highly stressed expectant mothers must have endured under the rigours of the Society's 'severe and humiliating labour test' which was applied, 'to all indiscriminately and without regard to the fitness or capacity of the applicant'.⁶¹ Allegations abound of the Society's investigators ruthlessly conducting the inspections, ensuring all saleable possessions in an applicant's house were sold.⁶² So feared were the Society's visitors that 'numbers of people have said that they would rather starve or go to the workhouse than apply to the Central Relief for aid'. Ironically, the Central Relief Society, which sought to suppress pauperism and promote independence and self-help, drove many 'willing and deserving' families to seek the indignity of the workhouse, rather than suffer the indignation of receiving a visit from the Relief Society.⁶³

The fact that the Ladies' Committee and the Management Board President, Thomas Bushby, were instrumental in persuading the hospital's supporters to employ the Central Relief Society to inspect its applicants, at a time when the Society's investigation methods came under considerable local criticism, and when no other charity, except the Marine Society, employed their services, requires further explanation. Whilst the Ladies' Committee had a long history of house visiting and no doubt felt a genuine sympathy with the methods and objectives of the Central Relief Society, it is no coincidence that practically a third of the Relief Society's executive comprised men whose wives supported and subscribed to the maternity hospital (Table 4.2). Moreover, it is no mere coincidence that Thomas Bushby, who personally led the campaign to become affiliated with the Relief Society, had only months before becoming President of the hospital's Board of Management in February 1874, been appointed to the Executive Committee of that same Society. There was no more fitting way for a new member of the Executive to make an immediate impression than to secure the first and only 'investigation contract' with a voluntary hospital, which was desperately needed, if only to testify that at least one medical charity was committed to the Society's cause.⁶⁴ Similarly, William Grisewood, Secretary to the Central Relief Society, also became secretary to the Lying-in Hospital from 1883 only to be superseded by his son in the 1900s who then held the post until 1923.⁶⁵

Consequently, despite growing criticism of the Society's investigative techniques, the maternity hospital continued to patronise the Relief Society for the remainder of the century, paying £2 10s for every 100 cases investigated.⁶⁶

Another negative aspect of hospital admissions in which the Ladies' Committee played a leading role, was in their relentless denial of maternity relief to single women. It was during the 1870s that attention was first focused upon, and attitudes changed towards, the plight of unmarried mothers and their newborn, first with the introduction of the Infant Life Protection Act, 1872, and then with the alterations in the bastardy laws in 1872 and 1874, which undoubtedly prompted the hospital's own medical staff to call for the abolition of the hospital's marriage clause in April 1878, the first body of opinion at the hospital to do so.⁶⁷ Even though they secured the support of the local press and more importantly, the Gentlemen's Committee, who approved the motion for abolishing the marriage clause at the annual group meeting in February 1880, the ban upon single women remained in force. This was due to the Ladies' Committee who argued that subscribers 'might think they were encouraging what they would not desire to countenance'.⁶⁸ Though not expanded on, the point was made clear, that they, the female sponsors, were the charity's major subscribing force as well as its most active body of supporters and so their views, on issues where passions ran high, had to be respected. Given the risk of

offending the female supporters, there was no question of negotiating this point; they were too important a source of revenue for that.

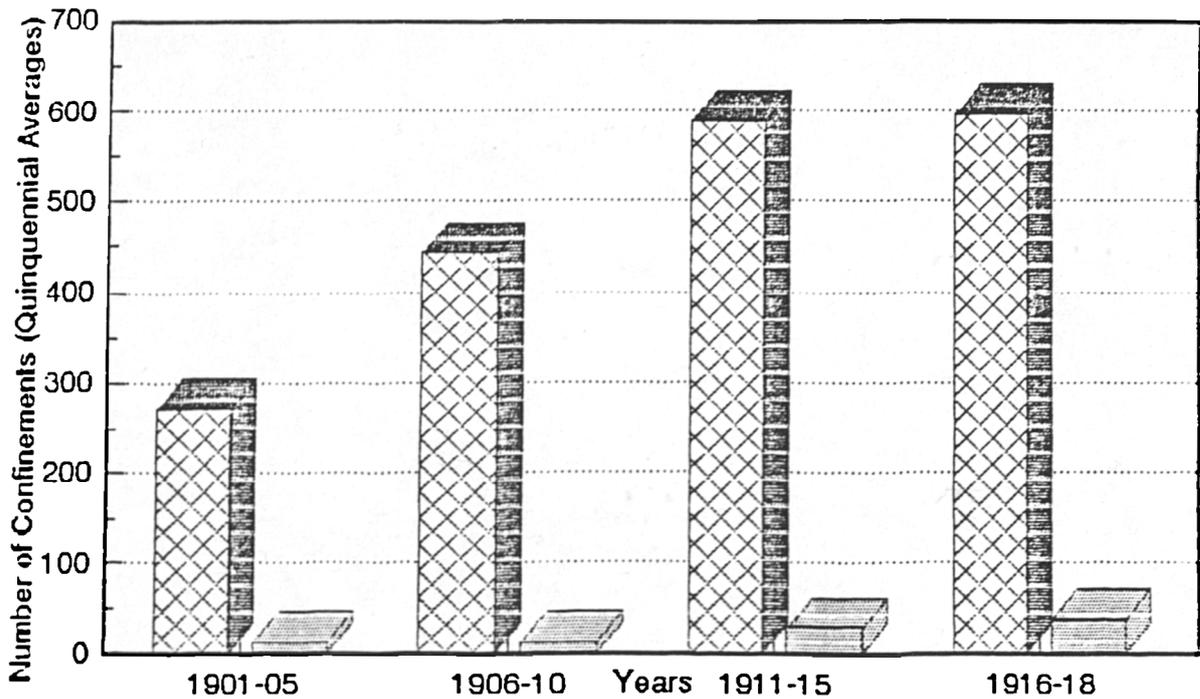
It was not until twenty years after the Medical Board first raised the issue, and then only following a nineteen-month debate, that it was finally agreed to accept single women, but only on the strictest terms as devised and implemented by the Ladies' Committee. At a special meeting of subscribers held in December 1898, it was agreed (by 43 votes to 31) to accept Mrs Tate's resolution:

That single women in exceptional circumstances, who after careful investigation by the Ladies' Committee are found to be deserving objects of charity, shall be eligible for admission into the hospital for their first confinement.

Clearly the prerogative remained with the Ladies' Committee, who had conceded very little. Admission of single women had been restricted to the 'otherwise respectable, such as the domestic servant and the shop assistant', as opposed to 'women of the pavement ...women purely of the profligate class and such women as were familiar to the rescue homes and the night missions'.⁶⁹ Even with such criteria, it was the Ladies' Committee who ultimately decided who was, and who was not, suitable for a hospitalized delivery.

Owing to such criteria and the inquisitorial nature of some of the enquiries, which prompted criticism from the local press and the hospital's own medical staff, the number of single women confined in any one year remained

**FIGURE 4.12: 'FALLEN WOMEN' ADMISSIONS
LIVERPOOL LYING-IN HOSPITAL 1901\5-1916\18**

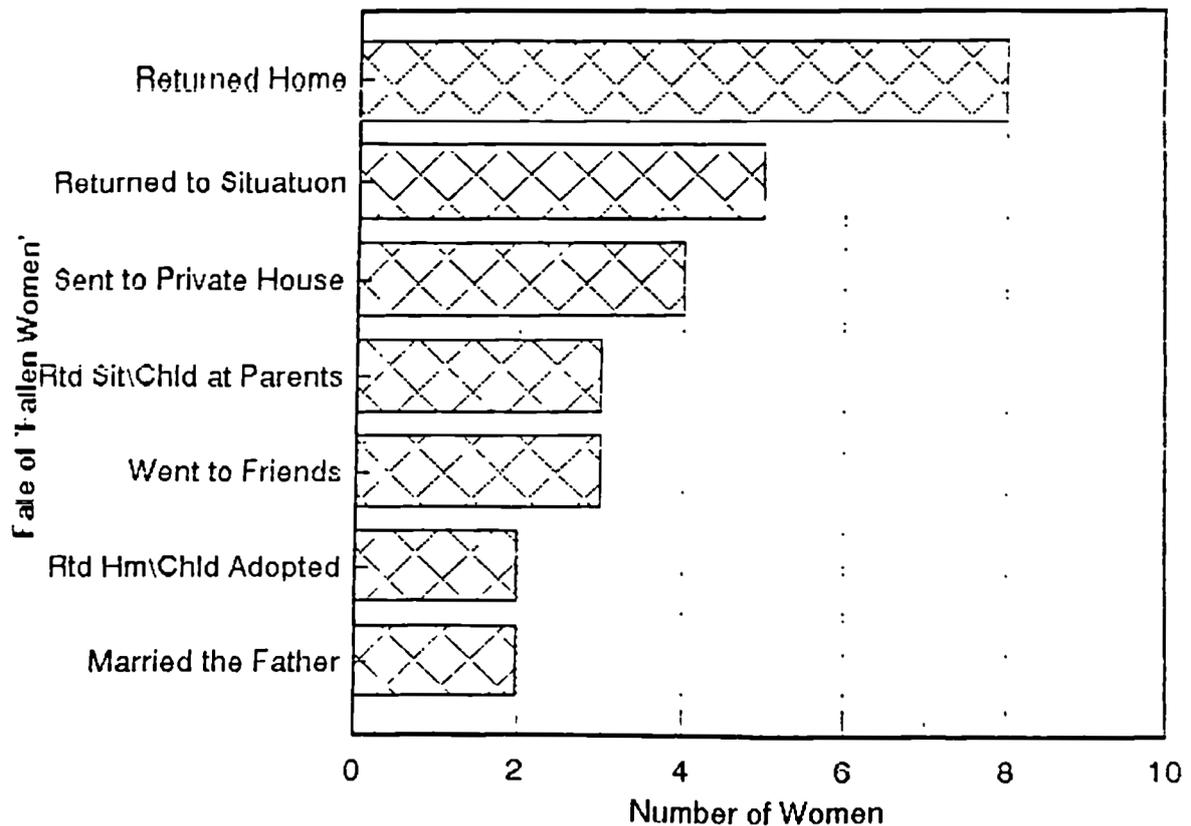


Sources: Liverpool Lying-in Hospital Annual Reports 1901-1918

Average No. of Women Confined
 Average No. of 'Fallen Women' Confined

FIGURE 4.13: FATE OF 'FALLEN WOMEN'

LIVERPOOL LYING-IN HOSPITAL JANUARY 1899 - MAY 1901



Source: Liverpool Lying-in Hospital Board Minutes 14 May 1901

relatively low (Figure 4.12).⁷⁰ During the first decade that single women were admitted no more than 18 were delivered in hospital in any one year, which accounted for only 4 per cent of the total number of admissions.⁷¹ The fact that single women were not allowed to be delivered in their familial home, which appears to have been their most important source of support, bears testimony to the discriminatory practices that took place and the importance of the institution 'not so much [for] special medical treatment of any kind, as kindly Christian influence, not only during their time of sickness, but in their after-life' (Figure 4.13).⁷² Consequently, single women were physically separated from those who were married, and placed in single wards, visited only by their case worker and other members of the Single-Girls Sub-Committee (Appendix 1).⁷³ The intention was to provide an alternative to the workhouse, to save single women from 'the detrimental and humiliating associations which may be encountered in that umbrageous institution'.⁷⁴ Yet the maternity hospital, at the Ladies' Committee's instigation, would appear to have been just as punitive and discriminatory in its methods as any Poor Law Institution.

The Medical Board's personal campaign, first for the admission of single women, then, from 1902, for their acceptance 'upon the same footing as married women', which was constantly thwarted by members of the Ladies' Committee 'the dragons of virtue and propriety', changes some fundamental perceptions about these two groups.⁷⁵

Whilst the cynic may argue that single women, because of their predicament, would have been more deferential towards, and indebted to their hosts, than many married women, and therefore less likely to protest at being used for classroom instruction or for medical research, hospital doctors expressed concern for the plight of single women long before research and tuition became significant issues. Even when students were eventually allowed in the wards, a year or so after the acceptance of single women, they could only attend single women when they were under anaesthesia.⁷⁶ There appears to have been no obvious gains made from campaigning on behalf of single women or to objecting against the Ladies' Committee's proposals to dismiss the midwives when they did, except out of a genuine interest in, and concern for patient welfare. On the other hand, members of the Ladies' Committee are increasingly portrayed as the villains in this account, for utilising training resources to promote their own class interests and for adopting a hard attitude towards prospective mothers who did not aspire to their ideal of a highly pious, all-conforming, respectability. Raised in an atmosphere of 'pre-marital chastity and ignorance', however, and regarded as the 'guardian of the home and family' the Committee members, all of whom were married, were hardly encouraged to act otherwise, and though their approach was highly orthodox and their contribution to charity work sometimes negative, in the main, they acted out of good faith and with sincere conviction.⁷⁷

At the same time, the women's strong sense of morality and decorum could have worked to the patient's advantage, protecting their interests at a time when those admitted into the hospital were unable to exert any real influence over their treatment or the doctor who administered it.⁷⁸ Patients were dependent upon the hospital's weekly visitors, members of the Ladies' Committee who served on a monthly basis to represent them and investigate any allegations of misconduct on the part of the medical staff. Thus, in March 1878, for example, the hospital's house surgeon, Mr Kelly, was forced by the Board of Management to resign his post, following allegations by the Ladies' Committee of 'inattention' and 'frequent absence' from the hospital when many patients were seriously ill. Two months later, it transpired that Mr Kelly's predecessor had also been discharged for neglect and suspected intemperance.⁷⁹ The fact that they earned only £50 a year, the same as the hospital matron, and were bound by strict regulations and procedures which virtually accounted for their every movement, may well account for the house surgeon's sense of disillusionment and neglect of duty.

However, the Honorary Medical Staff were also found by the Ladies' Committee to be absent from their duties, failing, amongst other things, to attend to cases once they had admitted them into the hospital. At the recommendation of the Ladies' Committee, an attendance register was to be signed by members of the Honorary Medical Staff who visited the hospital and it was further

requested that the doctor with the fewest cases attend those patients who had been neglected. This still did not deter, however, an Honorary District Medical Officer from neglecting his duties and being forced, on evidence submitted by both the Ladies' Committee and the Medical Board, to resign his post.⁸⁰ It was the Ladies' Committee's diligence that brought such cases to light and the Management Board's fear of a public scandal and subsequent loss of revenue that ensured a positive response.⁸¹

As the hospital ran into financial difficulties and maternity hospitals came under public criticism, so the Ladies' Committee found itself increasingly defending the integrity of the charity against propositions, by the Management and the Medical Boards, which threatened some of the most fundamental precepts governing the work of the maternity hospital and ultimately, the very hospital itself. Thus, when the two charities first merged in 1869, the medical staff immediately demanded that the Ladies' Committee withdraw its provision of free vaccination to all newborn, claiming this was doing a disservice to the public. Nothing, however, came of the objection, and the Committee's gratuitous offer remained and indeed, was keenly promoted, prohibiting any recipient of maternity relief from receiving assistance a second time if their first child had not already been vaccinated.⁸² In March 1880, when the suggestion was made, not for the first time, that a fee-paying maternity ward should be opened to offset falling income, the

Ladies' Committee objected. The Committee argued that it would not be consistent with the objects of the Charity to furnish a ward for the reception of a respectable class of labour cases who were willing to pay; the matter was taken no further.⁸³ The following month, the Medical Board's proposal that the 2s 6d given to district maternity cases should be stopped, and the £250 to £300 saved, be used to finance the gynaecology wards, was similarly noted, but taken no further.⁸⁴ To have actually charged women for their confinement or have deprived them of maternity relief, would, as Roy Porter concluded, 'instantly have thrown the delicate boundaries between donor and donee in to utter confusion, sullied grace with commerce and destroyed the ritual of the gift relation upon which the whole superstructure depended'.⁸⁵ Perhaps the female contingent at the hospital anticipated this, if the men did not, or were simply not prepared to see the practices they had developed under the Ladies' Charity so easily erased once they had amalgamated with the hospital. Whatever the reason, the women's ability to argue their own case was clearly proven.

The Crisis of 1882: Male v. Female Ideology

Nowhere were gender differences more apparent than in the women's stand against proposals by the Board of Management to turn the lying-in hospital into an institution solely for the treatment of female disorders

and to restrict the maternity services to home confinements. The hospital had for some time been developing its gynaecology services, initially running a special ward for ovariectomy cases and a dispensary for female and childhood diseases, and after amalgamation, it allotted half of the hospital's ward capacity to gynaecology cases and developed the department so quickly that the number of gynaecology cases soon exceeded maternity admissions (Figure 4.5).⁸⁶ In an age where gynaecology was pioneered by such distinguished figures as Charles Clay and Lawson Tait, where significant surgical advances, such as the successful performance of ovariectomies and the removal of fallopian tubes, were perfected, and where women's hospitals were founded in all the major provincial cities, it seemed inevitable that gynaecology would become an important feature of Liverpool's specialist medical services.⁸⁷ It seemed even more inevitable that it would prosper at the city's maternity hospital where gynaecology was becoming a much more important activity than maternity provision, its original objective. Contrary to claims by the Liberal Review that,

medical malcontents...that is, the medical staff and their families inside and outside the institution, wished...to reduce the Myrtle Street Lying-in Hospital to the level of a medical lecture room and operating theatre, for their personal and professional benefit

the initial idea to convert the premises into a gynaecology hospital came from the Management Board in August 1874.⁸⁸ The medical staff's initial reaction was

to resist the proposal, convinced, in the light of the work by Doctors Duncan and Churchill, two of the country's leading pro-maternity protagonists, that hospital mortality could be considerably reduced if only the 'sanitary arrangements' were perfected. As a result of their pleas, the Board of Management agreed to postpone the decision but requested that they receive monthly returns of the total number of deaths occurring in the district as well as the hospital.⁸⁹

The motion was tabled at a time when the viability of maternity hospitals, nationwide, was seriously questioned, and when the hospital itself had endured an outbreak of puerperal sepsis every year since its amalgamation, accounting for the lives of at least six women.⁹⁰ When the idea was again broached by a member of the Management Board in February 1881, to treat only gynaecology cases in the hospital wards, there had been a further series of sepsis outbreaks, accounting for four deaths in 1879 alone.⁹¹ There had also been an 'alarming presence' of childhood diseases including diarrhoea, which caused a substantial number of infant deaths in 1880 and prompted the eventual closure of the hospital in April 1881, until a permanent solution was found.⁹²

It was not that the hospital's professional staff had done nothing to arrest the problem, as the Liberal Review claimed, but what concerted and genuine efforts they did make to rid the hospital of infection and prevent closure, were mis-directed, ill-informed and not always adopted by the Management Board. As the medical

staff saw it, and indeed, the profession as a whole, the problem lay with inadequate sanitary facilities, overcrowding and poor ventilation.⁹³ Consequently, the medical staff concentrated their efforts on ensuring that hot and cold water taps were installed, that sewage pipes to channel waste away from the hospital were laid, that mattresses were regularly disinfected and the wards fumigated. In a ten-point programme of sanitary reform, submitted in March 1880, the Medical Staff also called for the introduction of ventilation systems, independent to each ward and a reduction in the number of beds to lessen overcrowding.⁹⁴

Though 'the point had sunk in at last that dirt and overcrowding bred disease', which resulted in pleasanter, cleaner and airier wards, it diverted attention from Lister's antiseptic methods introduced in the late 1860s which were the only real means of preventing puerperal sepsis.⁹⁵ For example, in December 1872, when the Medical Board received the house surgeon's report on the condition of the hospital, it concluded that the house surgeon 'was in error in ascribing the excessive mortality to puerperal diseases caused by the non-use of disinfectants'. If anything, the Medical Board argued, the problem lay with the house surgeon's all too frequent use of disinfectants and chemicals to fumigate the wards. It was not until 1879 that the Medical Staff expressed any interest in Lister's work and purchased a 'Lister Steam Spray', eight years after the original version had been introduced.⁹⁶ Yet even the Medical Staff's ten point

programme of reform, presented to the Management Board as a final attempt to solve the sepsis crisis, short of permanently closing the maternity wards, still made no reference to Lister's antiseptic methods.⁹⁷

Since the medical staff's ten point plan was never adopted by the Management Board, who themselves took the initiative in February 1881, and called for the hospital's conversion into an institution solely for female disorders, it is evident that whatever the medical staff said or did, was of little relevance; the Board, it seems, had already made a decision. As the Board of Management saw it, a body of 'clear-headed, shrewd businessmen', paying £6 8s 1d for a ward confinement that could prove fatal when they need only spend a fraction of the cost, 8s 10d, on delivering a woman in her own home and with far better results, simply did not make good economic sense.⁹⁸ In addition to which, there was little demand for a hospitalised birth. As early as 1872 it was openly admitted in the hospital's annual report (which always sought to appeal to sponsors rather than dissuade them) that there was difficulty in enticing women to be delivered in hospital, 'owing mainly to the disinclination of the patients themselves, the applicants for relief preferring to be treated at their own homes'.⁹⁹ One of the principal arguments against running a maternity hospital *per se*, was that 'it would be impossible to fill them [the maternity wards]' as 'it was generally admitted that patients had to be driven or coerced in, so great was their reluctance to enter the

Hospital'. In stark contrast, women were willing to pay up to £10 for treatment in the gynaecology wards, and even though the average fee was more like 10s, the fact that the hospital could appeal to a 'more respectable class' of female than those delivered in the hospital and raise revenue at the same time, made the idea of a woman's hospital all the more viable a proposition.¹⁰⁰

It was this response, by the Management Board, to market forces as opposed to social needs and its total disregard for the hospital's original objective, to provide hospital relief to maternity cases, that triggered an immediate and hostile reaction from the charity's female supporters. On the basis of a five-point questionnaire sent to all 16 members of the medical staff, of whom 11 responded, and of whom only seven considered it expedient to re-open the hospital for gynaecology cases only, the Board of Management resolved to propose at the next annual general meeting that the name of the Charity be altered to the 'Ladies' Charity and Hospital for Diseases of Women', and that maternity care be restricted to home confinements. Concerns, however, were raised at the annual meeting, held in mid-February 1882, by the non-subscribing husbands of four female subscribers, A. B. Forward, L. R. Baily, T. Cope and E. Banner, who questioned the constitutional legitimacy 'of devoting the hospital to purposes so foreign to the intention of the original founders and subscribers'.¹⁰¹ The meeting was adjourned and a special committee of enquiry, including A. B. Forward and

colleagues, was formed and, not surprisingly, supported the Ladies' Committee's view that a lying-in hospital was *sine qua non* if women were to be provided with an alternative to unsuitable home conditions and the workhouse. The Committee of Enquiry also found that if care were taken in the construction and sanitary arrangements of the hospital, mortality would be minimized; no mention, however, was made of Lister's work. Citing Liverpool Workhouse, where maternal mortality was only 3.2 per 1,000 births (1876-81), as a case example, at the re-adjourned meeting in late March 1882, it was resolved by 23 votes to 13, that as gynaecology and maternity cases were not compatible, requiring quite separate and distinct abodes, and as gynaecology was intended to be incidental to the hospital's original objective of providing maternity care, that a new hospital, purely for the reception of maternity cases, should be built.¹⁰²

As a result of this complete reversal of affairs, which began with the intention of abolishing the maternity hospital and concentrating solely on the admission of gynaecology cases, but ended with the permanent closure of the dispensary, as well as the gynaecology wards, and the opening of a new maternity hospital, all 13 members of the Management Board resigned their posts. Such an act is a powerful indication of just how important the idea of establishing a women's hospital was to the lay Board. Though two of the hospital's honorary medical officers, Richmond Leigh and

J. E. Burton, wrote independently to the Lancet, critical of that journal's support for the decision to maintain a lying-in hospital, the medical staff did not resign their posts.¹⁰³

The fact that both these all-male groups, over this and such other major issues as the admission of single women and the introduction of fee-paying maternity wards, were defeated by a contingent of females, surely attests to everything that Vicinus claims the Victorian female philanthropist was not; committed, assiduous, self-assertive and above all else, highly influential.¹⁰⁴ This was very much the case in 1882 when the women had not only secured a permanent future for the maternity hospital, which was rebuilt and opened three years on, but also selected, as core members of the new Board of Management, A. B. Forward and the three other husbands of female subscribers who had led the pro-maternity hospital campaign.¹⁰⁵ These were men who had no previous connection with the hospital except through their wives, and therefore had been selected by the women to express their viewpoint and act as their representatives within male debating circles; there is no reason to believe that this practice did not continue when the four men became key members of the Management Board.

In the absence of the Board of Management minutes, 1883-1895, it is difficult to assess in what way the Ladies' Committee consolidated and utilized their new source of power. Clearly, however, from the Medical Board minutes it is evident that the women, now with the

Board of Management's full support, went ahead with the building of a new maternity hospital, despite 'strong and unanimous' opposition from the medical staff, whose opinion on the matter seemed immaterial. Similarly, with regard to the instruction and subsequent employment of midwives, the women's views became increasingly more important than those of the medical staff. It was the Ladies' Committee, for example, who addressed the difficulties pupil midwives were encountering in their practical instruction, firstly by calling for a reduction in the number of births each pupil personally delivered, from 20, to a more realistic figure of 15, and secondly, by requiring all pupils to be instructed in the theory of natural labour before they began their practical work. The Medical Board accepted these arguments. However, when the Board called for the appointment of two midwives with equal authority in each district, as opposed to one midwife and an assistant, perhaps with a view to increasing the number of midwives capable of instructing students, the Ladies' Committee thwarted the idea. Also, in cases of complaint against a midwife, which were in the 1870s heard by the Medical Board, the Ladies' Committee had, by the 1880s, taken full responsibility, and decided for themselves the validity of any complaint lodged by a doctor against a midwife.¹⁰⁶ The degree of control exercised over the midwife was a particular bone of contention in the lay-medical dispute of 1896, when the Ladies' Committee was accused of totally disregarding the allegations and evidence presented by hospital

medical officers against midwives. Indeed, as it will become evident in Chapter 6, the extent of women's influence generally, even down to the expression of opinion, or so the medical staff claimed, 'on the pattern of an instrument selected by the staff...', was a major reason for the sudden and adverse reaction by the medical staff that year and the suppression of lay control thereafter, which had, to all intents and purposes, been female led.¹⁰⁷

Notes to Chapter 4

1. Margaret Versluysen, 'Midwives, Medical Men and Poor Women Labouring of Child in Eighteenth Century London', in *Women, Health and Reproduction*, ed. by Helen Roberts (London, 1981), pp.18-49 (p.21).
2. For an account of the traditional bipartite system of hospital management see, Brian Abel-Smith, *The Hospitals 1800-1945* (London, 1984), p.35.
3. Lindsay Granshaw, 'Fame and Fortune by means of Bricks and Mortar: The Medical Profession and Specialist Hospitals in Britain 1800-1948', in *The Hospital in History*, ed. by Roy Porter and Lindsay Granshaw (London, 1989), pp.199-220 (p.201).
Olive Checkland, *Philanthropy in Victorian Scotland* (Edinburgh, 1980), p.325, Versluysen, p.38.
4. Checkland, p.325.
5. Versluysen, pp.18-49.
6. See for example: J. A. Banks and Olive Banks, *Feminism and Family Planning in Victorian England* (New York, 1964), pp.51, 66-67; Harold Perkin, *Origins of Modern English Society*, rev. ed. (London, 1985), p.159; Martha Vicinus, *Independent Women: Work and Community for Single Women 1859-1900* (London, 1985), p.22; Angela Holdsworth, *Out of the Dolls House: The Story of Women in the Twentieth Century* (London, 1988), p.16.
7. So popular was the Dispensary for Childhood and Women's Diseases that women were issued with numbered tickets to ensure a quicker, fairer service. Liverpool City Record Office (hereafter as LCRO), 614 MAT 1/1, Board of Management Minutes, 11 January 1877.
8. The maternity hospitals lost a lot of public support in the early 1870s following J. Y. Simpson's onslaught on the hospital system in 1869, which 'caused, it was said, an immediate and serious falling off in the charitable donations upon which that system almost entirely depended'. A. J. Youngson, *The Scientific Revolution in Victorian Medicine* (London, 1979), p.168. LCRO, 614 MAT 9/3, Annual Reports, 1897, 1900.
9. 'Lying-in hospitals were not a popular charity'; the Edinburgh Royal Maternity Hospital, a prestigious institution with a distinguished panel of staff similarly found it difficult to raise

subscriptions during this period, Checkland, pp.185, 325.

10. LCRO, 614 MAT 9/2, Annual Report, 1884.
11. As long as the subscription was not 12 or more months in arrears, half guinea subscribers were entitled to recommend one in-patient and four out-patients and in proportion to each half guinea subscribed thereafter. LCRO, 614 MAT 9/1, Annual report, 1869.
12. LCRO, 614 MAT 9/1, Annual Report, 1869.
13. LCRO, 614 MAT 10/1, Newscuttings, Ladies Charity and Lying-in Hospital, Daily Post, 24 June 1896.
14. LCRO, 614 MAT 1/1, Board of Management Minutes, 18 February 1870.
15. LCRO, 614 MAT 2/2, Medical Board Minutes, 5 August 1897.
16. Annual Report of the Health of the City of Liverpool, 1906, p.108.
17. LCRO, 614 MAT 2/1, Medical Board Minutes, 29 January 1870; 1 October 1874 614, MAT 2/2, Medical Board Minutes, 27 October 1886.
18. LCRO, 614 MAT 2/1, Medical Board Minutes, 19 November 1869; 23 February 1875, 614 MAT 2/2, Medical Board Minutes, 29 April 1872; 1 July 1884.
19. LCRO, 614 MAT 9/1, Annual Report, 1889.
20. Pat Jalland, *Women, Marriage and Politics 1860-1914* (London, 1986), p.7. Juila Parker, *Women and Welfare: Ten Victorian Women in Public Society and Service* (Basingstoke, 1989), pp.20-29.
21. Parker, p.29. LCRO, 614 MAT 9/1, Annual Report 1869.
22. LCRO, 614 MAT 9/1, Annual Report 1869, LCRO, 614 MAT 1/2, Board of Management Minutes, 21 April 1903.
23. *Suffer and Be Still, Women In The Victorian Age*, ed. by Martha Vicinus (Indiana, 1972), p.xi. Vicinus, *Independent Women*, p.22. Leonore Davidoff, *The Best Circles, Society Etiquette and the Season* (London, 1973), p.54. Margaret Simey, *Charitable Effort in Liverpool in the Nineteenth Century* (Liverpool, 1951), p.63. J. Donnison, *Midwives and Medical Men* (London, 1977), p.119. R. E. Walton, *Women in Social Work* (London, 1975), p.14.
24. LCRO, 614 MAT 1/1, Board of Management Minutes, 19 October 1869; 10 April 1877; 14 November 1878,

- LCRO, 614 MAT 1/2, Board of Management Minutes, 14 July 1896; 8, 28 November 1898.
25. LCRO, 614 MAT 2/1, Medical Board Minutes, 20 May 1876.
 26. LCRO, 614 MAT 2/2, Medical Board Minutes, 18 April 1879.
 27. Of the 13 members of the Gentleman's Committee, three had wives serving on the Ladies Committee in 1870, LCRO, 614 MAT 9/1, Annual Report, 1870.
 28. LCRO, 614 MAT 10/1, Newscuttings, Subscribers' Meeting, *Daily Post*, 31 December 1898.
 29. One such fund raising event was a Bazaar at St. George's Hall (1885) to raise funds for the building of the new hospital, which raised £1,615 over three days. LCRO, 614 MAT 9/2, Annual Reports, 1885, 1891, 1893. LCRO, 614 MAT 1/2, Board of Management Minutes, 8 January 1901.
 30. Thomas Bickerton, *A Medical History of Liverpool from the Earliest Days to the Year 1920* (London, 1936), p.214.
 31. LCRO, 614 MAT 9/1, Annual Report, 1869.
 32. The Chairman of St. Mary's Hospital Board, Manchester, Duncan Matthews was representative of many, when after a visit to the all-female-managed 'New Hospital For Women', Euston Road, London (1892), he still spoke of women's contribution to hospital management in terms of 'the refining instincts of women. The vases of flowers...the engravings and plaster casts...the artistic and simple furniture...' St. Mary's, Manchester, Annual Report, 1892.
 33. Donnison, p.24.
 34. LCRO, 614 MAT 2/1, Medical Board Minutes, 27 December 1869; 26 October 1875.
 35. Donnison, pp.72-73.
 36. F. K. Prochaska, *Women and Philanthropy in Nineteenth Century England* (Oxford, 1980), p.6. Jalland, p.7. Simey, pp.21, 65.
 37. A trained midwife in private practice, as was seen in Manchester (Chapter 3), earned between 7s 6d and 10s 6d depending on whether it was a primipara or multipara birth. Attending between 150 and 200 deliveries a year midwives earned between £60 and £100 per annum. LCRO, 942 BIC 9M, Thomas H. Bickerton's Collections Towards a Medical History

of Liverpool, volume M, evidence by Mrs Massey, former pupil midwife at the Liverpool Lying-in Hospital (1888), interview conducted March 1934, p.275.

38. LCRO, 614 MAT 2/1, Medical Board Minutes, 26 October 1875. 614 MAT 1/1, Board of Management Minutes, 13 March 1879; 14 November, 12 December 1899.
39. Donnison, pp.72-76.
40. See Chapter 6.
41. For accounts of wet-nursing, see: Valerie Fields, *Wet Nursing: A History from Antiquity to the Present* (Oxford, 1988), pp.193-96; Patricia Branca, *Women in Europe Since 1750* (London, 1973), p.121; Guthorne-Hardy, *The Rise and Fall of the British Nanny* (London, 1972), pp.36-47; Theresa McBride, 'As the Twig is Bent: The Victorian Nanny', in *The Victorian Family Structure and Stresses*, ed. Anthony Wohl (London, 1978), pp.44-58 (pp.46-47).
42. LCRO, 614 MAT 9/1, Annual Reports, 1869, 1871-5.
43. For the historical significance of breast disorders and breast feeding problems, see Valerie Fildes, *Breasts, Bottles and Babies* (Edinburgh, 1986), pp.139-43. Deborah Dwark, 'Victorian Child: Lay Medical Manuals', *Maternal and Child Health*, (1983), p.212.
44. 'It is interesting that strong opposition to the 1872 Act came from members of the National Society for Women's Suffrage, who thought its provisions "would be costly and tyrannical in the case of poor women who take charge of infants for hire without sinister motives"'. Ann Oakley, 'Wise Women and Medicine Men: Changes in the Management of Childbirth' in *The Rights and Wrongs of Women*, ed. by Juliet Mitchell and Ann Oakley (Middlesex, 1976), pp.17-58 (p.44). For a fictitious but powerful indictment of the wet-nursing system see: George Moore, *Esther Waters*, a fascimile of the first edition, 1894 (Chicago, 1977), Chapter 17;. Elizabeth Lomax, 'Out Casts from Society: The Tribulations of the Nineteenth Century Unmarried Mother and her Newborn Baby', *Maternal and Child Health*, (1985) p.138-42 (p.140); Anthony Wohl, *Endangered Lives* (London, 1983), pp.28-30.
45. LCRO, 614 MAT 9/1, Annual Report 1872. 614 MAT 2/2, Medical Board Minutes, 22 February 1882.
46. Clients were increasingly particular about the women they employed as wet nurses, demanding they were of a high moral character, 'free from any sign or

- suspicion, of syphilis, scrofula or tuberculosis', with 'well-developed breasts, not too fat', a healthy complexion, good teeth, sweet smelling breath and prefably brunette hair; blondes and red heads were believed to produce inferior milk. A. L. Galabin, *A Manual of Midwifery*, 5th edn. (London, 1900), p.286. *Vitalogy: An Encyclopedia of Health and Home*, ed. by E. H. Ruddock (Chicago, 1930), p.391.
47. Fields, *Wet Nursing*, p.203. Branca, p.121. Gathorne-Hardy, p.208.
 48. Dwork, p.208.
 49. LCRO, 614 MAT Annual Reports, 1886, 1894-95. 614 MAT 9/3, Annual Report, 1901.
 50. LCRO, 614 MAT 9/1, Annual Report, 1869.
 51. Prochaska, p.110.
 52. LCRO, 614 MAT 1/1, Board of Management Minutes, 3 March 1870.
 53. Brian Harrison, 'Philanthropy and The Victorians', *Victorian Studies*, 9 (1966), 353-74 (pp.372-3). Simey, pp.62, 65. Prochaska, pp.121, 124. Jalland, p.7.
 54. Prochaska, pp.112, 125. Concerning issues of philanthropy and class see: Ann Summers 'A Home from Home: Women's Philanthropic Work in the Nineteenth Century', in *Fit Work for Women*, ed. by Sandra Burman (London, 1979), pp.33-63 (pp.3-38); Kathleen Woodroffe, *From Charity to Social Welfare in England and The United States* (London, 1962), pp.12, 22-23; Roy Porter, 'The Gift Relation, Philanthropy and Provincial Hospitals in Eighteenth Century England', in Porter and Granshaw, pp.149-178 (p.152).
 55. *Liverpool Medical-Chirurgical Journal*, 1857, p.157.
 56. The loan of a bed is significant because a hospital midwife would not attend a woman unless she had a beadstead. LCRO, 942 BIC 9M, Bickerton's Collection, evidence by Mrs Massey and Mrs Ferns (Hospital Midwife in the 1880s) in March 1934, pp.275-77. LCRO, H331 8 CEW, *The Poor of Liverpool: A Collection of Pamphlets*, William Grisewood, *The Poor of Liverpool and What is Done for Them*, 1899.
 57. LCRO, 614 H361 8 CEW, *Liverpool Central Relief and Charity Organisation Society Annual Reports, 1873-74, 1874-5*.

58. *Liverpool Lantern*, 4 January, p.204, 11 January, p.211, 18 January, p.227, 25 January, p.244, 1 February, p.259, 1879. See also *Liverpool Review*, 9 May 1885, p.4.
59. For a review of Liverpool's chaotic state of Charity affairs, see *The Liverpool Critic*, 10 March, p.147, 17 March, p.163, 24 March, p.180, 31 March, p.205, 1877. R. Porter, p.177.
60. LCRO, 614 MAT 9/1, Annual Reports, 1871-80. 614 MAT 1/1, Board of Management Minutes, 19 February, 14 March 1878.
61. *Liverpool Lantern*, 18 January 1879, p.227.
62. Simey, pp.95-96.
63. Complaints were lodged against the Relief Society Visitors, but only rarely were the instances recorded in the minutes and the nature of the complaint was never explained, LCRO, 614 MAT 1/3, Board of Management Minutes, 10, 13 September 1912; 12 March 1913. Simey, p.96. *Liverpool Review*, 16 April 1887, p.11.
64. LCRO, 614 MAT 1/1, Board of Management Minutes, 13 August, 10 September, 1874. LCRO, H361 8 CEW, *Liverpool Central Relief Society and Charity Organisation Annual Reports*, 1873-74, 1876-77. *Liverpool Lantern*, 4 January 1879, p.64.
65. LCRO, 614 MAT 9/1, Annual Report, 1883, 614 MAT 9/6, Annual Report, 1923.
66. LCRO, 614 MAT 1/1, Board of Management Minutes, 18 September 1871.
67. E. Lomax, pp.40-41. LCRO, 614 MAT 2/2, Medical Board Minutes, 5 April 1878.
68. *Liberal Review*, 22 April 1882, p.9. *Liverpool Review*, 6 January 1883, p.10. LCRO, 614 MAT 1/1, Board of Management Minutes, 15 March 1880.
69. LCRO, 614 MAT 1/2, Board of Management Minutes, 8 June, 13 July, 10 August, 5 November 1897; 8 February, 8 March, 5 April, 12 July, 29, 30 December 1898.
70. See for example, LCRO, 614 MAT 10/1, Newscuttings, *Daily Post*, 5 January 1899, LCRO, 614 MAT 2/2, Medical Board Minutes, 7 December 1902; 6 January 1903.
71. LCRO, 614 MAT 9/4, Annual Reports, 1898-1908.

72. An opinion held by Mrs Tate who proposed the resolution to accept single women, LCRO, 614 MAT 10/1, *Liverpool Courier*, 31 December 1898.
73. 'When it is known that at the hospital the two classes of patient are in no greater danger of being mixed than if they were in different houses, it is not likely that the poor married women will object to the presence of unfortunate sisters somewhere in the same range of buildings', LCRO, 614 MAT 10/1, *Newscuttings, Liverpool Courier*, 31 December 1898. LCRO, 614 MAT 1/3, Board of Management Minutes, Rules for Single Women, 1912. See Appendix 1.
74. LCRO, 614 MAT 10/1, *Newscuttings, Daily Post*, 4 January 1899; *Liverpool Courier*, 31 December 1898.
75. It was not until September 1919 that single women could be delivered in their own homes and not until the following year that single women were accepted 'upon the same footing as married women'. LCRO, 614 MAT 2/2, Medical Board Minutes, 7 December 1902. 614 MAT 1/4, Board of Management Minutes, 10 September 1919; 10 March 1920, MAT 614 10/1, *Newscuttings, Daily Post*, 5 January 1899.
76. LCRO, 614 MAT 1/2, Board of Management Minutes, 12 February 1907.
77. Jalland, p.30. Banks, p.108. Vicinus, p.xiv.
78. It was not until the 1920s that patients began to employ solicitors and sue the hospital for undue neglect and attention. A 'poor man's lawyer', for example, took the case of 'Mrs X's baby' and though the Board 'denied any liability on the matter', they did offer 'without prejudice a sum of £5 towards out of pocket expenses'. Four years later (1925) and another out of court settlement was made for £30 to a woman on whom an operation had been wrongly performed, LCRO, 614 MAT 1/4, Board of Management Minutes, 12 April, 12 May, 14 June, 11 October 1921; 14 October, 4, 9 December 1924, 13 January, 10 March 1925.
79. LCRO, 614 MAT 1/1, Board of Management Minutes, 14 March, 11 April 1872; 9 May 1878.
80. LCRO, 614 MAT 1/1, Board of Management Minutes, 14 November 1878; 28 December 1880.
81. William B. Howie, 'Complaints and Complaint Procedures, in the Eighteenth and Nineteenth Century Provincial Hospitals in England', *Medical History*, 25 (1981), 345-62.

82. LCRO, 614 MAT 2/1, Board of Management Minutes, 7 December 1869, 614 MAT 9/1, Annual Report 1869.
83. LCRO, 614 MAT 1/1, Board of Management Minutes, 12 June 1877; 13 March 1880.
84. LCRO, 614 MAT 2/2, Medical Board Minutes, 13 April 1880.
85. Porter, p.168.
86. LCRO, 614 MAT 2/1, Medical Board Minutes, 31 May 1870.
87. Gynaecology facilities were made available in Leeds (1853), Manchester (1856, 1866), Sheffield (1864), Newcastle (1866), Birmingham (1871) and Nottingham (1875), either in conjunction with maternity and children's hospitals as in Manchester, Leeds and Sheffield, or as separate hospitals, as in Birmingham and Nottingham. *Burdett's Hospitals and Charities Annual Year Book*, 1894. V. B. Green-Armytage, 'The Rise of Gynaecology 1800-1950', in *Historical Review of British Obstetrics and Gynaecology 1800-1950*, ed. by J. M. Kerr (London, 1954), pp.357-369.
88. *Liberal Review*, 1 April, p.9, 8 April p.9, 1882. LCRO, 614 MAT 1/1, Board of Management Minutes, 13 August 1874.
89. See Chapter 1. LCRO, 614 MAT 2/1, Medical Board Minutes, 25 August 1874. 614 MAT 1/1, Board of Management Minutes, 10 September 1874.
90. LCRO, 614 MAT 9/1, Annual Report, 1869. LCRO, 614 MAT 2/1, Medical Board Minutes, 17 February 1871; 31 December 1872; 20 August 1873; 24 February 1874.
91. LCRO, 614 MAT 1/1, Board of Management Minutes, 11 December 1879; 14 February 1882.
92. LCRO, 614 MAT 1/1, Board of Management Minutes, 31 August 1880. 614 MAT 2/2, Medical Board Minutes, 6 October 1880, 23 March 1881.
93. Youngson, Chapter 5.
94. LCRO, 614 MAT 2/1, Medical Board Minutes, 17 February; 12 April 1871; 20 August, 10 September, 1874. 614 MAT 2/2, Medical Board Minutes, 16 March 1880.
95. Youngson, pp.185-86.

96. LCRO, 614 MAT 2/1, Medical Board Minutes, 31 December, 1872. 614 MAT 2/2, Medical board Minutes, 8 April 1879.
97. LCRO, 614 MAT 2/2, Medical Board Minutes, 16 March 1880.
98. LCRO, 614 MAT 1/1, Board of Management Minutes, 14 February 1882.
99. LCRO, 614 MAT 9/1, Annual Report, 1872.
100. LCRO, 614 MAT 1/1, Board of Management minutes, 27 January 1874; 10 April 1877; 4 November 1878; 4 April 1881. 614 MAT 9/1, Annual Report, 1874.
101. The wives of these non-subscribers were respecting nineteenth century conventions that women refrained from public speaking. Prochaska, p.37. LCRO, 614 MAT 1/ Board of Management Minutes, 10, 29 August, 24 September, 9 november, 1881; 17 January, 14 February, 1882.
102. LCRO, 614 MAT 1/1, Board of Management Minutes, 16, 27 March 1882.
103. Leading Article, *Lancet*, 29 April 1882, p.697. Richmind Leigh, 'Lying-in Hospital v Hospital For Women', 13 May 1882, p.811. J. E. Burton, 'Maternity Charities', 3 June 1882, p.937.
104. Vicinus, *Suffer and Be Still*, p.xi; idem, *Independent Women*, 1985, p.22.
105. LCRO, 614 MAT 1/1, Board of Management Minutes, 27 March 1887.
106. LCRO, 614 MAT 2/2, Medical Board Minutes, 19 February 1883; 3 December 1886; 26 January, 30 March 1887; 28 February 1888.
107. *Lancet*, 30 May 1896, p.1509. LCRO, 614 MAT 10/1, Newscuttings, Medical Staff Circular to Subscribers, May 1896.

Chapter Five

'One of Those Delightful Old Charities ...'

Comparative Studies of Provincial Maternity Hospitals

1860-1900

Key Issues Reconsidered:

One of the major difficulties with adopting a case study approach is that no matter how significant the findings, their representativeness is often brought into question. This chapter aims to overcome these difficulties by introducing new material from maternity hospitals other than those of Liverpool and Manchester located in Birmingham, Newcastle and Sheffield. The purpose will be two-fold: firstly to expand upon views already discussed, with regard, for example, to the importance of women not only to the running of the hospitals but to the patients themselves, as sponsors, relief agents, welfare officers and midwives. Secondly, to provide new aspects to the study of Victorian maternity hospital provision, such as highlighting the extensive use of students by one particular maternity hospital to deliver women and its consequences, and the manipulative and controlled use of midwifery instruction by another, depriving its host community of competent midwifery for all sections of the population. Rather than contradicting the findings to date, this new evidence places them in perspective and serves only to enhance the significance of the Manchester and Liverpool maternity hospitals to their respective communities.

A Lay or Medical Affair? The Composition of the Board of Management

One of the first aspects to be discussed, with special reference to the Jessop, a hospital for maternity and gynaecology cases in Sheffield, is the force behind its foundation and the way this influenced its subsequent management. True to character, this specialist hospital was founded by medical men: Doctors James Aveling and William Jackson, both of whom lectured on midwifery at the city's medical school and had written several specialist papers on the subject. Aveling, the principal founder of the hospital, had come to South Yorkshire highly recommended by the obstetrician, James Simpson, and when the Jessop opened, he was an Honorary Member of the Dublin and Edinburgh Obstetrical Societies, as well as a Fellow and Branch Secretary of the London Obstetrical Society; these were individuals who were far from unknown quantities in their specialist field.¹

Though Aveling and Jackson dominated inaugural proceedings, determined the Charity's objectives and even drafted the rules and regulations governing the work of the hospital, theoretically the management of the Jessop, as at Birmingham's Lying-in Hospital, was a lay affair, conducted by a Board of twelve male Governors and ten Ex-Officio Members, annually elected by subscribers who donated one guinea or more each year to the hospital coffers.² The reason for the lay involvement, many of

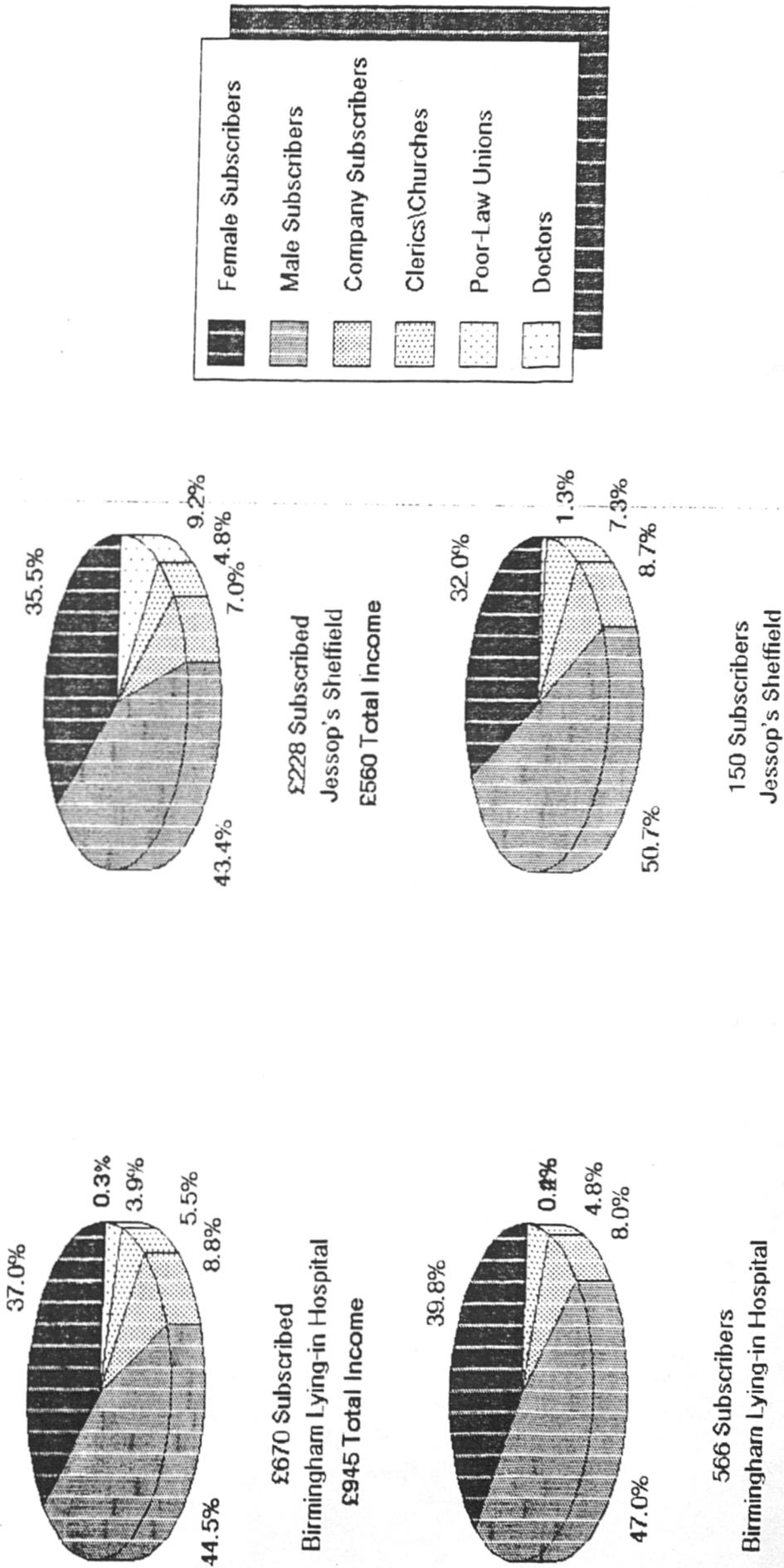
**TABLE 6.1: JESSOP'S GOVERNING BODY DURING
ITS FOUNDING YEAR 1864**

	Marital Status	No. Of Childr.	Occupation	Public Offices Held	Other Voluntary Interests	Wife
President T Jessop	M		Manufacturer	Councillor	General	Involved Subscriber
Vice-Presidents:						
Albarran Vickers	M	11	Scholar	Councillor(Guardian)		Ld's Cttee Pres.
Rev. Wilkinson						
Trustees: B. Wake						
M Ellison			Scholar		Public Hospital	
Treasurer W Dixon JP	M		Manufacturer	Councillor	General	Ld's Cttee Ld's Cttee
Secretary Dr Aveling	M		Doctor			
Board of Governors:						
Rev. Sale			Anglican Cleric		General Infirmary	
E. Vickers JP	M					Ld's Cttee
R. Leader	M		Newspaper Owner	Town Trustee		Ld's Cttee
G. Hounsfield JP	M		Banker			Subscriber
T. Rodgers JP						
W. Butcher JP			Manufacturer	Town Trustee	General	Subscriber
Albarran Hoole	M					
Albarran Bradley						
Albarran Saunders			Shop Proprietor	Councillor(Guardian)		
W. Watson						
D. Doncaster						
H. Newbold						

Source: Jessop Annual Report 1864, Newspaper Obituaries & Local Trades Directory

whom were 'household names', with an acumen for business and philanthropic works, was that they were essential to the 'economy of the Institution' both as fund raisers and financial managers. Thomas Jessop, the hospital's first President and namesake, for example, was regarded as 'one of Sheffield's most energetic, enterprising and successful [steel] manufacturers' who had, by the time of his death in 1887, donated £34,000 to the hospital's funds, in addition to 'his annual and most liberal subscriptions' of £42 a year.³ Similarly, a Jessop Trustee, Bernard Wake, 'a very liberal contributor to local charities', and 'a splendid man of business', was co-director of several local companies as well as a partner in a firm of solicitors. A prominent Board member, Robert Leader, an individual of 'rare business qualifications', was proprietor and editor of the Sheffield and Rotherham Independent newspaper and a Council Member of the local Chamber of Commerce.⁴ Leader and Jessop were also town trustees and along with Board colleagues, Alderman Saunders (Town Councillor and Poor Law Guardian), William Butcher (Town Councillor and former Master Cutler), William Dixon (Town Councillor) and Alderman Vickers (Town Councillor and Poor Law Guardian), they took a very active role in public life (Table 5.1). They also may have been familiar with the kind of work the Charity was doing, for Vice-President Alderman Vickers, for example, whose wife was President of the Ladies' Committee, had fathered eleven children, three of whom had died.⁵ It is quite clear, therefore,

**FIGURE 5.1: TOTAL VALUE AND NUMBER OF SUBSCRIPTIONS
BIRMINGHAM LYING-IN HOSPITAL AND THE JESSOP 1864**



Source: Annual Reports of Respective Hospitals 1864

that personal connections, business associations and possible family ties, account for the composition of the hospital's governing body, for five of the Governors had wives serving on the hospital Ladies' Committee and most of them sat on the same city council, mixed in the same social circle and conducted business in the same commercial setting (Table 5.1).

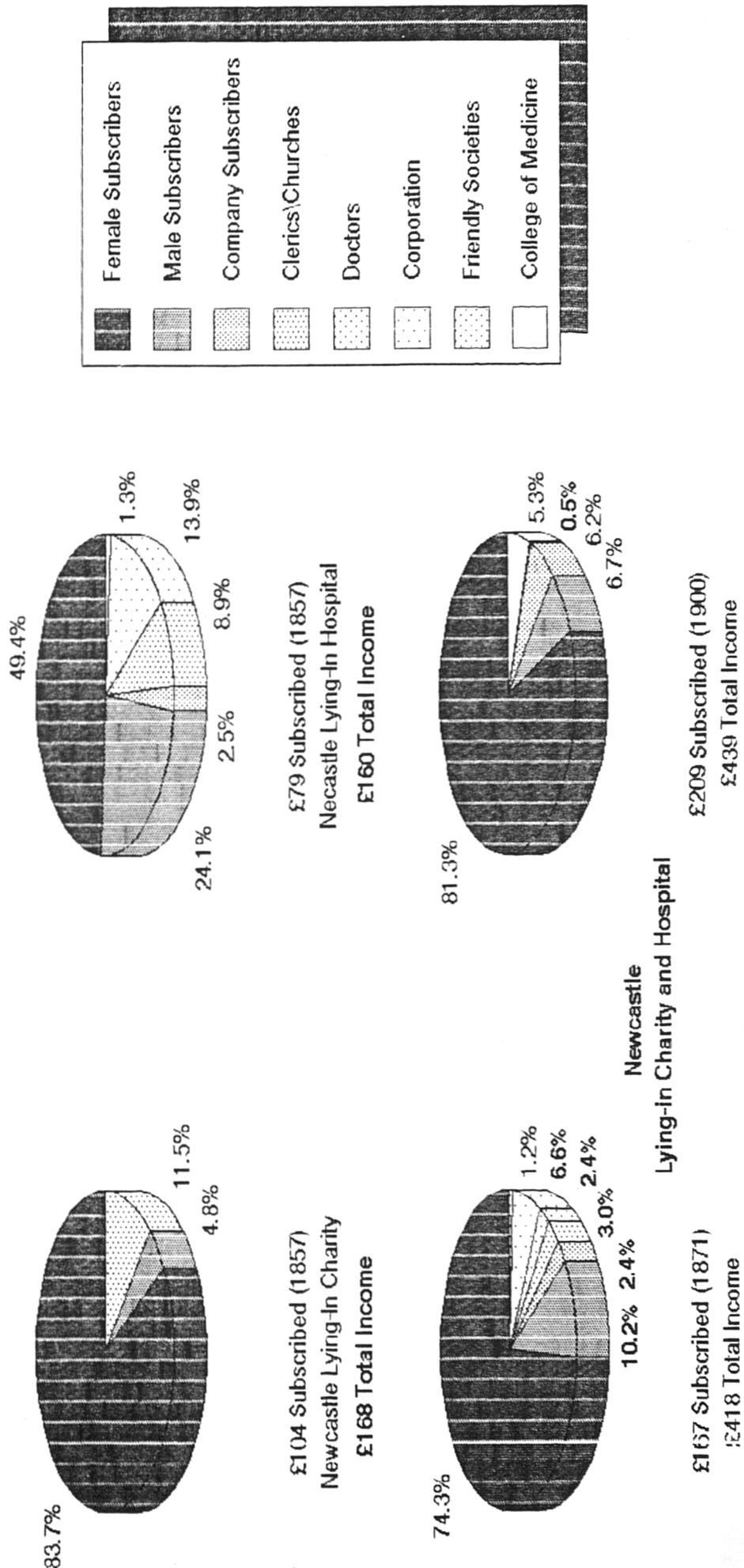
The Role of Women as Sponsors and Volunteers

Notable and distinguished though these men were, their position of absolute authority and influence in institutional affairs failed to reflect the gender composition of the hospital's sponsors and volunteers, for women, who were just as important to the overall running of the hospital, had only a subservient and subsidiary role to play. Aveling's inaugural address at the Jessop, where female subscribers were required to vote by proxy, were discouraged from attending annual meetings and were prohibited from joining the Board of Governors, underlines the point:

In Sheffield, there is, and has been for five-and-twenty years, room for a Lying-in hospital. The movement now seems forced upon us by the progress of civilization, for it is found that as civilization advances, so does also the regard and care which the male sex has for the female.⁶

The remarks, overtly patriarchal in style and completely oblivious of women's financial and practical efforts to assist their own gender, clarify contemporary attitudes

FIGURE 5.2: TOTAL VALUE OF SUBSCRIPTIONS
NEWCASTLE LYING-IN CHARITY AND HOSPITAL 1857 1871 1900



Source : Newcastle Lying-in Charity and Hospital Annual Reports 1857 1871 1900

and those of some latter-day historians, that women could never become providers of charity only its recipients.⁷

On the contrary, in the realms of finance for example, it was inevitably to 'the wives of the privileged and affluent' that the hospitals' governing bodies inevitably turned, for 'sympathy', 'succour' and hard cash.⁸ In 1864, when the Birmingham Lying-in Hospital relied heavily on subscriptions for most of its revenue, and when the Jessop first opened in Sheffield, female subscribers were responsible for 37 and 36 per cent of the subscription totals respectively (Figure 5.1). In Newcastle in 1857, on the eve of amalgamation of the Lying-in Hospital with the Ladies' Outdoor Charity, women accounted for one-half and four-fifths of the totals collected respectively, and continued throughout the Victorian era to provide, along with a host of practical gifts, food parcels and items of clothing, at least three-quarters of the annual subscription revenue (Figure 5.2).⁹

Inevitably whenever financial difficulties arose or major extension programmes were launched, it was those 'Ladies interested in the Hospital' who were expected not only to provide the necessary funding, but also organise its collection. It was only as a result, for instance, of the ingenious efforts of an all-female Bazaar Committee, which raised £2,272 in December 1885, partly from the sale of 'fancy goods' (unavailable in Sheffield at the time) and partly from the engagement of Baroness Burdett-Coutts to open the bazaar ('and it was with

difficulty that the police managed to clear her a path, by linking arms'), that The Jessop managed fully to utilize hitherto unoccupied wards.¹⁰ Similarly, when Birmingham Lying-in Charity decided to re-open its maternity hospital in 1907, forty years after the original had closed, its female supporters were immediately called upon to establish a canvassing committee to organise various fund-raising activities. Ranging from charity balls and evening dances, to garden fetes and 'a pound and gift day', these activities, along with Mrs Cadbury's gift of land and an anonymous donation of £1,500, provided the necessary funds, in excess of £16,000, to open the new hospital.¹¹ Women's subscriptions and fund raising activities not only ensured the expansion of these institutions, but their very solvency.

Women as financial sponsors, voluntary relief agents and welfare advisers, also featured very highly in the lives of the patients themselves, maintaining a far higher profile than a lay Board Member or Honorary Doctor. From the moment an application for relief was made, the female hospital supporters were involved in the process, for in many cases they held the recommendation tickets necessary to secure a hospital bed or assistance with a home delivery. At Newcastle-Lying-in Hospital (1871), for example, 74 per cent of the 319 recommendations available for a home delivery had been distributed to female subscribers of half a guinea or more. Similarly, in 1900 women accounted for 80 per cent

**TABLE 5.2: COMPOSITION OF SUBSCRIBERS
NEWCASTLE LYING-IN HOSPITAL 1871**

Value of Subscriptions	10s 6d	£1.00 1s	£2.00 2s	£3.00 3s	£4.00 4s	£5.00 5s	£10.0 10s	TOTAL: No. & Values
Female Subscribers	29	60	15		1	2		107 £124 8s
Male Subscribers		8	1	2				11 £16 16s
Company Subscribers		2	1					3 £4 4s
Clerics: Trinity Hse						1		1 £5 5s
Doctors		2	1					3 £4 4s
Cmpny of Hoastmen			1					1 £2 2s
Newcastle Corp.							1	1 £10 10s
TOTALS No. & Values	29	72	19	2	1	3	1	127 £167 9s

Values rounded to the nearest shilling

**TABLE 5.3: HOLDERS OF RECOMMENDATION TICKETS
NEWCASTLE LYING-IN HOSPITAL 1871**

	Maximum No. of District Recommendations	OR Maximum No. of Ward Recommendations
Female Subscribers	237	104
Male Subscribers	32	16
Company Subscribers	8	4
Clerics: Trinity Hse	10	5
Doctors	8	4
Cmpny. of Hoastmen	4	2
Newcastle Corp.	20	10
TOTALS	319	145

10s 6d = 1 District (Home Delivery) Recommendation
Each £1 1s = 2 District OR 1 Ward Recommendation[s]
Source: Newcastle Lying-in Hospital Annual Report 1871

of the recommendations issued (Tables 5.2 and 5.3 and Figure 5.2). At the Jessop, Sheffield, and the Lying-in Hospital, Birmingham, female subscribers, who could recommend four cases for every guinea subscribed (1864), held some 30 per cent of the recommendations issued by their respective institutions. Again in 1900, when the number of recommendations available for every guinea subscribed had been reduced to two at the Jessop but increased to five at the Birmingham Lying-in Charity, women still held a significant proportion of the recommendations available, which was 25 and 29 per cent respectively (Tables 5.4 and 5.5 and Figure 5.10).¹²

Once in receipt of assistance, which had, at Newcastle, to meet with the approval of a lady visitor, and at Birmingham a midwife, the woman's welfare continued to be overlooked by the more affluent of her gender. At Newcastle, an all-female Committee of Management was responsible for monitoring the quality of attendance charity cases received from midwives and doctors, whilst another body of 24 women served on a rota basis and visited the hospital daily, ensuring that patients were regularly attended, properly fed and clad, and housed in wards which were 'sufficiently neat, clean and free from impure or offensive smells'. It was also a legacy of the Ladies' Out-Door Lying-in Charity, which merged with the Lying-in Hospital, Newcastle, in 1858, that the Charity's recipients received 8 shillings during a period of four weeks following their confinement, supplemented, at their discretion, by the loan of linen

and baby clothes.¹³ At Birmingham too, the Ladies' Association had responsibility for overseeing 'the requirements and comforts of the patients' in the hospital whilst distributing to home cases, items such as stockings, combs, linen, shoes and firewood, as well as supplies of meat, milk and bread.¹⁴ At the Jessop, women actually organised themselves into a Samaritan Society (1896-1912) for this very purpose, providing over 3,000 mothers, more than 20 per cent of the hospital's case total, with their cab fare, items of clothing and tickets for 'Bovril, milk, meat and occasionally coal' which, it was hoped, helped to 'assist their recovery to health and strength and thereby enable them to resume their household work or even their livelihood'.¹⁵

A strong female presence was admittedly not a conscious decision of the hospital managers and doctors, who saw women volunteers as nothing more than housekeepers, and their work, a mere extension of their domestic duties.

to give orders, make all payments required for the domestic management of the Hospital, to engage and dismiss the servants and generally assist the matron in the management of the Institution.¹⁶

Ill at ease with their situation, women proved to be a much more restless, demanding and ultimately influential force than either their male colleagues intended or their biographers have credited. Nowhere is this more readily illustrated than at the Lying-in Hospital, Birmingham, in 1866, when the resignation of over half of the 35 members of the Ladies' Association prompted an internal enquiry,

provoked heated debates and initiated reforms that radically altered the Charity's role. The Enquiry, a committee of eight men appointed to consider the reasons for the resignations, attributed them partly to the matron's decision to work independently of, and often in conflict with, the Ladies' Association, and partly to the Board's apparent refusal to consider the women's case against the matron. Censuring the Board for neglecting to hear the women's case, the Enquiry concluded that as 'the presence and services of the Ladies' Association was essential to the well-being of the Hospital', not least of all because nearly half of the total number of subscribers were female, 'only those Gentlemen should accept office on the Board who agree to the value of action by the Ladies' Association similar to that defined by the Law of 1844'.¹⁷

The Committee was in no way suggesting that women should be given representation on the Board of Management or any additional responsibility, other than their original task of overseeing 'the matron, the servants and all the internal arrangements of the house'.¹⁸ Yet, the Committee's conclusions promoted such a heated debate that many emerged from behind the superficial facade of the reports and press releases to air their true feelings on the subject. As a result, it soon became evident that whilst certain Board members were content to reap the results of women's efforts and had no hesitation in accepting their money, there was never any question of giving them real authority or power within managerial

circles. Life Governor, Alderman Brinsley, made no excuses: if the Management Board accepted the Committee's resolutions, 'they would be the laughing stock of the town', for he believed that 'many institutions in this town would not be in their present flourishing position if Ladies had been allowed to dictate to the officers'. Other Board Members including the Reverend Winter and Jacob Philips were much more subtle, but nonetheless vocal in their opposition to the Committee's report, for whilst they avoided making public judgements about female participation, they denounced every point the report had to make and demanded that it neither be 'received or adopted, but that it at once pass into oblivion'.

As the women were unable to represent themselves, J. H. Goodman, husband of one of the women who resigned, spoke on their behalf and refused to accept Winter's portrayal of the Matron's innocence and his claims that the women's grievances were no more than 'a series of petty annoyances'. Goodman declared that the matron had been 'untruthful', 'mischievous' and 'insubordinate' and proved herself totally unsuitable for office, but despite such allegations, the Board of Management, he claimed, never once considered the legitimacy of the women's complaints. Thereafter, the debates quickly disintegrated into a string of 'misinterpretations, contradictions, offensive language and personal imputations'.¹⁹ The only means of ending this was the appointment of a second Committee of Enquiry, not so much to dwell on the internal feud, as the future management

of the hospital, an aspect the first Committee of Enquiry had failed to consider.

This is where the irony lay, for the recommendations of the second Committee adopted in their entirety by the board in autumn 1867, unleashed 'sweeping and fundamental changes' which gave women a far greater say in the hospital's fate than had ever been envisaged by either supporters or opponents. There had been no suggestion during the first round of talks in February 1867, that there was to be any radical departure from the Charity's existing role. Indeed, the first Committee of Enquiry felt it could not 'close this report without expressing their full persuasion that the maintenance of a Lying-in Hospital is an object of great importance to this town and district'.²⁰ Yet three months later and the second Committee of Enquiry, similarly composed of Board members and male subscribers but also including Mr Goodman, was recommending the permanent closure of the maternity hospital and its replacement by a domiciliary based, maternity Charity.²¹

In part, this transformation from Lying-in Hospital to Lying-in Charity was undoubtedly influenced by the local press which followed the dispute with a keen interest and always seemed to predict the decisions made by the hospital's governing body.²² It was also influenced by the hospital's female supporters, whose own authority was greatly enhanced as a result of the changes. Thus whilst the Birmingham Daily Post was urging, on grounds of economy and maternal safety, the

replacement of the hospital by an outdoor charity, the Countess of Dartmouth, the late President of the Ladies' Association, was calling for the substitution of young medical men by 'respectable women' trained and employed as midwives.²³ The Birmingham Daily Post had presumed that the Lying-in Charity would continue to employ medical practitioners to deliver all the Charity's cases, abnormal or otherwise, but the Countess's idea, presented before the first Committee of Enquiry and adopted by the second, was regarded as 'a welcome boon' and 'beyond doubt a step in the right direction'.²⁴ The Committee was also eager that the Ladies' Association continue and turn its energies towards visiting, assessing and relieving maternity cases in their own homes.²⁵ The women's position as a result of their resignations and the subsequent enquiries and representations on their behalf, was not only restored but considerably strengthened and now meant that a charity confinement in Birmingham, for more than 90 per cent of recipients, was an all-female affair.

The medical profession's silence during these proceedings, which had been a lay matter throughout, was cause for comment by the Birmingham Gazette and does imply that the profession had very little influence on the constitutional changes that took place, despite having so much to lose. In the absence of Board minutes it is difficult to determine the medical staff's stance, but it is hardly likely to have been impartial, since they were not only losing their hospital posts, with all

the prestige and privileges that these entailed, but also any hope of developing the hospital into a centre for gynaecology, an idea which had been discussed during the course of debate but emphatically rejected by the press and subsequently discarded by the Committee.²⁷ The transition to a domiciliary service had other results: the loss of three residential surgeons, the loss of the right to instruct medical students, the loss of ex-officio status for Honorary Medical Officers on the Board of Governors and more to the point, the loss of autonomy in the birthing room.²⁸ Despite the findings at the Jessop, the maternity hospital, as shown in Liverpool and now in Birmingham, was not necessarily the professional haven it was reported to be.

Even at the Jessop, a bastion of professionalism, women were seldom deterred from attempting to influence events. Officially, their role was strictly 'to assist in the domestic management of the Hospital', but to the greatest irritation of the medical staff, they soon began to express their opinions and submit their recommendations on all aspects of hospital policy, not all of which were necessarily in the interests of the women they served. Few of their suggestions though were ever acted upon, such as the time they took to the high moral ground and demanded that all patients discharged from the hospital were required to return thanks to God, the traditional act of Churching. Similarly, the Ladies' desire to open a register for sick and monthly nurses, largely to serve their own needs, was vetoed by the

medical staff, and their scheme to charge in-patients, which directly challenged the idea of free provision, was rebuffed in 1874 and again in 1878.²⁹

Frustrated, angered and rejected, the tendency was for members of the Ladies' Committee to resign when they failed to make any progress. Thus in February 1873, a number of them resigned because of the delays over appointing a matron and placing her under their control, but such action simply resulted in the Ladies' Committee being reduced to a 'manageable' size, from 24 to 12 members, excluding the Lady President.³⁰ In October 1881, the whole Ladies' Committee, alarmed at the medical staff's admission of single women, despite their strong disapproval, tendered their resignations 'as their services seem no longer required in the management of the Jessop Hospital'. Unlike the events in Birmingham, the women's collective action prompted no minuted discussions, internal enquiries or public debates, just a formal acceptance of their resignations and resolutions of gratitude for their past service.³¹ Three years later a number of 'Ladies interested in the hospital' returned as house visitors, organised a bazaar and made personal appeals for new subscriptions, which raised over £2,000 and an extra £300 respectively, yet the Ladies' Committee remained disbanded.³² Reaping the rewards without loss of authority, the Board of Management could not have been left in a more comfortable position.

What female supporters of maternity hospitals sought to augment in Liverpool, successfully achieved in

Birmingham and struggled in vain for at Sheffield, autonomy and a voice in the running of the charity, had been attained in Newcastle by 1858. In that year, one of 'monetary crisis' and a general trade depression, Newcastle's Lying-in Hospital merged with the Ladies' Outdoor Charity, and from the new alliance an all-female Committee of Management emerged with full responsibility for the affairs of the institution, subject, of course, to the general approval of one guinea or more subscribers, the overwhelming majority of whom were women (Table 5.2). Once an application was approved by a Lady Visitor, the confinement could either take place in the hospital attended by a matron who 'must be a Midwife, and able to deliver in natural and easy cases', or in the woman's own home by a midwife selected from a list of eight; as with other provincial maternity hospitals, the medical staff had a marginal role to play in the birthing room, attending only difficult cases.³³

Within seven years of the amalgamation of the Ladies' Charity and Lying-in Hospital, however, female autonomy in the labour room was lost. The transition was completed in several stages. First, despite strong opposition from hospital midwives, medical students from 1861, were allowed to accompany midwives on their rounds. Then within a year, the Honorary Medical Officer, Dr. Gibson, suggested the employment of medical students and by 1863, a sub-Committee of five women met with medical staff to consider the best means of using medical students in lieu of midwives. By the spring of 1865, the

midwives had been replaced by three salaried surgeons and 'senior' medical students, and the matron was instructed to concentrate solely 'on the domestic concerns of the Hospital'. Lady Visitors were also discharged and their tasks transferred to the Committee of Management.³⁴

Unfortunately, the documentary evidence concerning the substitution of midwives by medical men (1863-65) discloses very little, for it refers to the results and not the process of debate and discussion. It therefore would be rash to surmise that the medical officers, all of whom had full representation on the Board of Management, had received an open invitation from their female colleagues 'to break the gender barrier' and monopolise the labour room in order to train students. However, it must be said that the transition did not appear to produce any resignations from the Committee of Management, promote any noticeable decline in the number of subscribers and contributions, provoke any intensive debate either in the Board Room or in the correspondence pages of the local press, or spark any sort of reaction which would indicate that women were disconcerted or uncertain in anyway about the transfer of control from the midwife to the doctor. Attended by physicians at their own confinements, even perhaps one of the Honorary Staff of the hospital, the Ladies possibly felt that they were acting in the best interests of their gender by offering working class women a service for which they themselves paid high fees and which they genuinely considered was a much safer and easier form of

confinement.³⁵ In reality, this could not have been further from the truth.

The Quality of Obstetric Care: 'Careful Midwives' and 'Skilled Doctors'?

When evaluating these changes in the hospital provision in Newcastle, it is clear that the standard of care offered to the hospital's district cases fell quite short of that provided to its female patrons. Whilst the latter received at least qualified, and possibly experienced professional attendance, the former had to accept uninformed, unqualified, and unsupervised medical students, albeit in their final years at college. When the idea was first proposed to dispense with the use of midwives the intention was to replace them with three visiting surgeons, who had in each of their respective districts,

to attend to and be responsible for the treatment of all cases receiving the Out-Benefit of the Charity...it being understood that he will have the assistance of the senior students of the College of Medicine.³⁶

It was in fact the 'assistants', the medical students, who conducted the majority of home deliveries, consulting the visiting surgeon, not on matters of training, but when they foresaw a difficult labour. This meant that what little instruction they received came from fellow students who had already completed the course, but as one student reflected 'there [still] came a day when you were left "all alone in your glory" and

the test came'.³⁷ Grey Turner and fellow students at the hospital in the mid-1890s were not so fortunate. He recalled that most undergraduates attended their quota of 20 home deliveries 'entirely alone and in most cases without having seen a woman in labour'. Turner was particularly critical about the lack of support he received from the hospital staff:

Only twice did I disturb the medical officer; once he refused to come and on the second occasion he accompanied me to a cellar dwelling and removed an adherent placenta. It was a crude performance, and the recollection of the illness of that woman before her death from septicaemia is still a terrible nightmare.³⁸

Though the students obviously felt they had a legitimate complaint and were genuinely perturbed about the lack of support and interest that the medical staff showed in their training, the staff were equally critical of those they taught. In *Hospital Surgeon Clark Newton's letter* of complaint to the medical school, about one of their students he had promptly dismissed, he felt

that of late we seem to be supplied with a class of students who attend midwifery with the intention of "getting signed" rather than for instruction, and...regret still more from your rules and the subscription of the College commands us to supply cases of students of this class.³⁹

Ironically, it was Newton's failure to provide sufficient instruction and support to medical students, which resulted in one woman's death from haemorrhaging in October 1887, that precipitated his own dismissal in the same year.⁴⁰

To the Matron of the Lying-in
Hospital

Dear Madam

This patient was put to
bed this morning at 2
o'clock at St Peters,
and if the Midwife
had not called in,
she would have been
lost, as the the Doctor
was not forthcoming
and would you please
tell the bearer, where
to get the groceries

Yours respectfully

Mary Arkle
St Peters

Whatever the argument and whoever the advocate, it was not the tutors or the students who were the casualties of the inept system of instruction but the women themselves. The inquiries held at the hospital in instances of malpractice and professional neglect are quite clear on this point. Herbert Ridley, a visiting surgeon to the Newcastle Lying-in Hospital, for example, was, in addition to a whole list of allegations of neglect, accused in November 1870 of causing the death of a woman because of his failure to attend her at her confinement. The all-female Committee who led the inquest were most thorough in their investigation. Ridley's explanation of the events was placed alongside evidence from the coroner's office which contradicted his account and alongside evidence from two of the Committee Members, who, independently of each other, encountered little difficulty in finding the late woman's house, which Ridley had claimed he could not find, despite an intensive search. The enquiry lasted six months at the end of which it was decided that the surgeon had been negligent and his resignation was demanded.⁴¹

The resignation of Ralph Young was similarly called for in October 1882, following a whole series of complaints against him, the first of which was made in May 1879. In this instance, the complainant, the patient herself, Mary Arkle, alleged in her own handwriting, that Young had not attended her confinement and that she would have lost her life had it not been for the chance intervention of a midwife (Sample Text 5.1).⁴² Again in

Memorandum
 FROM The Charity Organisation Society,
 18 Northumberland Court
 Newcastle-on-Tyne.
 To Mr H. Pringle
 Northridge Street.

Catherine Angus, Residence 17 Gibby yard,
 East Bank. The made inquiries in the above
 case on the 7th ult. She is a notorious gaint
 Dacent Cad. Her husband works
 every day plenty of food in their house
 She is a great impostor.

I remain
 Yours Obedient Servant
 R. H. Ellison

Sample Text 5.2: Charity Organisation Report on Maternity Applicant, Catherine Angus, to Mrs Pounder, Hospital Matron, Newcastle Lying-in Hospital, 1 March 1882

March 1882, a woman submitted a similar complaint against Young, and only six months after that, another woman claimed that Young had refused to attend her, but not before he demanded a guinea in payment. Similar complaints followed. Only at the third complaint was Young found 'guilty of wilful neglect of duty in not attending her' and his resignation called for.⁴³ The first case against him was dismissed, for according to Young, the woman showed no signs of approaching labour when he examined her and she showed more concern about the free groceries that she received as a charity recipient than about attendance by a doctor (Sample Text 5.1).⁴⁴ The second complaint was also dismissed because of evidence submitted from the Charity Organisation Society which claimed the woman making the allegation was 'a notorious great Drunkard...a great impostor', which automatically nullified her claim and her right to be heard (Text Sample 5.2).⁴⁵ Such was the extent of allegations of neglect by Young, Newton and others attending women on behalf of the hospital, 'that the tickets of the hospital', the Committee alleged, 'have been refused when offered, as persons have stated that at a time of need they did not receive that attention to which they were entitled'.⁴⁶

This was, however, even amongst the professionally led maternity Charities in Manchester and Sheffield, not normal practice. It was in fact, totally at variance with the informed, regulated and empathetic treatment that most women received when attended by a hospital

midwife, who, it must be stressed, attended the majority of hospital cases. To be sure, hospitals such as the Jessop that used midwives had their share of fraudulent women who submitted claims for labours they had never attended, midwives who were dismissed for being inebriated and in one instance, a nurse who proved 'too fond of stimulants, and also takes opium...[and] she seemed such a nice woman...'.⁴⁷ In not one of these incidents, however, did the midwife's misconduct influence the outcome of the birth or constitute the subject of a post-mortem enquiry, as had been the case in Newcastle.

On the contrary, the rigorous selection, training and employment procedures used by all midwife-based charities, ensured the provision of highly trained and competent women for attendance at all normal labours. Both the Jessop and the Lying-in Charity, Birmingham, required midwifery candidates of more than 20 and 25 years of age, respectively, who could 'produce reliable testimonials of good moral conduct and respectability, and be able to write well'.⁴⁸ Once accepted, training was far more rigorous than that received by medical students, for if accepted at the Birmingham Charity as a pupil midwife, the candidate had, during a three month period, to complete two, 12-lecture courses, submit regular reports to her course tutor, sit a written and oral examination and under the guidance of a charity midwife, deliver 25 women.⁴⁹ The 'systematic training' received as a pupil midwife in the maternity department at the Jessop

lasted 12 months, during which time the candidate was expected to make a full contribution to the running of the maternity wards and under the supervision of the Superintendent of Midwifery, personally attend 30 cases of labour. On successful completion the candidate received a certificate confirming she was 'a competent and trustworthy woman, able to conduct skilfully any case of natural labour, and to take general charge of the lying-in room'.⁵⁰

The two institutions then recruited full-time midwives from their own pool of candidates. Compelled to reside in the district allotted to her and 'attend all patients therein', the midwife, as at Liverpool and Manchester, was governed by a strict code of conduct dictating 'what she could do and what she ought not to attempt', the number of visits she made to each case, the tasks she was to carry out on each occasion and the procedures that had to be followed in the event of an outbreak of sepsis.⁵¹ Whilst such rules were devised and enforced by the medical staff, in reality doctors were there only to offer 'counsel and help when required' and oversee a difficult or complicated labour, which occurred amongst district cases, in one case in 41 at Birmingham's Lying-in Charity (1866\70-1896\1900) and about one case in eight at the Jessop (1865, 1872-73).⁵² With a Superintendent of Midwifery, Kate Keslo (1831-1901), in charge of running the Jessop maternity wards, responsible for attending 'all cases of labour occurring in the house...for the nursing and proper care of the mother and

child as long as they remain in the house', midwifery, from the woman's perspective, remained very much a female affair.⁵³

Within a framework devised by male doctors and lay officials, but executed by qualified midwives and female volunteers, the supply of 'skilled help...to a large number of poor women at their own home or in the Hospital,' was assured, and the result 'so far as our Hospital work is concerned, [was] a marked diminution in the mortality and mischance attending on parturition'.⁵⁴ The impact of this is nowhere more clearly illustrated than at Birmingham's Lying-in Charity, after it replaced its house surgeons with district midwives. Hesitant at first, the Board of the former Lying-in Hospital retained all three surgeons and appointed only one midwife in April 1868, to manage one of its four districts on a trial basis. The midwife, a woman of 20 years' experience at the Royal Maternity Charity and 'highly recommended by the officers at that institution', was so successful that another three trained and certificated midwives were appointed within the year, and the services of the salaried doctors dispensed with.⁵⁵

During the transition period, Board members had been 'most careful to satisfy themselves at each step that the system was the right one before extending it', and did so from two different perspectives: firstly, and perhaps most surprisingly, from the view point of its own patients, 40 of whom were interviewed after being attended by a midwife. All 40 of them apparently spoke

very highly of the new system, with remarks to the effect, 'better attended than when a surgeon attended', 'paid every attention', 'very good indeed', 'a very kind midwife'.⁵⁶ Secondly, from the viewpoint of mortality and morbidity returns, conclusions about which had to be drawn from over a much longer period, but nonetheless proved favourable. Within a decade of the midwives being appointed, the Birmingham Lying-in Charity had been selected by the Registrar General, William Farr, as one of two 'remarkable institutions' for achieving a maternal death rate of 2.32 per 1000 mothers delivered (1869-78), which averaged 'less than one half that of the whole kingdom'.⁵⁷

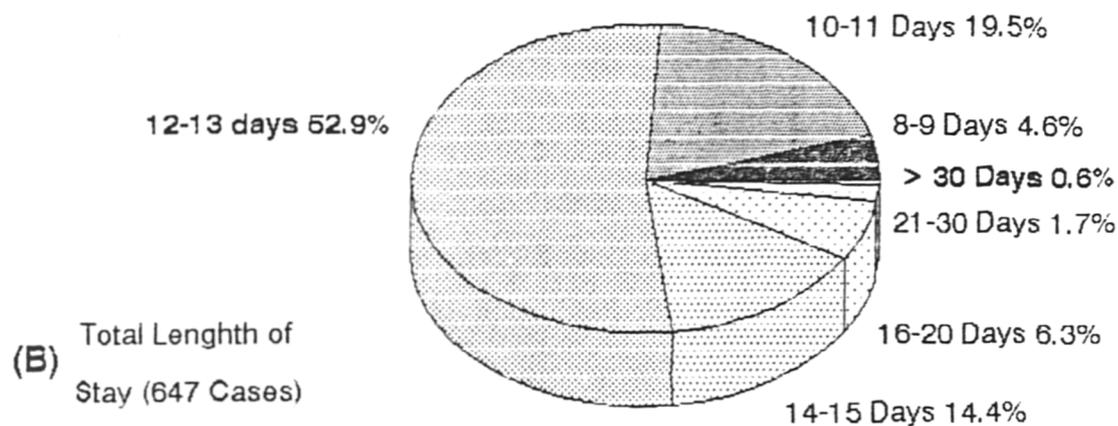
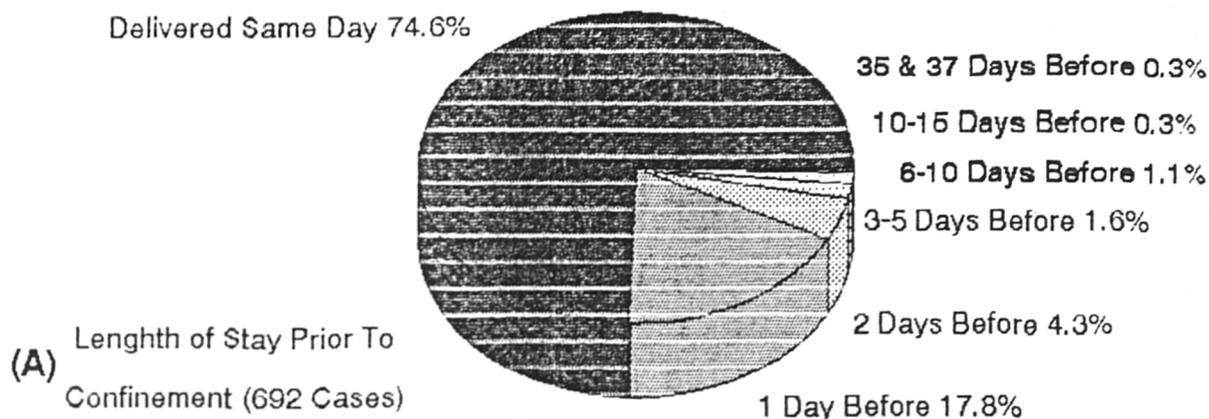
The significance, however, of having 'rescued [charity cases] from the hands of the ignorant and untrained midwives, and placed [them] under the care of women who have been carefully taught and whose conduct and efficiency are periodically inquired into', cannot be judged in terms of mortality statistics alone, 'eminently satisfactory' though they may have been. Other aspects of the consequences of birth, including the risk of dislocated uteri, lacerated perineae and post-natal traumas, have also to be considered and though impossible to quantify, it is highly probable that morbidity levels were much lower amongst women attended by a hospital midwife, a 'proper person of known good character and intelligence', than the 'unqualified and ignorant'.⁵⁸ As one of the latter, a medical student at Newcastle,

reflected 'I blush to think of some of the experiences for which my ignorance was responsible'.⁵⁹

Yet whether or not the actual presence of a maternity hospital could offer any more than the Birmingham Lying-in Charity was already doing for parturient women in their own homes, raises an important point for discussion. As with Sinclair and the opening of the Southern's Maternity Hospital, Manchester, the idea of opening a maternity department at the Jessop originated with the medical staff who intended to use it to provide 'competent midwives', but 'for the purposes of the hospitals' only, and not for the community as a whole, as Aveling, the hospital's original founder had envisaged. Whilst this in-house scheme, limited to the instruction of two probationers, and no doubt designed to protect the pecuniary interests of general practitioners, greatly benefited those women in the hospital's care, it did little to reduce the large class of 'pretentious and ignorant [midwives]; causing grief and misery, and now and then inaugurating frightful tragedies...', that Aveling had identified as one of the principal reasons for establishing a maternity hospital in Sheffield.⁶⁰ Unlike the case in Manchester and Liverpool, where the maternity hospitals trained substantial numbers of midwives, the restriction on midwifery training at the Jessop severely curbed its communal role and in no small way accounted for the great vacuum in midwifery services in Sheffield in 1905, when it was found that less than 40 per cent of midwives were trained and that amongst the

FIGURE 5.3: LENGTH OF PATIENTS' STAY

JESSOP'S 1891-1895



(C) LENGTH OF STAY WITH REGARD TO AGE AND PARITY

	Case Total And %	Average Age	Average Parity
Length of Stay:	(647 Cases)		
8-9 Days	30 (5%)	27	3.1
10-11 Days	126 (19%)	28	3.9
12-13 Days	342 (53%)	28	3.6
14-15 Days	93 (14%)	29	3.9
16-20 Days	41 (6%)	27	3.0
21-30 Days	11 (2%)	35	3.8
> 30 Days	4 (1%)	24	1.2

remainder, the Central Midwife Board regulations proved so difficult to comprehend that a simpler set of rules had to be devised.⁶¹ In this sense, the Jessop achieved no more than the Birmingham Lying-in Charity for outdoor cases, in failing to supply competent midwives to a greater patient-ratio than their own.⁶²

The existence of in-house training also meant that a large proportion of the Jessop admissions were normal deliveries and that the hospital was not the depository of difficult cases, as at St Mary's or the Southern in Manchester, where midwives and students were taught in the district. Even as late as 1904, when the Chairman of the Jessop Board, Colonel Cutler, at a time of increasing admissions and greater professionalism, felt the hospital should concentrate solely on accepting potentially difficult or complicated labours, the medical staff insisted 'on the necessity of continuing the admission of natural cases, otherwise all training will have to be abandoned'; the issue it seemed, was non-negotiable. This meant that except for such cases as haemorrhaging or convulsions where constant supervision was paramount to the woman's survival, the medical staff were not prepared to accept women 'until labour has either commenced or is immediately pending so that there is no occupying of beds with its accompanying expense for weeks or even days before labour is expected' (Figure 5.3A).⁶³ As a result, the scope for treating complications was severely curbed to what actually arose on the day of admission and the opportunity was lost to pre-empt such complications as

eclampsia, an obstructed birth or a severe case of haemorrhaging.

This is not to say though that the hospital was unimportant to those women who chose a hospital birth. Once the maternity department was opened, the Jessop Medical Staff arranged it so that women who submitted their recommendations, some ten days before the baby was due, had the choice of being delivered at home or in hospital, without the need for permission from the doctor or any additional commitment from their sponsors, whose recommendation tickets were valid for either form of assistance.⁶⁴ At Newcastle Lying-in Hospital the prerogative lay not with the maternity applicant but the sponsors, for it was they who decided what their one guinea subscription would be used to recommend (two out-patient or one in-patient), so long as the woman who was admitted into hospital was free of contagious disease, had completed her seventh month of pregnancy and had come equipped with a child's dress.⁶⁵ Apart then from the 'urgent cases of labour', the women who entered the Jessop did so by choice, and the sharp increase in ward deliveries in the initial years of opening the maternity department, from 38 in 1879, to 70 in 1882, to 125 a year by 1885, attests to the real demand that there was in certain cases and circumstances for a hospitalized birth (Figure 5.7).

One particular set of circumstances, for which hospitals often justified a ward delivery and from which women themselves were often escaping, were the insanitary

conditions of their homes. At Newcastle Lying-in Hospital, for example, medical staff spoke of the 'unpleasant localities in which the patients reside...' and attributed at least one maternal death, 'to the insanitary condition of the cellar kitchen'.⁶⁶ At Birmingham too, the Board of Governors of the Lying-in Hospital justified a hospitalised birth where the woman's home was too 'wretched' to deliver a child, arguing that in such cases a more 'successful' and 'satisfactory' result could be obtained from a ward confinement. Three years later (1867) the same Board had turned the argument on its head and announced that due to the *threat* of puerperal fever its wards had to be closed and women solely confined in their own home, but it was still quick to point out that only one maternal death had resulted amongst 281 hospitalised deliveries (1864-67).⁶⁷ Also, when the Jessop was first establishing its maternity wards in the early 1880s, puerperal fever was not the threat to in-patient safety that it had been 20 years earlier, when Birmingham's maternity hospital had existed. This is not to say, as some contemporaries claimed, that puerperal fever had 'diminished almost to vanishing point' in maternity hospitals, but if any one body of practitioners was actually incorporating the ideas of Semmelweis and Lister into their work, then it was those associated with the maternity hospital.⁶⁸ This point was illustrated at the Jessop by such singular references in the minutes as the distribution of 'hand towels' to all wards in October 1888, the use of oil

**TABLE 5.6: MATERNITY ADMISSIONS
JESSOP'S 1891-1895**

	1891	1892	1893	1894	1895	TOTAL
No. of Admissions	119	131	129	158	165	702
No. Confined	116	131	129	155	164	695
No. of 1st Births	17	13	19	21	30	100
(% of no. confined)	15	10	15	14	18	(14%)
No. of Complications	28	17	22	37	38	142
(% of no. confined)	24	12	17	24	23	(20%)
No. of Twins	7	2	6	5	1	21
No. of Births	123	133	135	160	165	716
No. of Child Deaths	13	4	8	23	14	62
No. of Live Births	110	129	127	137	151	654
No. of Mat. Deaths	4	2	3		2	11
(per 1,000 Births)						16.82
Abortions	1				1	2
Threatened Abortions	2					2
Born En Route				2		2
Miscarried				1		1

**TABLE 5.7: 'FALLEN WOMEN' ADMISSIONS
JESSOP'S 1891-1895**

	Days Stayed	Age	Prev. Births	Complications And Treatment	Fate of Mother\Child
Each Case Admitted in					
1891: March		21	0		
June	13	21	0	Sml Pelvis\Version	Child Dies
Oct.	14	27	1		
Nov.	22	20	0	Torn Perinium	
Nov.	13	24	0	Mal-Presentation	
1892: Nov.		24	0	Craniotomy	Both Die
1893: Feb.	20	28	0	Torn Perinium	
April	13	28	0		
May	15	22	0		
June		17	0	Eclampsia\Induced	Mother Dies
1894: Jan.	18	30	0		
April	13	33	1	Born in Rail Car	
July		23	0	Sml Pelvis\C. Sect	Trsfr\Chld Dies
1895: Jan.	13	21	0		
Feb.	11	22	0		
Aug.	13	20	0	Craniotomy	Child Dies
Average Stay\Age	14	24	0	8 Complications	2 Mothers Die
Case Totals				15 Confined	4 Children Die

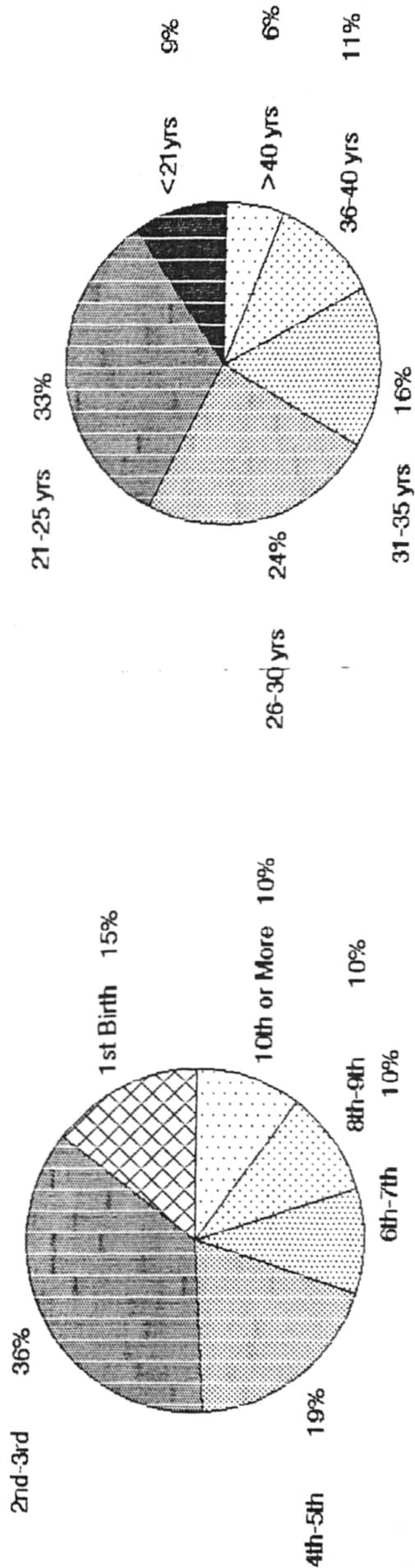
Source: Jason Hospital Maternity Register, May 1879-October 1896

sheeting on maternity beds in March 1889, and of burning sulphur to disinfect the maternity wards, which on one particular occasion, October 1892, caused an explosion and created a three-foot-diameter hole in the floor.⁶⁹

Another category of applicant who benefited from a hospital confinement were single women. As much to escape the gossip mongering and social embarrassment as to receive medical assistance, guardians or lovers, as well as women themselves, eagerly sought a hospital confinement for cases of illegitimacy. Thus the French Consul was willing to pay 5s a week for the admission of his unmarried servant girl and indeed, such was the demand that the Newcastle Lying-in Hospital raised admission fees for single women from 5s to 6s in 1869, to 7s the following year and by another 3s only five years after that.⁷⁰ Generally, however, as the case details for the Jessop (1891-95) attest, the admission of single women was highly curtailed, for reasons of propriety, and because of this, those that did secure a hospital bed, 2 per cent of admissions, tended to be the more difficult obstetric cases and the ill-nourished and rachitic, for whom 'refusal to admit would have been downright cruelty' (Table 5.7).⁷¹

Considering, however, that their average age was 28 and their parity rate was an average of four labours (1891-95), women entering The Jessop need not have come from wretched homes or have been carrying an illegitimate child to have appreciated the benefits of a clean bed, a regular diet or competent medical attendance. Thus,

FIGURE 5.4: AGE AND PARITY DISTRIBUTION OF MATERNITY CASES, JESSOP'S 1891-1895



Distribution of 685 Cases by Parity

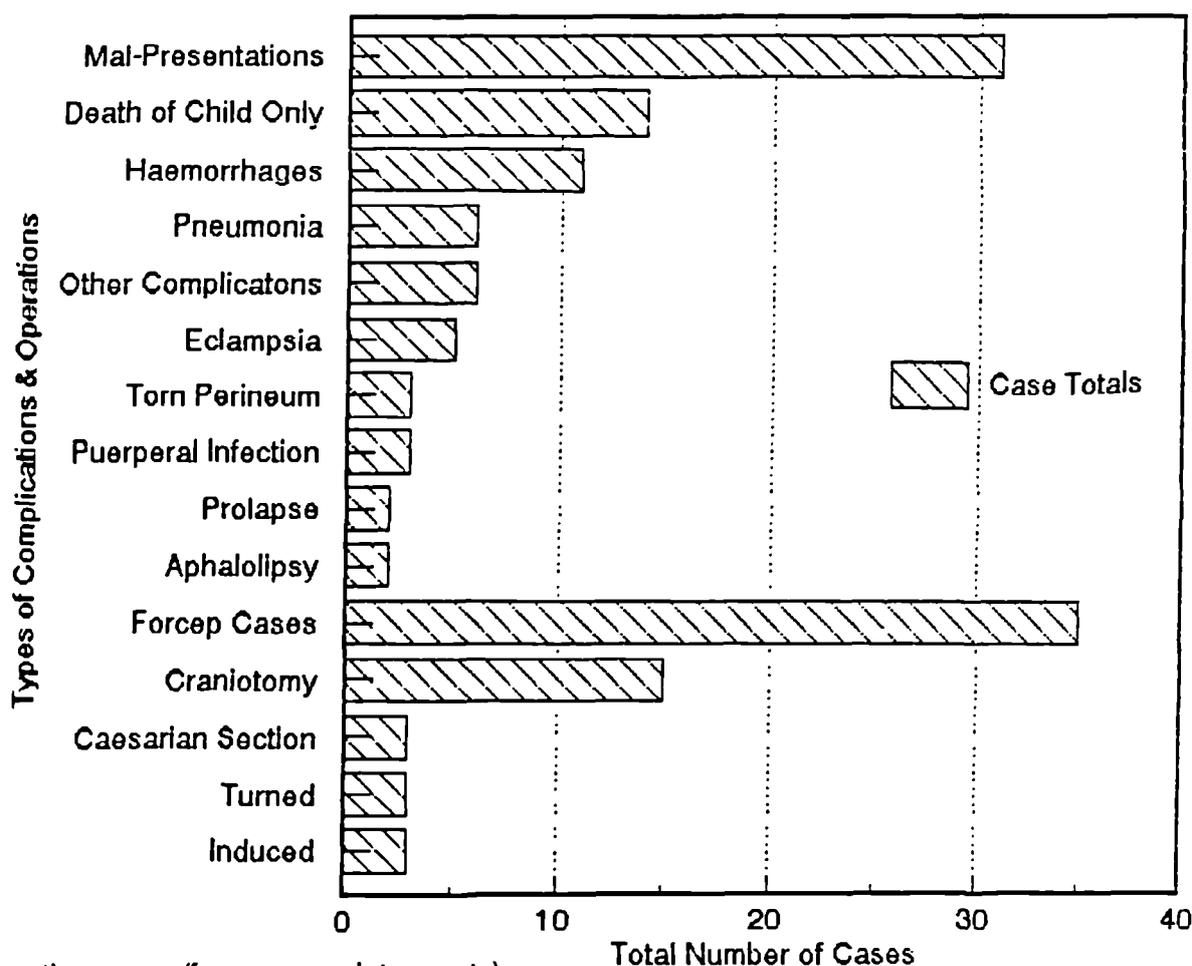
Distribution of 685 Cases by Age

Source: Jessop Hospital Maternity Register, May 1879-October 1896

whilst the average stay was 12 to 13 days, there was a tendency for women in their thirties with four or more children, to stay an extra one or two days, whilst women in their twenties, with a below average parity, tended to leave on the eighth or ninth day after their delivery (Figures 5.3B and 5.3C). Those who remained beyond the 15 days did so for particular reasons, regardless of age and parity, but which were not always recorded. If an explanation was offered, then it generally tended to be a medical one. For example, one 19 year old remained in hospital 18 days because of an adherent placenta and two others remained 31 and 32 days respectively, because the former, 41 years of age, had a caesarean section, and the latter, only 25, suffered eclampsia exacerbated by heart disease.⁷²

It is apparent that age and parity presented problems in themselves. Practically half the 685 women admitted to the Jessop (1891-95) were there to deliver their fourth or subsequent child, and 20 per cent their eighth or more (Figure 5.4). These women would have been considered 'grand multiparae cases', and by their very nature, more prone to mal-presentations, haemorrhaging and prolapsed umbilical cords. A further 100, or 15 per cent of the total, were attending hospital for their first confinement, a parity 'looked upon generally as the most serious and dangerous' because the labour was usually more protracted and infection therefore more common.⁷³ Age too was a 'great factor' when considering the risks of childbearing. 'The age of least mortality'

**FIGURE 5.5: COMPLICATED AND OPERATIVE CASES
JESSOP'S 1891-1895**



Operative cases (forceps, craniotomy, etc)
refer only to those where a complication was not recorded

**TABLE 5.8: FORCEPS DELIVERIES WITH REGARD TO AGE & PARITY
JESSOP'S 1891-1895**

Forceps Applied To:	Age (Yrs.)						GRAND TOTAL
	<20	21-25	26-30	31-35	36-40	41-45	
1st Birth	3	5	1	1			10
2nd Birth	1	3	1	1			6
3rd Birth	1	2					3
4th Birth		1	3	1	2		7
5th Birth				1			1
6th-10th Birth		2		5	1	1	9
11th or More Birth					3	3	6
Parity Unknown			1	1			2
CASE TOTALS	5	13	6	10	6	4	44
Average Parity: 7th Child					Average Age: 29 years		
As a % of Labour Total (695) 6.3% = Forcep Cases							

Source: Jessop Hospital Maternity Register, May 1879-October 1896

was considered to be 25 and increasing thereafter, and though over half the case sample referred to women in their twenties, of the 392 individuals concerned, 50 per cent were either primiparae or grand multiparae labours (Figure 5.4).⁷⁴ In the case of the 18 year old who had already had five children (the age of consent being 13 until 1885 when it was raised to 16 years of age) and that of the 42-year-old expecting her 21st child, who had to be delivered by forceps, neither age nor party stood in their favour, but both survived in hospital, as did their newborn.⁷⁵

Amongst the 31 cases of mal-presentations (1891-95), all of whom survived in hospital, well over two-thirds were either older than 30 or expecting their fourth or more child. The very nature of case admissions, mature, multiparae and impoverished, guaranteed a natural pool of complicated labours irrespective of their intake of sudden emergencies or potential abnormalities (Figure 5.5). Similarly, forceps deliveries, which accounted for one woman in 16 (1891-95), or 6.3 per cent of the case total (a far cry from the 30-70 per cent in many private medical practices) were applied most frequently to older women, who, on average, were in their mid-thirties and expecting their seventh child (Table 5.8). Whereas forceps were applied at the Jessop to one woman in 20 in their twenties, it was one in 12 in their thirties, and one in 10 in their forties, and whereas forceps were applied to one in 28 women who were expecting their second or third child, they were applied to one in 16 who

**TABLE 5.9: MATERNAL DEATHS
JESSOP'S 1891-1895**

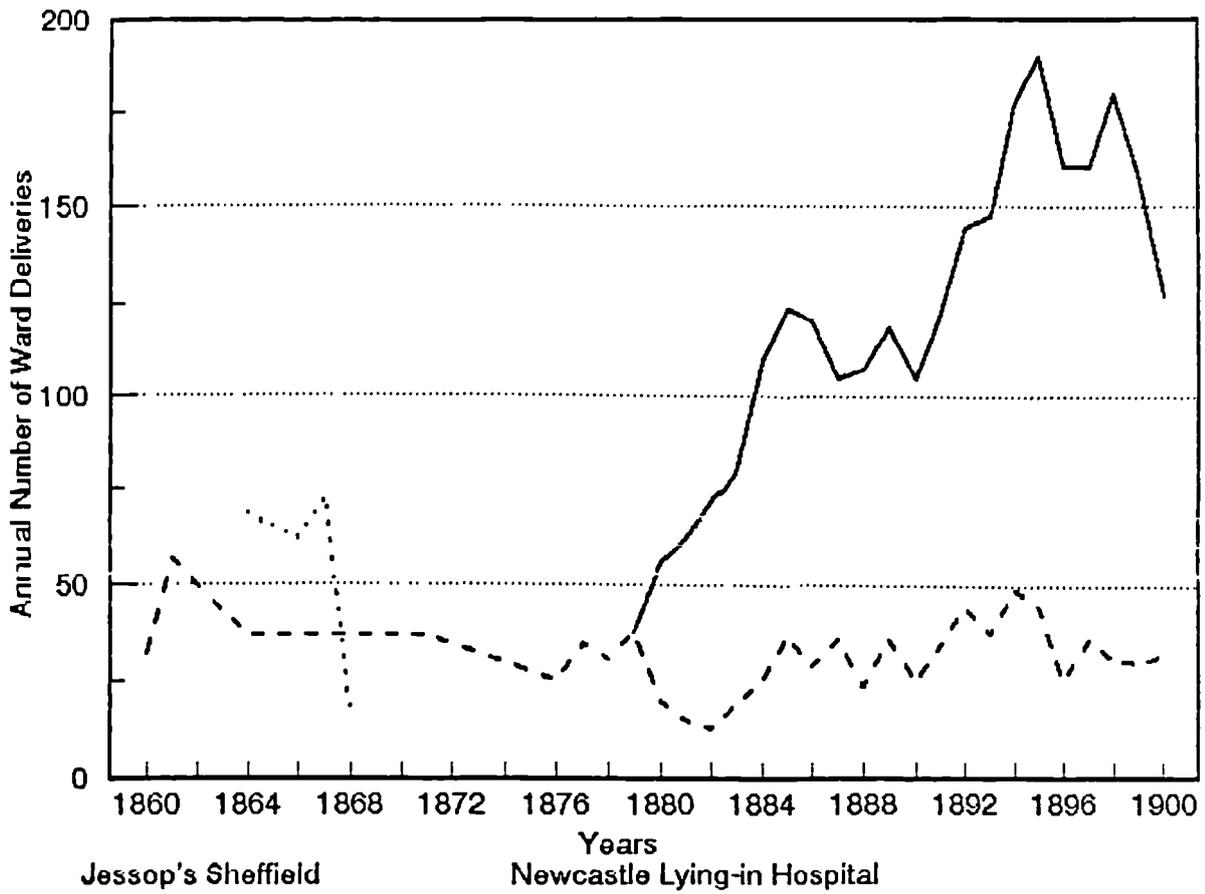
	Year	Her Age	Expecting Xth Child	Days Admit. Before Del.	Days Died After Del.	Treatment (If Known)	The Child:
'In Extremis'	1891	29	?	0	3 Days	?	Dead
Severe Flooding	1891	36	?	2 Days	7 Days	Forceps	Dead
Eclampsia	1893	17	1st	0	0	Induced	?
Placenta Praevia	1891	37	8th	0	0	Turned	Dead
Placenta Praevia	1895	26	5th	0	13 Days	?	Alive
Craniotomy	1892	24	1st	0	6 Days	?	Dead
Torn Perineum	1891	43	13th	0	13 Days	?	Alive
'Puerperal'	1895	32	3rd	1 Day	20 Days	?	Alive
Embolism	1892	30	6th	0	6 Days	?	Alive
Pneumonia	1893	26	4th	3 Days	18 Days	?	Alive
Pneumonia	1893	22	1st	0	16 Days	?	Alive
Abortion	1891	33	8th	3 Days	8 Days	?	--

Source: Jessop Hospital Maternity Register, May 1879-October 1896

were expecting their fourth or fifth, and one woman in 9 who were expecting their eleventh or more child (Table 5.8). Clearly age and parity played a far more decisive role in influencing the use of forceps than the mere whim of a doctor, but when they were eventually applied it was to the woman's advantage, reducing the pain and curbing the threat of further complications. Only one woman died after a forceps delivery, but it was due more to the loss 'of gallons of liquor amni' and her moribund condition on admission than the use of forceps.⁷⁶

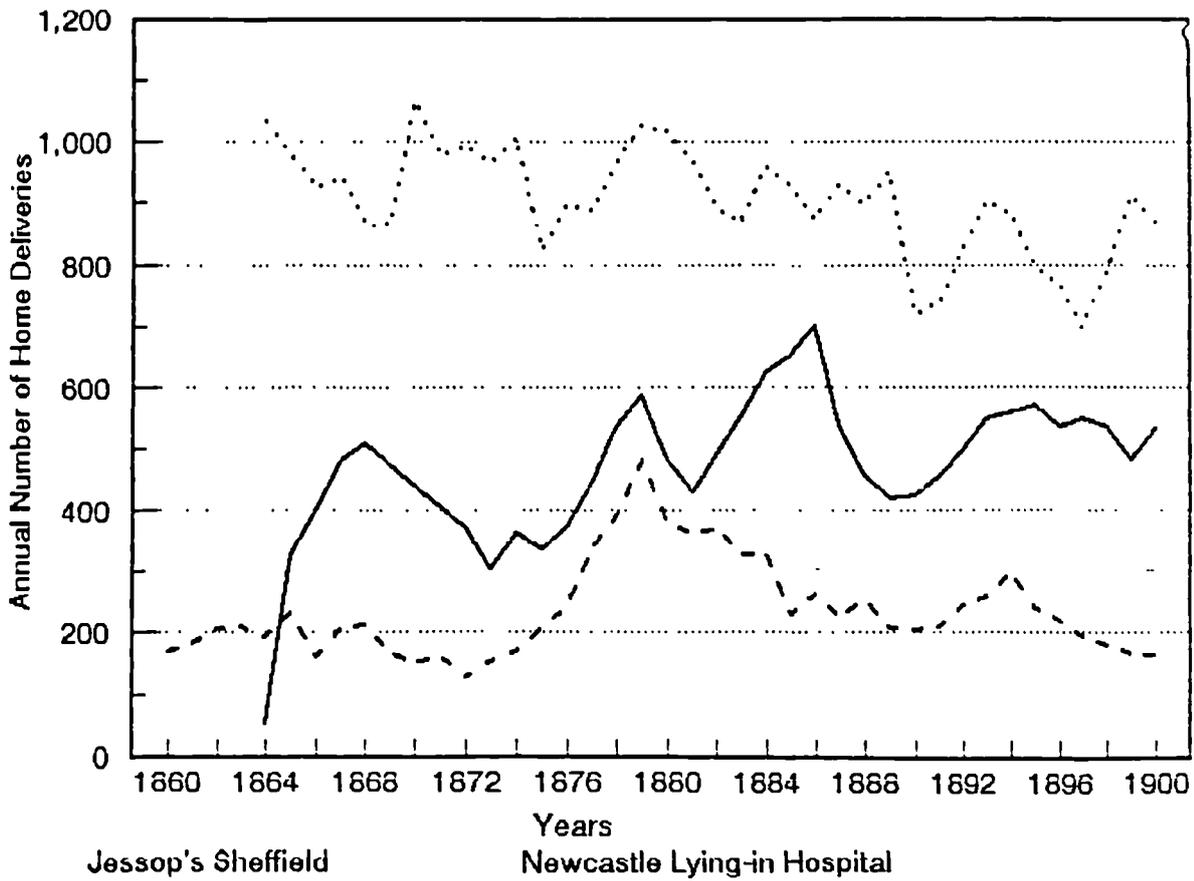
The women who lost their lives in hospital tended to be those who were admitted and delivered on the same day and therefore already facing severe complications before being seen by the hospital medical staff. Thus, two of the three cases of placenta praevia (1891-95), where the placenta obstructed delivery of the foetus, which were admitted on the same day as delivery, proved fatal, and one of the five suffering from eclampsia, a 17 year old primipara, also lost her life on the same day she entered hospital, but her baby boy survived (Table 5.9). In such situations the Jessop could do little, for though the hospital could be accused of not accepting the cases early enough to pre-empt an eclamptic state or avoid performing a craniotomy, which instantly terminated the infant's life and greatly endangered that of the mother, ante-natal provision was not officially recognised, let alone practised, until the pioneering work by Ballantyne in the early 1900s.⁷⁷

**FIGURE 5.6: WARD DELIVERIES
PROVINCIAL MATERNITY HOSPITALS 1860-1900**



Birmingham Lying-in Charity
.....

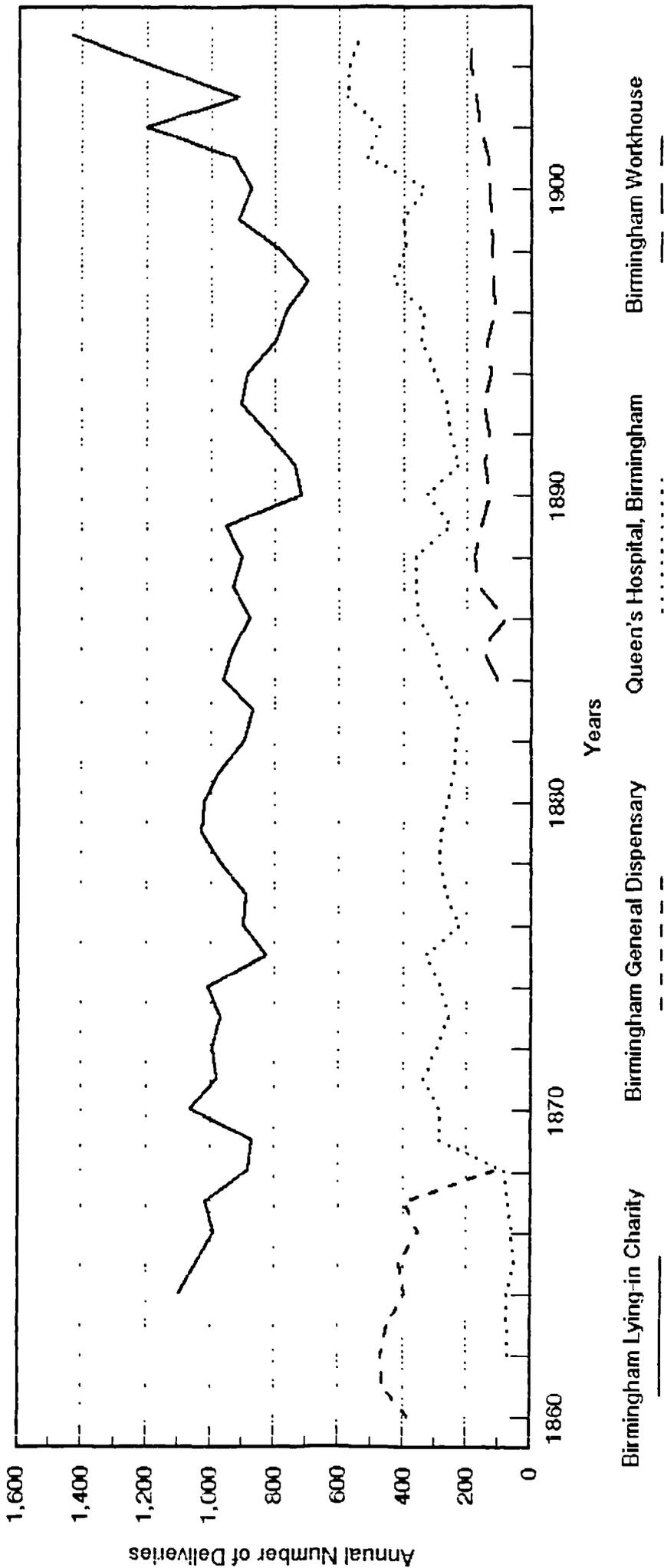
**FIGURE 5.7: HOME DELIVERIES
PROVINCIAL MATERNITY HOSPITALS 1860-1900**



Birmingham Lying-in Charity
.....

Sources: Annual Reports of Respective Institutions and Financial Accounts. Newcastle Lying-in Hosp.

**FIGURE 5.8: ANNUAL NUMBER OF DELIVERIES BY CHARITY AND POOR LAW ORGANISATIONS
BIRMINGHAM 1860-1905**



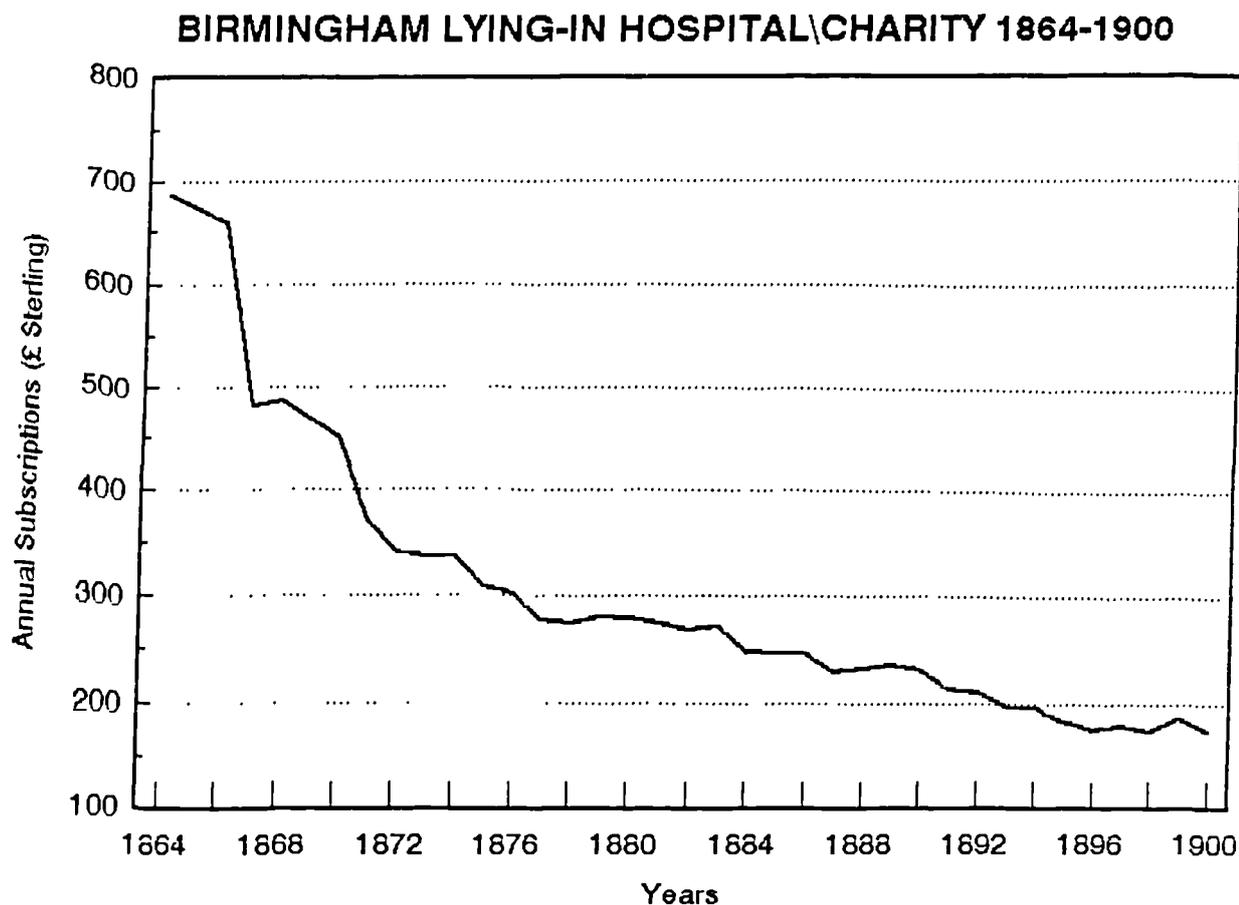
Birmingham Lying-in-Charity 1860-63/65 No Data
 Sources: Annual Reports of Respective Charities, 1860-1905
 & Parish of Birmingham Annual Financial Statements, 1884-1905

Where the hospital may well have been able to do more and perhaps even prevent a death, was in the case of the 'puerperal' fatality in August 1895 and the death involving a 'torn perineum' in July 1891. Both deaths occurred soon after delivery and for no apparent reason other than that stated, but given the time period and in one case, the torn perineum, exposing the woman to infection, there is every indication that puerperal sepsis was the cause. Yet whether this were as a result of poor hospital hygiene, incompetent medical attendance or due to interference prior to admission, the hospital registers prove conveniently elusive.⁷⁸

Case Totals: Their Demographic Limitations

Though all the common precepts governing maternity hospitals were shared by the respective institutions (a free confinement, for 'deserving' cases, living within the prescribed boundaries) the number of cases involved was very small (Figures 5.6 and 5.7). Whilst the Lying-in Charity, for example, was Birmingham's principal maternity organisation, confining three times the annual number attended by the Queen's General Hospital and five times the annual number delivered by the local workhouse, its own case load, throughout the period, remained 'about the same, viz., 1,000 more or less, per annum' (Figure 5.8). With a city birth total of about 16,000 a year, the charity's own annual case total was 'small' and left

FIGURE 5.9: ANNUAL SUBSCRIPTIONS



Figures for 1865,69 unavailable

Values rounded to the nearest pound

Annual Subscription

**TABLE 5.10: RECOMMENDATIONS AVAILABLE
BIRMINGHAM LYING-IN CHARITY 1864 AND 1900**

Amount Subscribed:	1864			1900		
	Col. A	Col. B	Col. C	Col. A	Col. B	Col. C
1 Guinea	4	476	1,904	5	128	640
2 Guineas	8	35	280	10	15	150
3 Guineas	12	4	48			
4 Guineas	16	4	64			
5 Guineas	20	3	60	25	1	25
26 Pounds Sterling	100	1	100			
TOTALS:		523	2,456		144	815

Col. A = Subscription:Recommendation Ratio

Col. B = No. of Subscribers

Col C. = Total Number of Recommendations Available (AxB)

Source: Birmingham Lying-in Hospital\Charity Annual Reports 1864-1900

an increasing number 'of really deserving persons, who were unable to obtain assistance from this Charity...obliged to employ untrained midwives or such casual help as they can obtain'.⁷⁹

Such was the speculation that the Charity would double its case load once the maternity hospital was closed and women were delivered solely in their own homes, that Birmingham's General Dispensary and, for two years, Queen's Hospital, disbanded their maternity departments in 1868 and 1869 respectively (Figure 5.8).⁸⁰ Yet, rather than attracting additional *funding* as prophesied, the closure of the maternity hospital resulted in an immediate and substantial fall in subscriptions, donations and legacies.⁸¹ The funds from these sources fell from £928 per annum in 1864, three years before the hospital was closed, to £470 six years later, to less than £200 by the end of the century (Figure 5.9). This tremendous fall in subscriptions not only precluded the possibility of ever creating a fifth district to accommodate a rapidly expanding city but it also greatly reduced the availability of recommendation tickets which were issued by the sponsors in proportion to the amounts they subscribed (Table 5.10). A domiciliary-based charity, conducted from an anonymous office somewhere in the city, just did not have the same appeal as a hospital building, a tangible and very visible landmark to which the subscribing public could relate.

Yet it was not just the Lying-in Charity that found difficulties raising the necessary funds and responding to the host community's ever-changing demographic and maternity needs; Newcastle's Lying-in Hospital encountered similar problems. The number of hospitalised confinements was never more than 50 a year, and similarly in the district, which until 1889 only included women who had borne two or more children, the number of annual confinements was limited to between 200 and 300 cases a year, which was negligible in comparison to the city's own annual birth total of 7,000 (Figures 5.6 and 5.7). Except during the high unemployment years (1878-79) when district totals reached a maximum of 484 confinements a year, the Newcastle Lying-in Hospital remained immune to trade cycles and demographic changes which would normally encourage an increase in case capacity (Figure 5.7). Concentrating on midwifery provision, which was not, unlike the plight of the sick child or the emergent interest in gynaecology, an area of philanthropic interest, the Newcastle Lying-in Hospital struggled to maintain an annual income; the annual revenue for 1900 was £439, only £21 more than it had been 30 years earlier (Figure 5.2). Clearly, an increase in the hospital's case capacity could never have been sustained, irrespective of demographic changes and local maternal needs.

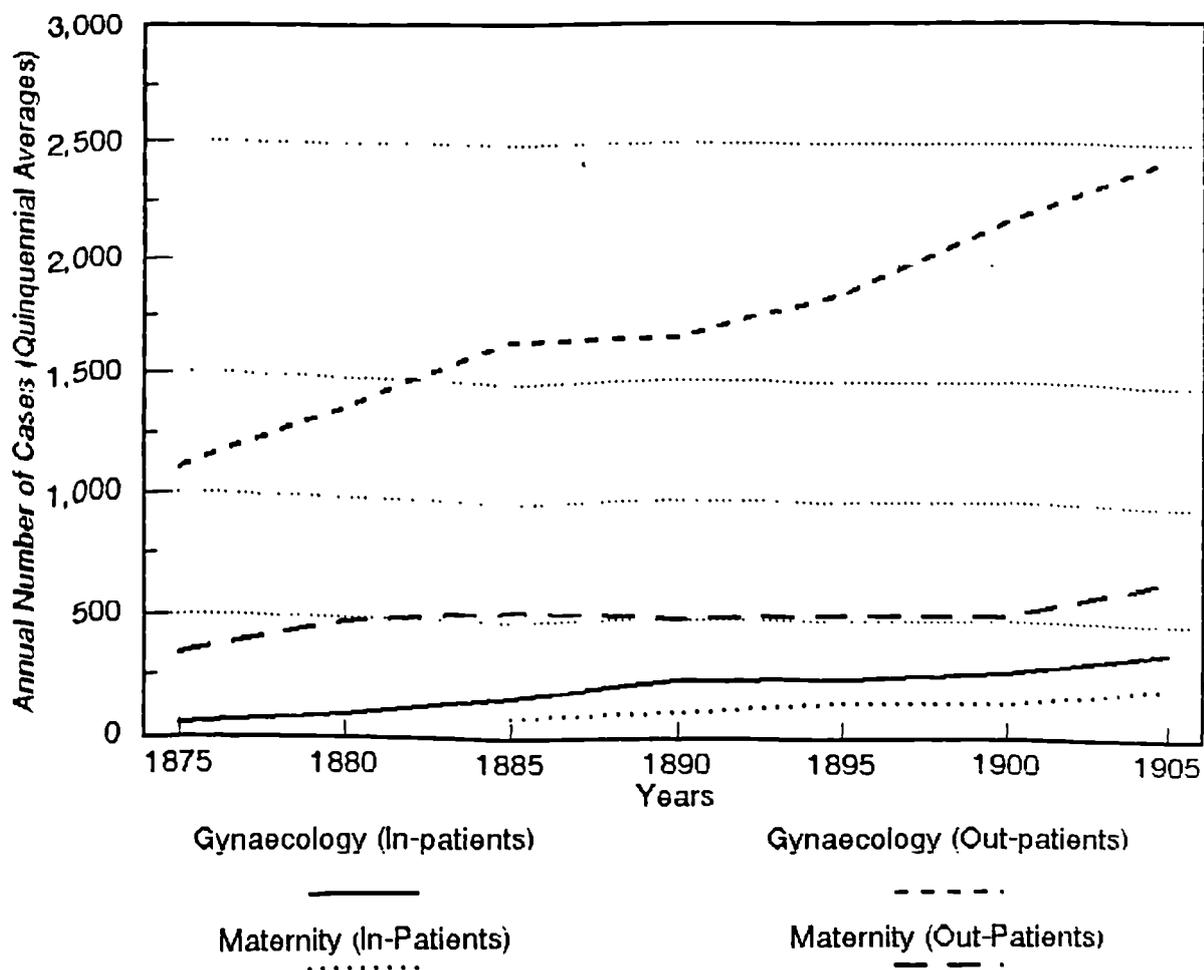
It was not simply a question of funding, however, but of priorities. At the Jessop for example, revenue totals, largely as a result of increases in annual

TABLE 5.11: REVENUE SOURCES

JESSOP'S 1864, 1875 AND 1900

	1864	1875	1900
	£ s d	£ s d	£ s d
Subscriptions	156 13 6	358 14 0	1860 6 0
Donations	389 4 0		304 16 8
Saturday and Sunday Fund		114 13 9	491 19 9
Student Fees		1 1	
Miscellaneous Receipts			32 15 10
Interest and Dividends	13 13 5	122 2 6	777 12 4
Revenue Totals	559 10 11	596 11 3	3467 10 7

FIGURE 5.10: CASE TOTALS: QUINQUENNIAL AVERAGES
JESSOP'S 1871\5-1901\5



Case Totals 1871-75, Based on four year average

Source: Jessop Hospital Annual Reports 1864-1905

subscriptions, donations and interest-yielding investments, rose from £560, in its inaugural year, (1864) to £855 (1875) to £3,460 (1900) (Table 5.11). Yet after the initial and inevitable years of rapid growth, the hospital's maternity figures remained very stable, between 300 and 550 district and 150 ward cases a year, whilst the number of gynaecology cases rose from about 1,400 to 2,200 out-patients and from 100 to 300 in-patients, a year (1876/80-1896/1900) (Figure 5.11). Even at those institutions which were ostensibly maternity organisations, more and more gynaecology cases were being dealt with each year to the point where they were drawing money and other relevant resources from the original purpose of delivering women. The Liverpool Lying-in Hospital, which has already been discussed, is a case in point, but also at Birmingham, when the future of the maternity hospital was being considered and it was admitting as many gynaecology in-patients (78 per annum, 1864-74) as maternity cases (67 per annum), there were proposals to convert the hospital into a gynaecology unit. Although due to financial and constitutional reasons this never happened, the establishment of a gynaecology hospital in 1871 by disgruntled lay supporters and medical staff, undoubtedly attracted funds away from the new district maternity charity, and in so doing, indirectly inhibited its development and thwarted all aspirations of doubling its case capacity.⁸²

Case totals were also small, because apart from the midwifery instruction available at the Liverpool and

Manchester maternity hospitals and some obstetric research at the latter, there was little activity upon which to focus resources and generate the necessary funds, other than the confinement and material relief of charity cases. Though well-intentioned, the instruction of pupil midwives at Birmingham's Lying-in Charity, for example, had only lasted three years (1877-79) and involved only nine pupils.⁸³ Whilst at the Jessop, suitable lectures on midwifery were offered, examinations arranged and personal delivery of 30 cases of labour required, only two probationers were appointed at any one time and then for a year, which greatly restricted the numbers instructed; the numbers were sufficient to ensure a cheap and regular source of assistants but they were never significant enough to threaten the local doctors' lucrative midwifery practices.⁸⁴ As for Newcastle, even the employment of trained midwives had stopped at the request of the 'medical men' at the Lying-in Hospital and senior students from the local medical college.⁸⁵ Suffice to say, that in each of these three cities at the beginning of the twentieth century, between 60 and 90 per cent of practising midwives were still untrained.⁸⁶

Student instruction was equally very poor. Despite constituting an original aim of both the Birmingham Lying-in and Jessop Hospitals, very few were taught. In the case of the former, student instruction ended with the closure of the maternity hospital in 1867 and in the case of the latter, only 16 guineas (one guinea for each student) was collected in tuition fees (1867-86).⁸⁷ Even

at Newcastle's Lying-in Hospital where sweeping changes took place in favour of medical students 'to ensure the proper way of the Institution', medical instruction was still very badly taught and poorly organised, so much so that many students, like their counterparts in Liverpool, went to the Rotunda, Dublin, and Queen Charlotte's, London, to fulfil their midwifery requirements. 'The [Newcastle Lying-in] hospital', one former medical student (1893-8) recalled, 'was one of those delightful old charities in which nobody seemed to take much interest from the professional as opposed to the philanthropic side'.⁸⁸

Though of invaluable assistance to the limited numbers of women they attended, both materially and medically, there was little that could be said to be professional about any of these nineteenth-century maternity institutions, and that perhaps was what concerned their respective medical Boards most of all. Particularly in the 1890s, obstetric practice, instruction and research, suddenly became a major issue and the hospital a prime focus for that attention; that was, as the Liverpool study will illustrate, the opportune time to turn professional.

Notes to Chapter 5

1. Unnamed Author, 'A History of Jessop's Hospital For Women Sheffield', Lecture Notes, Jessop's Hospital (Sheffield, no date). For the history behind the development of specialist hospitals see: Lindsay Granshaw, *St. Mark's Hospital London: A Social History of a Specialist Hospital* (London, 1985); idem, 'Fame and Fortune by means of bricks and mortar: the medical profession and specialist hospitals in Britain 1800-1948', in *The Hospital in History*, ed. by Lindsay Granshaw and Roy Porter (London, 1989), pp. 199-220; *The London and Provincial Medical Directory 1864* (London, 1864).
2. Jessop's Hospital Archive (hereafter, JHA), Minute Book No. 1/2, 12 December 1863. For an account of the inaugural proceedings and management composition of the Birmingham Lying-in Hospital see, Smallwood Savage, 'Some Modern Maternity Hospitals, With Plans: II. Birmingham Maternity Hospital', *Journal of Obstetrics and Gynaecology of the British Empire*, 13 (1908), 197-206.
3. Thomas Jessop financed the building of the current hospital, along Gell Street, Sheffield, in 1874 at a total cost of £30,000 including the purchase of the site, the erection of the building and provision of all the furnishings, JHA, Annual Reports, 1874-75, 1878. 1898 Obituary, *Sheffield and Rotherham Independent*, 1 December 1887.
4. Obituaries, *Sheffield and Rotherham Independent*, (Bernard Wake), 1 May 1891, (Robert Leader), 2 November 1885.
5. Obituary, *Sheffield and Rotherham Independent*, 20 March 1882. Also obituaries in the same newspaper for: George Hounsfeld, 12 February 1870; Alderman Saunders, 1 August 1870; William Butcher, 9 November 1870; William Jeffcock, 25 November 1871; William Frederick Dixon, 29 December 1871; Rev. Cannon Sale, 22 September 1873.
6. It was not until 1898 that women were encouraged to attend the Annual Subscribers' meeting, but even then their vote was still by proxy and it was not until 1918 that women were finally appointed to the Board of Management at Jessop's. 'Inaugural Meeting of Jessop Hospital', *Sheffield and Rotherham Independent*, 12 December 1863, JHA, Minute Book No. 6, 28 February 1898, Annual Report, 1918.
7. See Chapter 4.

8. Birmingham Central Library (hereafter, Birmingham CL), L46.24, Annual Report of the Birmingham Lying-in Hospital, 1864.
9. Newcastle Central Library (hereafter Newcastle CL), L362.1, Annual Reports, 1857-1900.
10. JHA, Minute Book No. 1/2, 4 December 1884, Annual Reports 1884, 1885. Sheffield Central Library (hereafter Sheffield CL) *Pamphlets*, Vol. 83, no. 13, 'Address to the Right Honourable The Baroness Burdett-Coutts and Her Remarks on opening the Bazaar June 1885', Newspaper Cuttings, Vol 10, p.112. Recollections of Kate Braisford, a Lady Visitor to Jessop's, *Sheffield Telegraph*, c1930. To have secured the presence of the 71 year old Baroness Burdett-Coutts, 'the premier Victorian Philanthropist...Madame Philanthropic herself' and 'recipient of hundreds of appeals each month', would have been something of a major achievement in itself. For more information on Burdett-Coutts see David Owen, *English Philanthropy 1860-1960* (London, 1964), pp. 413-20. Similarly, the Glasgow Samaritan Hospital emerges as the largest women's hospital in the United Kingdom after extensive renovations completed in 1903 and yet it remained free of debt, 'largely as a result of a Bazaar'. Derek Dow, *Rottenrow: The History of the Glasgow Royal Maternity Hospital 1834-1984* (Glasgow, 1984), p.80.
11. Birmingham CL, L46.24, Annual Reports, 1904, 1905, 1906, 1907.
12. The calculation for the Jessop (1900) is based on the number of subscribers who made annual subscriptions of between 10s 6d and 5s 5d inclusive, for which they received one recommendation for every half guinea subscribed. Whether this recommendation was used for delivery in the home or hospital was the decision of the mother and the duty medical officer. For amounts exceeding five guineas the number of recommendations issued was determined by a Special Resolution of the Board which in 1900 involved 30 subscribers, only two of whom were women. JHA, Annual Report, 1900.
13. Tyne and Wear Central Archive (hereafter Tyne and Wear CA), HO/PM/1/8, minutes, Rules and Regulations of the Institution 1859.
14. Birmingham CL, L46.24.
15. JHA, Minute Book No. 6, 12 May 1896, Minute Book No. 11, 11 November 1913, Annual Reports, 1896-1912.
16. JHA, Minute Books No. 1/2, 4 September 1871.

17. *The Birmingham Journal*, 9 February 1867. For women challenging their subordinate role in the field of philanthropy generally, see Frank Prochaska, *Women and Philanthropy In Nineteenth Century England* (London, 1980), pp.17,222.
18. *The Birmingham Daily Gazette*, 19 February 1867.
19. *The Birmingham Daily Gazette*, 19, 26, 27 February 1867.
20. *The Birmingham Journal*, 9 February 1867.
21. *The Birmingham Journal*, 13 June 1867.
22. See particularly, *The Birmingham Daily Gazette*, 23 February, 13 June 1867, *The Birmingham Journal* 9 February, 2 March, 30 November 1867. For details of the 'considerable influence' the press wielded on hospital development see, Gerald Rivett, *The Development of the London Hospital System 1823-1982* (London, 1986), p.16.
23. *Birmingham Daily Post*, 25 February 1867, *Birmingham Daily Gazette*, 26 February 1867.
24. *Birmingham Daily Gazette*, 13 June 1867.
25. *Birmingham Daily Gazette*, 13 June 1867, Correspondence, *Birmingham Daily Gazette*, 29 June 1867.
26. *Birmingham Daily Gazette*, 20 June 1867.
27. *Birmingham Daily Gazette*, 13, 20 June 1867.
Birmingham Daily Post, 25 February 1867.
Birmingham CL, Annual Reports 1867, 1868.
28. Birmingham CL, L46.24, Annual Report, 1867.
29. JHA, Minute Book No. 1/2, 4 March 1867; 7 March 1870; 13 April 1874; 1 April, 6 May 1878. 'Churching' was the Anglican practice of thanksgiving after childbirth, only after which women traditionally could take up normal life again and resume marital relations. Whilst perhaps not as strictly adhered to, Mary Chamberlain in her study of fenwomen in 1975 found women in the 1970s still talking about 'the churching of women ceremony, when you thank God for a safe delivery, so the vicar says'. Mary Chamberlain, *Fenwomen: A Portrait of Women in an English Village*, (London, 1975) p.84.
30. JHA, Minute Book No. 1/2, 6 January, 3 February, 3 March 1873.

31. JHA, Minute Book No. 1/2, 10 October 1881; 13 February, 9 October, 13 November 1882; Ladies Minute Book, 1878-1882, 7 October 1882.
32. JHA, Annual Report, 1884. Sheffield CL, Address to Burdett-Coutts.
33. Tyne and Wear CA, HO/PM/1/8, Minutes, Rules and Regulations of the Institution 1859.
34. Tyne and Wear CA, HO/PM/1/8, minutes, 27 March, 3 April, 24 November 1861; 2 April 1862, 3 April 1863; 24 February 1865.
35. Pat Jalland, *Women, Marriage and Politics 1860-1914* (Oxford, 1985), pp.143-48.
36. Tyne and Wear CA, HO/PM/1/8, 24 February 1865.
37. For full transcript, see Appendix 2. W. D. Arnison, 'The Life of the School 1882-1886', in *The Newcastle Upon Tyne School of Medicine 1834-1934*, ed. by Grey Turner and assisted by W. D. Arnison (Newcastle-Upon-Tyne, 1934), p.107.
38. For further accounts of incompetent student practices see, John Edgar, 'Is There Room for Improvement in our Present Mode of Clinical Instruction in Midwifery?', *Glasgow Medical Journal*, 50 (1898), 174-184, and for the embarrassment it caused the patient, George Moore, *Esther Waters*, a facsimile of the first edition, London, 1894 (Chicago, 1977), pp.115-16.
39. Tyne and Wear CA, HO/PM/1/10/3, loose papers, letter from R. C. Newton, Visiting Surgeon to Medical School, 3 July 1889.
40. Tyne and Wear CA, HO/PM/1/9, minutes, 6 October, 5 November 1897.
41. Tyne and Wear CA, HO/PM/1/8, minutes, 9,16,30 November, 1870; 10 May 1871.
42. Tyne and Wear CA, HO/PM/1/10/1, loose papers, letter from Mary Arkle to Mrs Pounder, the Matron of the Lying-in Hospital, May 1879. HO/PM/1/9 minutes, 22, 29 May 1879.
43. Tyne and Wear CA, HO/PM/1/9, minutes, 9 March 1881; 26 October, 9 November 1882. HO/PM/1/10/3, loose papers, letter from Ralph Young to the Hospital Committee, 1 March 1882, HO/PM/1/10/7-8, 10, loose papers, letter from Ralph Young to the Hospital Committee, 16 October 1882.

44. Tyne and Wear CA, HO/PM/1/10/2, loose papers, letter from Ralph Young to Hospital Committee, 23 May 1879.
45. Tyne and Wear CA, HO/PM/1/10/4, loose papers, letter from the Charity Organisation Society to Mrs Pounder the Hospital Matron, 1st March 1882.
46. Tyne and Wear CA, HO/PM/1/9, minutes, 21 May 1874.
47. JHA, Ladies' Minute Book, 3 May 1879, Minute Book No 3, 11 December 1883, Minute Book No. 1/2, 2 December 1872, Minute Book No. 4, 23 February 1891.
48. Birmingham CL, 486694 C/25, Birmingham Institutions, Rules and Regulations to Be Observed By The Midwives of The Birmingham Lying-in Charity, 1872. For details concerning the recruitment of a pupil midwife for Jessop's, see Appendix 4.
49. Birmingham CL, 486694 C/25, Lying-in Charity Rules.
50. JHA, Minute Book No. 3, 6 February 1888.
51. Birmingham CL, 486694 C/2, Lying-in Charity Rules, 1872, L46.24, Annual Report 1870, JHA, Minute Book No. 1/2, 12 December 1863; 12 March 1883.
52. Birmingham CL, L46.24, Annual Reports, 1861-1900. JHA, Annual Reports, 1866, 1872, 1873.
53. JHA, Minute Book No. 1/2, 7 March 1881.
54. JHA, Annual Report, 1890.
55. Birmingham CL, L46.24, Annual Report, 1868.
56. Birmingham CL, L46.24, Annual Report, 1866.
57. *Annual Report of the Registrar General of Births, Deaths and Marriages in England, Abstract for 1876* (London, 1878), p.243. Birmingham CL, L46.24, Annual Report 1881, for other features and examples of the Lying-in Charity's low maternal mortality rates, see the *Lancet*, 24 May 1879, p.747; 16 February 1884, p.323; 21 April 1894, p.1015.
58. Birmingham CL, L46.24, Annual Report, 1893.
59. See Appendix 3.
60. *Sheffield and Rotherham Independent*, 12 December 1863.
61. Sheffield CL, Annual Report of the Health of the City, 1905.

62. At Birmingham Lying-in Charity a midwifery course was first initiated in 1872, costing six guineas and lasting three months, but it was not until 1877 that the first two pupil midwives were trained and by the end of the decade, only a further seven had enrolled, resulting in the examination of midwives only from 1880. Consequently, the proportion of midwives who were trained by 1905 in Birmingham, when the Midwives Act was enacted, was less than 10 per cent compared with practically 90 per cent in Liverpool and 70 per cent in Manchester. Birmingham CL, L46.24, Annual Report, 1871-80, Savage, p.203.
63. JHA, Minute Book No. 7, 10 May 1904.
64. JHA, Minute Book No. 1/2, 7 March 1881.
65. Newcastle CL, L362.1 Annual Reports, 1859, 1880, 1890.
66. Tyne and Wear CA, HO/PM/1/10/3, loose papers, letter by Ralph Young to the Hospital Committee in defence of his neglect of a patient, 1 March 1882, Newcastle CL, L362.1, Annual Report, 1896.
67. Birmingham CL, Annual Report, 1864, 1867.
68. See for example: C. J. Cullingworth, 'Undiminished Mortality from Puerperal fever in England and Wales', *Obstetrical Society of London Transactions*, 39 (1897), 91-114, (p.93); William Williams, 'Puerperal Mortality', *Transactions of the Epidemiological Society of London*, 15 (1895-96), 100-133 (p.103); Leading Article, 'Puerperal Mortality: Real, Supposed and Ideal', *BMJ*, 17 September 1898, p.823; D. Galabin, 'Inaugural Address', *Transactions of the Obstetrical Society of London*, 31 (1889), 88-103 (p.92).
69. JHA, Minute Book No. 3, 9 October 1868, Minute Book No. 4, 12 March 1889, Minute Book No. 5, 11 October 1892.
70. Tyne and Wear CA, HO/PM/1/8, minutes, 7 November 1860; 6 April 1866; 11 November 1868; 26 May 1869; 26 October 1870; 21 January 1875.
71. JHA, Minute Book No. 5, 10 October 1893.
72. JHA, Maternity Admissions Register, May 1879-October 1896, Cases cited, admitted on, 6 November 1894; 16 June 1892; September 4 1893.
73. Such was the perceived danger of a first pregnancy, that for those seeking life insurance, the premium for a woman pregnant for the first time was three

times higher than that for a subsequent pregnancy. John Playfair and T. Wallace, 'Pregnancy In Relation to Life Assurance', *The BMJ*, 17 September 1898, pp.765-69. J. H. Young, 'The Grand Multiparae', *Journal of the College of General Practitioners*, 8 (1964), 49-59 (p.8). William Gilliat, 'Maternal Mortality, Still-Birth and Neonatal Mortality', in *Historical Review of British Obstetrics and Gynaecology 1800-1950*, ed. by J. Munro Kerr (Edinburgh, 1954), pp.257-93 (pp.8-9). J. Matthews Duncan, *On the Mortality of Childbed and Maternity Hospitals*, (Edinburgh, 1870), pp. 29,33,37-39,43. 'On the Mortality of Childbed as affected by the Number of the labour', *Edinburgh Medical Journal*, 2 (1865-66), 201-12 (pp.209-10).

74. Proposal for insurance from a woman aged 30 or more who was pregnant for the first time was to be delayed, whilst a proposal from a woman aged 40 or more was to be discarded, whatever the number of the pregnancy, Playfair, p.769. J. H. Young, 'Age and Parturition in Primigrauidae', *Journal of Obstetrics and Gynaecology of the British Commonwealth*, 80 (1963), 632-642 (pp.636,642). Duncan, 1870, pp.59, 61.
75. JHA, Maternity Admissions Register, May 1879-October 1896, cases admitted 18 January, 25 March 1893.
76. JHA, Maternity Admissions Register, May 1879-October 1896, case admitted, 6 February 1891.
77. J. W. Ballantyne 'A Plea for A Maternity Hospital', *BMJ*, 6 April 1901, pp.813-4; 19 October 1901, p.1192; 11 January 1902, p.65.
78. JHA, Maternity Admissions Register May 1879 - October 1896, cases admitted, 28 June 1891; 9 August 1895.
79. Birmingham CL, L46.24, Annual Report, 1883.
80. Birmingham CL, L46.4, Birmingham General Dispensary, Annual Report, 1867, *Birmingham Journal*, 22 February 1868. L46.11, Queen's Hospital Annual Report, 1871.
81. Birmingham CL, L46.24, Annual Reports 1872, 1876, 1878, 1885, *Lancet*, 23 September 1871, p.451. *Birmingham Journal*, 9 February 1867.
82. Birmingham CL, L46.24, Annual Reports 1864-1867. L46.25, The Birmingham and Midland Hospital For Women, Annual Report 1871.
83. See note 62 above.

84. JHA, Minute Book No. 3, 6 February 1888.
85. Tyne and Wear CA, HO/PM/1/8, Minutes, 24 February 1865.
86. See Chapter 7.
87. Birmingham CL, L46.24, Annual Report 1867, JHA, Annual Reports, 1867-1886.
88. See Appendix 3.

Chapter Six

A Medical Affair

The Politics of Hospital Management

(Part Two)

Liverpool Lying-in Hospital

The Medical Board 1869-1896: An Ineffectual Body

God and the doctor both like and adore,
 But only when there's danger, not before.
 The danger o'er, both are alike requited-
 God is forgotten and the doctor slighted.¹

"POSSIBLE" 15 May 1896

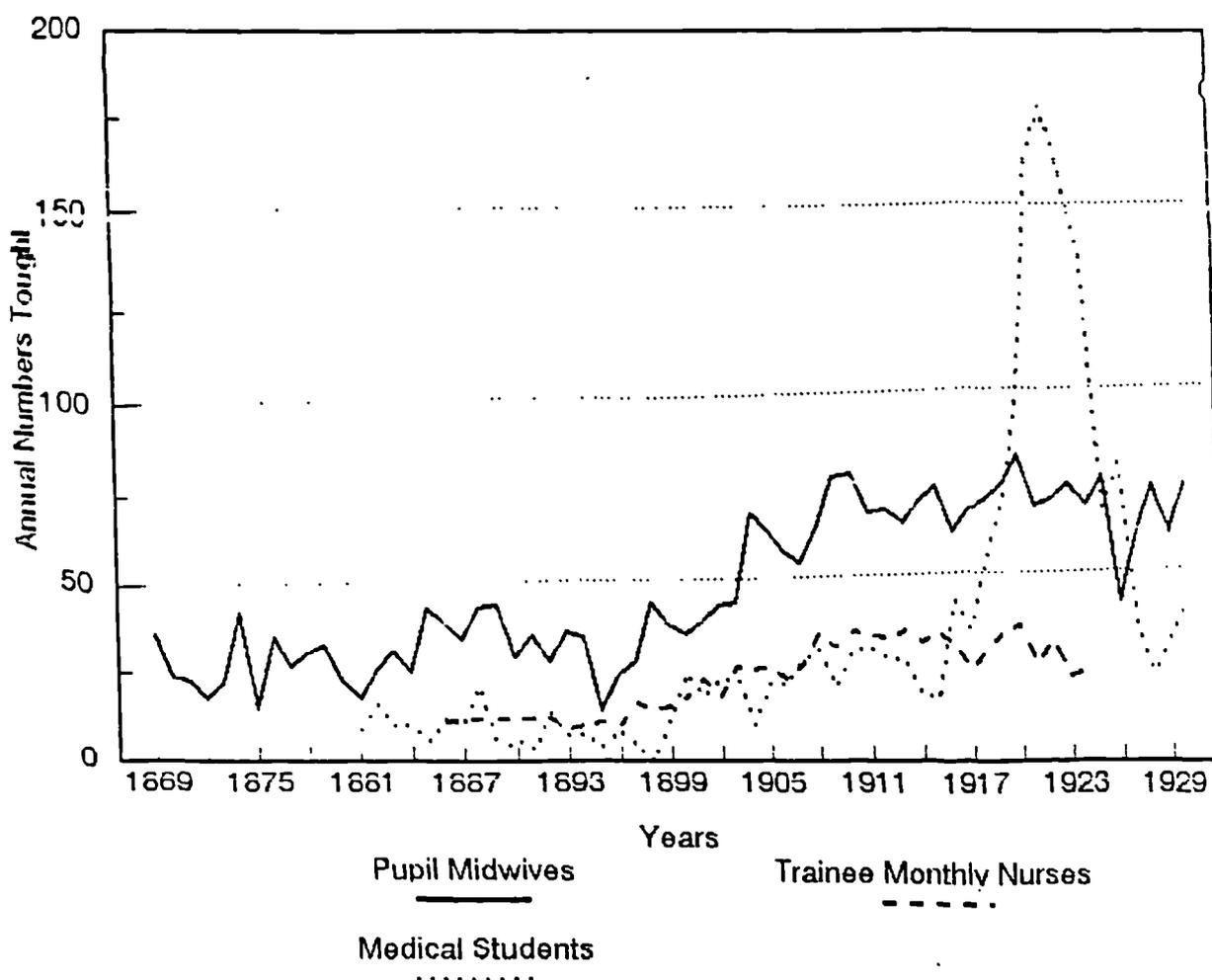
Unlike other specialist institutions during the Victorian period, where doctors had personally founded the hospital, recruited their own family and friends to manage the charity's affairs and secured voting rights on the Board, the Liverpool Lying-in Hospital could never have been regarded as the 'training ground' and 'work place of the medical élites', where lay control was rejected and the professional influence all pervasive.² To some extent, hospital regulations and the presence of a very active Ladies' Committee guarded against this. The honorary medical officers were only permitted, for example, to hold their appointments for ten years which did little for continuity of leadership amongst the ranks of the professional staff. They were also subject to annual re-elections, which, given the uncertainty about renewal of the honorary appointments they could hold, no doubt discouraged tendencies to be too outspoken or critical about their patrons' policies.³ Though the medical staff would have had plenty of freedom to manage institutional affairs between the monthly management meetings, it was the Ladies' Committee, not the Medical Board, who controlled the daily running of the hospital.⁴ Yet even when in session, the regulations prohibited the

TABLE 6.1: MEDICAL REPRESENTATION ON HOSPITAL BOARDS OF MANAGEMENT LIVERPOOL 1881

	No. of Board Members	No. of Honorary Doctors	No. of Doctors on the Board	One Doctor Represented in:
Royal Infirmary	25	7	7	4
Eye and Ear Hosp.	16	3	3	5
Child's Infirmary	17	7	2	8
Dispensary	26	12	3	9
Northern Hospital	27	5	2	13
Southern Hospital	28	6	2	14
Chest Hospital	26	3	1	26
Lying in Hospital	13	3	0	0

Source: Liverpool Lying-in Hospital Medical Board Minutes 16 November 1881

FIGURE 6.1: ANNUAL NUMBER OF MIDWIFERY STUDENTS LIVERPOOL MATERNITY HOSPITAL 1869-1930



Source: Liverpool Lying-in Hospital Annual Reports 1869-1930

medical staff from actually being represented on the Board of Management, which made the Lying-in Hospital unique among the city's eight voluntary hospitals in not having any medical representation on such a Board (Table 6.1).

Consequently, rather than dictating the pace and nature of change, the medical staff were forever protecting their existing position, finding themselves constantly on the defensive. This was particularly the case with the preservation of their own ranks, for as early as January 1874 the Medical Board was putting forward their arguments against a managerial decision to reduce the number of honorary posts. Similarly, in November 1876, having successfully secured a house surgeon's post five years earlier, the Medical Board was fighting to ensure the appointment remained open.⁵ Their efforts, however, were generally in vain, for although professional posts were regularly being dissolved and recreated, it soon became apparent that the number of honorary medical officers would rarely surpass the original total of 18 and that the hospital's one salaried medical post, that of house surgeon, which was filled for only half of the 1870s, would finally be abolished in 1880.⁶ The loss of these individuals, the Medical Board argued, not only placed women confined in their own home at great risk, because of reduced access to emergency assistance from one or more doctors, but prevented, 'junior members of the profession of zeal, ability and character by being connected with it [the hospital] to

attain to eminence'.⁷ It is not entirely clear to which of the two arguments the Medical Board attached greater importance, but it is most evident that professional advancement, within an institutional setting, was something the medical staff held in high regard and which under lay-management was being denied them.⁸

Resigned after the loss of the House Surgeon's post, to only occasional visits to the hospital, when, for instance, a complicated birth arose (on average, only 21 times a year, 1885-95), many of the other traditional advantages that institutional practice afforded the hospital's honorary staff were also denied them.⁹ The lack of complicated admissions, accounting for no more than 14 per cent of the 1,654 ward cases (1885-95), illustrates the point, that despite requests by the Medical Board to discourage the admission of natural labours in favour of complicated cases, the medical staff were denied any choice over the type of cases accepted.¹⁰ This meant that there was hardly any scope to carry out the sort of statistical analysis, pioneering experiments and surgical techniques for which specialist institutions were renowned.

In addition, the absence of a salaried medical officer and the lack of professional control over admissions meant that the doctors were given little opportunity to instruct medical students. Though the Lying-in Hospital had received medical students from the Liverpool Royal Infirmary as early as 1857, and had appointed its midwifery lecturer as an ex-officio

Honorary Surgeon a year later, it had never attached the same importance to their instruction as it had to pupil midwives. Consequently, the hospital had never been very receptive to the mounting criticism from the Liverpool Medical School about the inadequacies of its facilities for the instruction of their students.¹¹ 'We are', as the hospital secretary, James Lister, remarked in May 1896, 'essentially an institution for the training of midwives and treatment of maternity cases by means of them', and so what training resources were available and what teaching-related initiatives were adopted, tended to focus on the midwife.¹² Hence the enrolment in 1885, for example, of 43 midwifery pupils compared with only six medical students, and the exodus of medical students from Liverpool, during their midwifery course, to attend the necessary quota of confinements at other maternity hospitals, such as the Rotunda, Dublin, where systematic teaching of medical students had been conducted since 1766 (Figure 6.1).¹³

The problem lay, as the Medical School saw it, with the student's attachment to a midwife, who, the school argued, did not always call the student to the birth, so that the student never 'had an opportunity to fulfil their necessary quota of attendances'. Though nothing was ever documented, it no doubt irritated, if not plainly annoyed many medical men, that medical students were placed under the control of a midwife. The fact that it was a woman who remained in charge of the student throughout his practical training made it all the more

frustrating; hence the Medical School's request for students to be allowed to deliver cases without the attendance of a midwife in February 1879.¹⁴ Whilst, to a certain extent, the Board of Management was able to overcome the midwives' reluctance to call students to attend the birth, by offering them 1s for every confinement to which they invited a student, the Board was not prepared to disband the midwife instruction scheme and endow students with the freedom that the Medical School was demanding.¹⁵ To have done so would have caused offence and even injury to those delivered by young, unsupervised and unqualified male students. This is just one example where the lay Board was able to check the more excessive, insensitive and potentially harmful demands of the medical profession.

The Crisis of 1896: Profession V. Lay Ideology

Matters, however, came to a head in late November 1895, when in a letter to the Dean of the Medical Faculty, University College, Liverpool, the Management Board stressed that only 'where difficulty arise' were its medical officers 'responsible for the safety and well-being of the mother and infant'; at all other times they were the responsibility of the midwife.¹⁶ The medical staff's reaction was immediate and resolute, insisting that they had the right to visit 'any [charity] patient, at any time, whether doing favourably or not'

and in order to avoid such conflicts of opinion in the future, called for representation on the Board.¹⁷ The Management Board felt such representation was 'inappropriate on the grounds they [the Honorary Medical Staff] derived certain emoluments from midwifery instruction' and, still adamant that the midwife should have complete authority over all normal confinements, aimed to clarify the position by changing the existing rules. This was to be done before the subscribers' meeting on 15 April 1896, when the Management Board proposed to amend rules 25 and 37 to give the medical officer 'professional charge' of complicated cases as opposed to 'sole charge of all patients' and the midwife control of all other cases, including the responsibility of deciding which women required medical attention.¹⁸ Refusing to countenance such a decision, the medical staff threatened to resign if rule 25 were not altered to emphasise that the medical officers had absolute *control* over all patients in the hospital, and if rule 37, which placed the matron under the authority of the duty medical officer, were not retained.¹⁹ When it became apparent that the Management Board were to proceed with their proposals, the medical staff collectively withdrew their services on 30 March, resolving only to return when the rules were changed in their favour and when they gained representation on the Management Board.²⁰

Initially, the resignation of all 16 medical officers did little to alter the opinion of the subscribers who resolved at the special meeting on 15

April, that whilst they recognised the medical staff's responsibility for general supervision of all medical matters, 'the subscribers regard the executive responsibility of and attendance upon normal cases as resting with the matron midwife'.²¹ The Management Board President, William Bartlett, immediately sought to appease the medical officers. Initially, Bartlett attempted this by granting the medical officers access to all wards and representation on the Board. When these concessions were rejected, he then gave them the right to formulate the rules governing the treatment of normal cases by the matron-midwife and fellow nurses, and also access to the wards to conduct as many examinations as necessary to ensure their regulations were being carried out. Bartlett maintained throughout, however, 'that the Board do not see their way to relieving the matron-midwife of her future responsibility for all normal cases'. The Medical Board replied on 30 April 1896, as it had after Bartlett's first series of concessions on 24 April, that it was not willing to share the responsibility of the patients' lives with a midwife over whom they would not have full authority.²²

Already supported by the local press and the country's leading medical journals, The Lancet and The British Medical Journal, the Medical Board's bargaining position was considerably strengthened by the resolution passed at the Liverpool Medical Institution on 11 May 1896.²³ 'Attended by 215 gentlemen and two ladies', the Institute meeting agreed that no doctors were to accept

office at the Lying-in Hospital or give assistance to its officials, either gratuitously or for gain, after 19 May.²⁴ Launched with a scathing commentary on the inadequacies of the hospital's Board of Management by Mitchell Banks, President of the newly inaugurated Liverpool Medical Club, and followed by a stream of trade union rhetoric and threats against 'any Blacklegs who imagine they see an opportunity for personal interest', it is hardly surprising that the maternity hospital's recruitment of new medical staff proved futile.²⁵

Initially, the Management Board did secure the services of a female doctor from a neighbouring town who gave several lectures to the pupil midwives, but on receipt of an anonymous and intimidating letter, she resigned her post. 'But for Mr Bank's letter, and terrorism of this trade union', speculated James Lister, 'we should have had dozens of applications from qualified doctors, ladies and gentlemen, on our own reading of the rules'.²⁶

Only nine days after the boycott had been enforced, but 59 days since the medical staff had walked out, the Management Board, finding itself without any emergency cover for complicated births or a lecturer for its pupil midwives, sought an arbitrator to solve the matter between themselves and the Medical Institution; the inclusion of the latter in proceedings underlines the importance of outside interests to the course of events. The same day, 28 May, the Council of the Lancashire and Cheshire Branch of the British Medical Association, of which Mitchell Banks was also President, pledged their

support for the action taken by Banks and the Liverpool Institution. Their hand strengthened and clearly fighting a cause which went far beyond the concerns of the Liverpool Lying-in Hospital, the medical staff on 3 June unanimously rejected the idea of an arbitrator, for the simple reason that 'there is nothing to arbitrate about'.²⁷

Once arbitration was refused, support for the hospital's Board of Management, which, the opposition argued, was dominated by the President and three or four other Board Members, began to decline and splinter.²⁸ Having witnessed something of a 'revolt' 'in the citadel of management', the Lancet predicted on 13 June 1896, that it would all 'probably lead to the retirement of the President from office'. The President resigned 11 days later.²⁹ The body leading the 'revolt' was the Ladies' Committee, or at least certain key members, such as Mrs Henry Tate who had sympathised with the doctors' cause from the beginning. The Ladies' Committee now wished to make it publicly known, two days after arbitration failed, that they no longer supported the Board of Management, but rather the medical staff and the proposal that they should have 'sole and entire medical charge' of all the hospital births. In addition, the Ladies' Committee felt the medical staff should be given two representatives on the Management Board, but they still wanted to see the matron-midwife recognised as the hospital house-surgeon, which would have been consistent

In another column appears a divert-
After the Storm. ing cartoon, depicting the capitula-
 tion of Alderman Bartlett, chairman
 of the Ladies' Charity and Lying-in
 Hospital, to Dr. Mitchell Banks, the champion of
 the medical staff. At the meeting of the subscribers
 last week the Board caved in, and consented to allow

the doctor on duty to play first fiddle instead of
 the matron midwife. This was the boue of coun-
 tention which caused the three months war!
 The concession thus made has restored peace to
 the distracted institution, and with the view of
 removing all further cause of friction the members
 of the locked out medical staff have been re-
 instated. Mr. James Lister, who is taking rest
 after the battle at Wynlass Beck, Windermere,
 has decided to continue on the committee, at the
 earnest request of Mr. Wm. Rathbone; and I
 believe that Mr. Adanson, another valiant defender
 of the Board, will keep him company. It is not
 yet known whether Alderman Bartlett will resign
 his chairmanship or face the music of the new
régime.



Surrender of the Hôpital Des Kids to the gallant Linseed Lancers at the Enceinte Gate.

with the women's efforts to improve the professional status of midwives.³⁰

Bearing testimony to the influence of the Ladies' Committee, the Liverpool Mercury felt 'now that they had spoken out so clearly, and with so much emphasis, we can pretty safely anticipate the nature of the verdict that will be rendered by subscribers'. At the women's initiative, a subscribers' meeting was arranged to discuss their proposals and William Rathbone was called to arbitrate on their behalf. Under Rathbone's influence and 'at the request of the ladies and with the consent of the board of management', the subscribers' meeting, arranged for June 23 1896, finally resolved to give the medical profession, 'sole and entire medical charge of the patients in the hospital', but dismissed the idea of the matron-midwife acting as house-surgeon and agreed to three medical representatives on the Board of Management. This was followed the next day by the reinstatement of the medical staff and the resignation of their principal opponent, William Bartlett, along with pledges of resignations by several influential members of the Ladies' Committee (Sample Text 6.1).³¹

Professional Control Consolidated: For What Reasons?

The six-month controversy over medical control of the birth, which generated a substantial amount of

interest in the correspondence columns of the local press and captured the attention of the country's leading medical journals, is of great importance, for it encapsulated many of the debates of the day and offers substance to current text-book accounts on the medicalisation of childbirth.³² Though passions ran high and the two opposing camps constantly bombarded each other with acrimonious and derisive remarks, it is well to steer clear of the conflict of personalities and concentrate upon why the medical staff took the unprecedented step of collectively withdrawing their labour and why fellow practitioners 'for the first time in the history of the medical profession of this city...made for absolute unanimity of opinion', and fully supported a boycott of the maternity hospital. Moreover, the Management Board's resolution to alter the rules was not actually changing anything that was not already in practice; for a midwife to call a doctor only when requisite was no new idea and the midwife had been responsible for the hospital's normal confinements, 'as far back as anyone connected with the charity can remember'. So 'how is it that they [the medical staff] have only recently discovered that their position is an intolerable one?'³³

Whilst the correspondent who raised this particular question failed to pursue it, he did make a connection with the Medical Board's desire 'to turn the institution into a school for students', and this is in part where the answer lay. Throughout the debate the medical staff

had stressed that the primary reason for their stance was out of concern 'for the care and safety of patients', and the threat they felt the Management Board's resolutions posed to such a position. They feared that if a midwife were placed in charge of all maternity cases arriving at the hospital, potential complications would not be recognised early enough to avoid maternal disablement or even loss of life. Speculation as to any other reason was quickly dismissed and strongly denounced for engendering 'side issues' which served only 'to divert the attention of the subscribers from the real questions', between themselves and the Management Board. One such 'side issue' was the doctors' 'desire to gain possession of our little hospital for the medical student'. This the Medical Board categorically denied, insisting 'that the question of utilizing the opportunities of the hospital in assisting students of medicine in their education forms no part of the present dispute'.³⁴

To claim this was to deny the considerable pressure the Medical Board was under, by the mid-1890s, to improve the hospital's instruction for local medical students. With an intake, on average, of only seven medical students a year (1891-95), and a continuous exodus of students to Dublin for their midwifery practical work, the inadequacies of the maternity hospital's training facilities were all the more glaring and no longer acceptable to the local medical school.³⁵ The school itself was also under pressure to improve the quality of

its midwifery instruction, for as the registration and compulsory instruction of midwives was fast becoming a reality, so the need for competent practitioners, well versed in the art of midwifery, became all-important if the medical profession were to compete successfully with well-trained midwives. Also, under the medical legislation of 1886 and the General Medical Council resolutions of 1888 and 1896, medical schools were not only compelled to teach midwifery, but strongly recommended to ensure that the students they taught in the district attended a minimum of twenty deliveries, five of which had to be conducted personally.³⁶ Consequently, the Dean of the Medical Faculty, in May 1895, called on the Liverpool Lying-in Hospital to improve the conditions under which students received their practical midwifery instruction by allowing them to attend district confinements without the presence of a midwife and to enter the hospital wards. The alternative, the Faculty warned, would be the establishment of a rival Lying-in Hospital.³⁷

The Medical Board responded without delay and without consulting the Board of Management, fully agreeing to the Faculty's demands for student access to the maternity wards and the substitution of the midwife by the district medical officer, as the student's principal instructor at the confinement.³⁸ Since the District Surgeon was not in the habit of attending normal confinements, a change in the rules would have left the medical student unsupervised and with complete authority

at the delivery. The Management Board was fully aware of this and the fact that it was highly critical of the medical staff's proposals and went on to deal with the Faculty directly, indicating that it was not going to sanction these changes in student instruction, was undoubtedly a contributory factor to the honorary staff's revolt in November 1895.³⁹

Closely related to the restraints on obstetric instruction was the Management Board's suppression of attempts to test new methods and carry out experimental work, which was becoming an increasingly vital element of the obstetrician's work. It was management's idea of the hospital as 'more of a home than a hospital...to which women come whose homes are unfit for their being delivered there', that deprived the medical staff of suitable case material and any real opportunity to perform experimental surgery and employ new techniques.⁴⁰ The Management Board attempted to enforce this idea in January 1894, when, faced with a bill of £35 for one order of surgical instruments, it resolved, 'that where the necessity for an operation could be foreseen in time, the patient be at once removed, but, if absolutely necessary to perform the operation in the Lying-in Hospital, the necessary instruments be hired'. Regardless of whether a complication could be foreseen or not, which prior to the ante-natal work of the early 1900s was rarely the case, the Medical Staff were simply not given any equipment or resources to perform the most basic of operations. The Medical Board did present the

Board of Management with a deputation on this issue, but the latter rejected it, 'as they have quite made up their mind on the subject', which now meant women had to be moved to another institution if any surgery were required. The point was further clarified in June 1894, after the Honorary Staff had performed a caesarean section, when the Management Board insisted that those operations performed in the hospital were on cases admitted as ordinary confinements and with the full consultation of all the medical staff.⁴¹

Underlying the Management Board's resistance to teaching and research demands was a real fear of a professional takeover and a re-shaping of the Charity's work in the profession's own image. 'A Subscriber' in a letter to the editor of the Liverpool Courier reflected the fears of many philanthropists when he posed the question, 'for what object do you subscribe?', asking them whether they were,

supporting a charity or a mere theatre for experiments on the patients, for scientific research and for statistical observation? If the former, then support the board of management; if the latter, the Medical Board.

In one letter to the Medical Board, William Bartlett did make a series of concessions, allowing the medical staff to draw up the regulations governing and inspecting the work of the midwives, wards and patients, on a regular basis. He was nonetheless adamant, however, 'That under no circumstances are the normal cases in the Hospital to be treated as subjects for general observation, for the

purpose of compiling statistics or literary articles, or for the instruction to students'.⁴²

The warning followed claims that two newly appointed medical officers to the hospital, replacing senior medical staff in July and October 1895, had commenced to take charge of all cases and attend them not only when summoned, 'but for the distinct purpose of taking statistics, making measurements, and pursuing other investigations, useful in a medical school'. This change in medical personnel and their interest in experimental work might well explain why the Medical Board launched the attack when they did and why the Management Board was so fearful of a medical takeover. Such fears were dismissed by Mitchell Banks as 'a malicious and cowardly statement...intended to stir up popular indignation'. Banks felt that the only justification for these fears was the medical staff's use of the external pelvimeter to assess the need for instrumental delivery, which, he explained, was 'about as offensive and harmless as measuring a person for an elastic stocking'.⁴³ The British Medical Journal similarly chose this example, but whilst it dismissed the allegations of experimental work as unfounded, it defended the profession's position and was highly critical of the Management for placing the hospital within, a kind of Chinese Wall, from which no statistics and no information for the benefit of humanity should issue and within which no instruction should be given except to a few aspirant midwifery nurses.⁴⁴

Whilst the creation of a 'Chinese Wall', at a time when obstetrical instruction and research were taking on a whole new importance, accounts for the timing and intensity of the medical staff's opposition to the Board of Management, it does not fully explain why Mitchell Banks and the other Liverpoolian practitioners, who had no personal connection with the Lying-in Hospital, supported their hospital colleagues. Indeed, under normal circumstances, many general practitioners would have viewed the institutional specialist, with whom they competed for patients, with nothing but disdain and distrust. The one unifying cause, which ensured the support of the Liverpool practitioners, was the medical Staff's quest to control the midwife, for as one contributor 'to the paper warfare' observed, 'I take it that the doctors are really aiming a blow at the midwives and that is the cause of the whole thing', and the real reason why they secured so much support.⁴⁵

During a very early stage of the controversy, William Bartlett spoke 'of a movement on the part of a section of the Medical Profession to depose midwives from their position', and though he recognised that it might not have included the hospital's own Honorary Staff, he still considered it to be something 'which the Board of Management think it their duty to guard against'.⁴⁶ In so doing, the debate was being moved beyond issues pertinent only to the Liverpool Lying-in Hospital to encompass a subject relevant to the profession as a whole, the control and registration of midwives.

It was no coincidence that the controversy at the hospital occurred at the height of the national debates on midwife registration and in a locality where many doctors were vehemently opposed to the midwife under any circumstance. Throughout the debates, doctors nationwide had specifically requested that if registered, the midwife remained under their control and restricted to performing natural labours.⁴⁷ The fact that the third attempt at a Midwives' Bill in May 1895 reached the Committee stages of the House of Lords, only to be radically altered in order to curb medical control and remove any explicit restrictions on midwives attending normal labours, intensified medical opposition to the Midwife Registration Bill. Two months later, fearing that a registered midwife posed a threat to a practitioner's livelihood, the British Medical Association, at its annual meeting, passed a resolution condemning midwife legislation.⁴⁸ Four months after that, in November 1895, an argument arose at the Liverpool Lying-in Hospital about whether the doctor or the midwife had ultimate responsibility for the birth. It was clearly to the medical staff's advantage to launch the dispute when they did, when the same issue was at the top of the profession's political agenda. This was especially the case in Liverpool, from where Robert Rentoul led the national campaign against the registration of midwives and Mitchell Banks presided over the British Medical Association's Lancashire and Cheshire Branch to ensure that if registered, midwives were

accepted only as 'obstetric nurses' under the strictest control of local practitioners.⁴⁹ Whether totally opposed to the idea of midwife registration or not, the medical profession was clear about one point, absolute control of the midwife, and what more appropriate a campaign at which to express such solidarity than a demonstration of support for the medical officer's cause at Liverpool's Lying-in Hospital?

The dispute at the hospital served as a rallying call to the medical profession, which was ideally timed to capitalize on anti-midwife sentiment and ideally located to give Liverpool's practitioners, who were particularly hostile towards midwives, a sense of direction and purpose. Though the dispute was undoubtedly important in highlighting to the rest of the country professional unanimity on the midwifery question, and in strengthening the practitioners' resolve to secure the passage of a Registration Bill which protected their interests, the rallying call was also an end in itself, and in many ways as important as the subject under discussion. 'The great lesson to be learnt from this contest', wrote Mitchell Banks, who had led the boycott against the maternity hospital, 'is the power we possess as a body when we can be persuaded to hang together'.⁵⁰ To Banks, 'the actual dispute was not one of very great consequence'; what was of consequence was the opportunity it brought to unify the profession, conceding to those who accused him and his colleagues of trade unionism

'that this is exactly what we are aiming at, only we call it a professional union'.⁵¹

A successful and very public display of 'professional unionism' was the dispute's chief legacy at a time when practitioners throughout the country were beginning to unify and participate in professional action to realise their demands. This was particularly the case with regard to the formation of medical clubs by general practitioners in direct opposition to those run by the lay bodies of Friendly Societies, which the doctors claimed exploited their services and threatened private medical practice, because of their failure to impose income limits on their members.⁵² The dispute at Liverpool occurred in the midst of this so-called 'battle of the clubs' and the professional action taken at Coventry and Cork, for example (largely in the form of mass-resignations from friendly societies, the subsequent boycott of the vacant posts and the establishment of alternative medical services for the poor, run by doctors rather than lay officials), no doubt inspired the medical profession in Liverpool to take the action they took and in the form they took it.⁵³

At the same time as the 'battles of the clubs' inspired the dispute at the maternity hospital, so in turn, events at the hospital encouraged other groups of practitioners to unify and confront the lay controlled provident societies. The British Medical Journal cited the activities in Lincoln as a case in point, for on the same day Liverpool's medical staff resigned their posts,

30 March 1896, Lincoln's medical practitioners adopted a common policy towards the city's provident medical clubs, demanding a fair rate of remuneration, representation on the management committees and the right to establish a scale of earnings, beyond which claimants were refused assistance. Along with these proposals came the threat of resignation by the practitioners employed by the provident clubs if their demands were not met. As the two provident societies concerned refused, 'either to accept the conditions or to recognise the right of the medical practitioners in Lincoln to dictate to them', the medical officers resigned in mid-April, their vacant posts were boycotted and a Provident Medical Association was formed as an alternative to the two friendly societies. This was followed by similar grievances and action taken in: Dundee, Leicestershire, Inverness and Portsmouth.⁵⁴

The British Medical Journal, which had documented 'the battle of the clubs' throughout the mid-1890s, recognised the invaluable contribution the Liverpool dispute made to the debates by stimulating other local groups of doctors to unify and pursue their demands collectively. The action of the medical profession in Liverpool, concluded the Journal, at the height of the 'club battles', 'is particularly valuable at the present time because it shows how and how only, the desired result is to be obtained, that is by a unified front in face of a common danger'. In the same editorial, the Journal went on to portray the Honorary Staff at the

Liverpool Lying-in Hospital as something of an inspirational force,

The medical men of Liverpool in fighting their own battle, have also been fighting the battle of the whole profession, and they have increased the value of the services rendered by the splendid example of unanimity which they have given. The conflict is part of a greater conflict over a wider area - a conflict of which the end is not yet, but which can only be allowed to end in one way. True the *casus belli* is not always the same in one place it is the arrogance or false sentimentality of a lay Board of Management presuming to speak in the name of charity, in another the parsimony and self-seeking of club managers in another diagnosed under the name of providence, the frankly commercial schemes of a trading company to make a profit by sweating the doctors in their employ. The medical profession is awakening to the necessity of asserting its rights against encroachments on every side.⁵⁵

The Liverpool Lying-in Hospital, it is clear, played a key role in that awakening.

Once re-appointed, the medical staff lost little time in consolidating their position at the hospital. Of prime concern was the staff's subjection to re-election by the Board of Management and the Board's right to dismiss any honorary doctor without consultation. As early as January 1898, the medical staff attained the right to be re-elected by the subscribers, and though the Management Board maintained the authority to dismiss a medical officer, the Honorary Staff were no longer prohibited from holding a professional appointment in another public charity, thus enhancing their research opportunities and professional standing. Unity amongst the Honorary Staff was further strengthened by increasing their term of office from a maximum twelve year tenure,

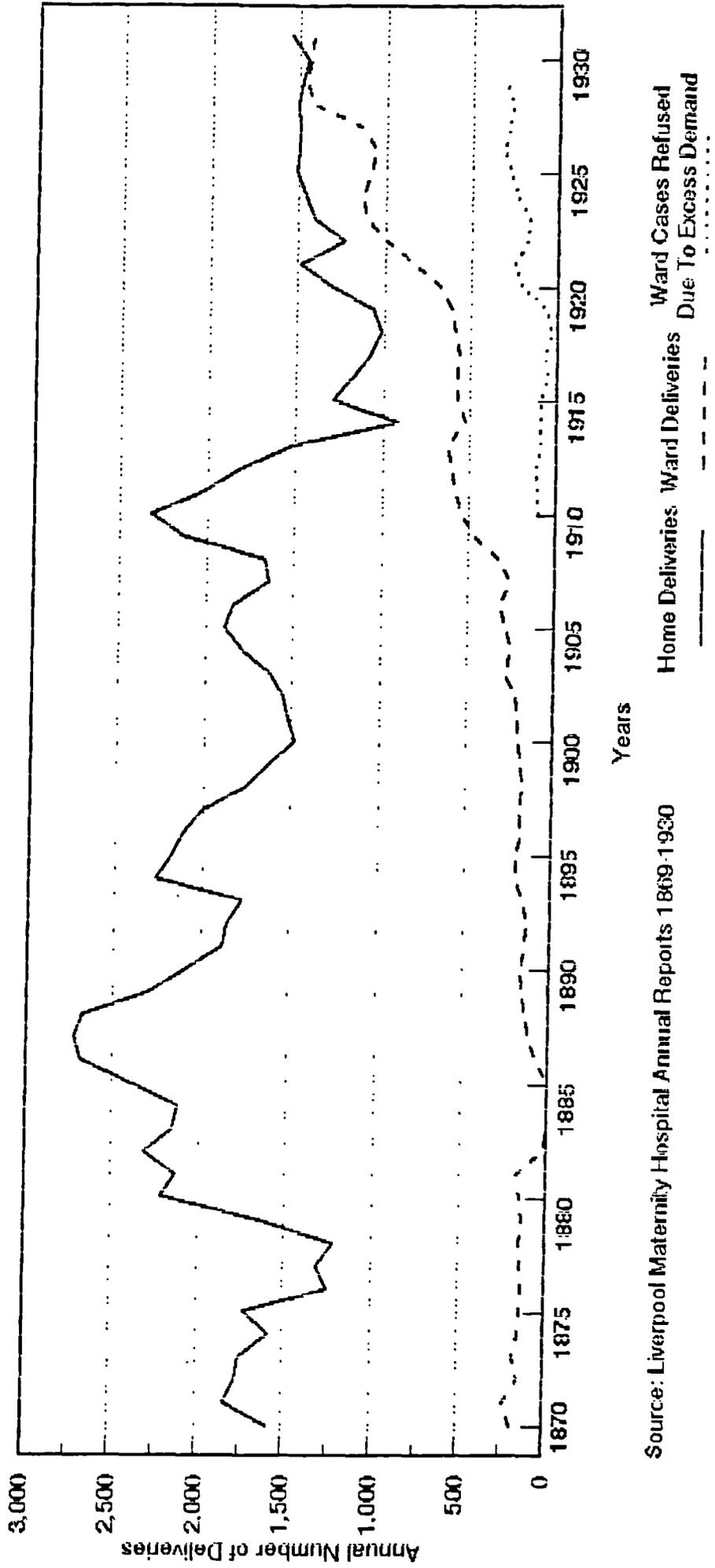
to a retiring age of 60, which promoted continuity in leadership and a greater sense of belonging to a professional body. For reasons not explained, but no doubt influenced by memories of the 1896 dispute, the Ladies' Committee had objected to this proposal, requesting that the term of office be limited to 15 years service or 50 years of age.⁵⁶ As a result, the proposal to increase the term of office up to 60 years of age was postponed, but still took effect a year later, in January 1903, despite further disapproval from the Ladies' Committee. With only one married couple serving on the Ladies' and Gentlemen's Committee respectively by 1900, the women's influence was beginning to wane.⁵⁷

Gains and Losses: Demographic Relevance, Student Instruction and Female Philanthropy

Their position consolidated and some of their most vocal opponents, including William Bartlett and James Lister, out of office, the Medical Board was able to achieve all their objectives, implicit as well as explicit, for which they had fought the campaign. Whilst it had always been asserted, for example, that 'the medical student part of the question has very little bearing on the controversy...and at no time is there any probability of their being many [students]', there was an

immediate improvement in the training facilities for students following a rapid rise in their numbers, once the dispute had ended (Figure 6.1).⁵⁸ In the first of a series of educational reforms, the district medical officer, when available, was to supervise the student at the confinement, whereupon the midwife was to act as a monthly nurse. To assist, a fully qualified obstetric assistant was nominated by the medical school and employed by the hospital from January 1899 to oversee the clinical instruction of students, *accompanying them on a domestic confinement and demonstrating childbirth procedures.*⁵⁹ Also, for the first time, and despite assurances from the medical staff during the dispute that free access to wards would not involve the presence of medical students, students were soon being invited into the hospital.⁶⁰ Initially, students were permitted into the hospital, a maximum of six at a time, to observe a complicated delivery, but this soon changed to allow students to visit any hospital case with an obstetric assistant, whether the case were complicated or not.⁶¹ Moreover, with permission from an honorary doctor, up to two students were allowed to participate in an internal examination of a ward patient. Consequently, within two years of the dispute ending, two of the three demands had been met, namely, the removal of the midwife as the students' principal instructor and student access to the wards, which had, for many years previously, been denied to the Medical School and the Hospital Medical Board. The third demand, unsupervised students attending a home

**FIGURE 6.2: ANNUAL NUMBER OF DELIVERIES
LIVERPOOL MATERNITY HOSPITAL 1869-1930**



Source: Liverpool Maternity Hospital Annual Reports 1869-1930

birth, which the Management Board had persistently prohibited, was to the horror of the city's Medical Officer of Health, attained by World War I, when students were not only attending natural confinements on their own but were being sent out to deal with a complicated delivery. This was in the opinion of the Medical Officer of Health, totally unacceptable and illegal.⁶² Ultimately the professional coup of 1896 had opened the floodgates to the doctors' more excessive, insensitive and potentially harmful demands.

If such training were to be conducted on any significant scale and the student demand anticipated, there had to be a radical increase in the number of ward confinements, particularly those of a complicated nature. During the controversy surrounding the admission of single women in 1898 it transpired that because of women's reluctance to enter the hospital, less than half the 15 beds available were being used and amongst those admitted, fewer than one fifth were complicated cases.⁶³ Within ten years, however, 'great strides in popularity' were made as the patient intake virtually trebled and the hospital became 'so full that cases had to be refused all most daily', with an ever increasing number of 'overflow' patients sent to a neighbouring workhouse (Figure 6.2).⁶⁴ Despite the reduction in a woman's residential stay, from 14 to 12 days, the hospital had become so overcrowded by 1909 that anxieties were expressed about the effect it was having on the general health of patients, and by 1910, when 25 'overflow patients' were referred to the

workhouse in January alone, plans were released to build a new hospital to accommodate the excess demand.⁶⁵ Throughout the late-Victorian period, the Liverpool Lying-in Hospital had struggled to fill 50 per-cent of its bed capacity. Yet within a decade or so of the medical staff emerging as a predominating influence, the maternity wards were filled to the point of 'overflowing' and a larger hospital was to be built; only under the professional influence does the hospital's full potential seem to have been fulfilled.

More women were willing to enter the hospital, partly because the medical staff removed some of the restrictions prohibiting their admission, but also because women increasingly looked towards the hospital and the medical profession as a means of relieving the burden of childbirth. As has been shown, until the mid-1890s, the hospital's Ladies' Committee had a very selective admissions policy which was neither receptive to true social needs nor the urgency of complicated cases, for hardly more than a tenth of admissions required medical attention.⁶⁶ On the suggestion of the Ladies' Committee (May 1901) a ward was re-fitted and furnished at a cost of nearly £60 and set aside for 'bad cases'. As a result, complicated cases (1906-10) soon accounted for virtually a third of the total number of admissions.⁶⁷ The hospital authorities also began to accept many more different groups of women than formerly; single women were admitted from January 1899, Jewish women from December 1901 and many other categories of

women formerly refused by the Central Relief Society. On average, only 12 women a year were refused after an enquiry between 1916 and 1920, compared with 246 cases a year between 1896 and 1900.⁶⁸ Whilst it may be argued that by accepting more complicated cases the hospital doctors, consciously or otherwise, were augmenting their authority in the delivery room and enhancing their own professional position, many more women were at last provided with more competent assistance than they had ever had at a complicated birth. Indeed, with 'the shadow of maternity, repeated over and over again in many women's' lives', and the possibility of death or debility from childbirth ever present, an increasing number of women sought medical expertise, whether their birth was complicated or not. Women's entry into hospital was as much a conscious decision by women themselves as it was by the medical profession to accept them.⁶⁹

Changes in opinions and attitudes did not only have to come from below but also from above, from the ranks of the Ladies' Committee, if the medical staff hoped to broaden admissions, experiment with new therapeutic measures and generally promote their specialty. As noted in Chapter 4, the women fought very hard to maintain their position of authority over the deployment of the hospital's resources and over the birth itself, so much so that by 1896 there was much resentment amongst professional circles toward the Ladies' Committee. It was The Lancet that captured the mood of the profession in an editorial in May 1896 when it was highly critical

of the hospital's female contingent of supporters, which it considered to be 'all powerful just now...[a] female thralldom' from whom the Gentlemen's Committee would do well to emancipate themselves.⁷⁰ In the first of five grievances cited before the subscribers that month, the medical staff drew the subscribers' attention to the numerous married couples serving on the respective Management Boards, incensed that members of the Ladies' Committee, 'did not hesitate to criticize the professional actions of the Medical Officers, and have even afforded their opinion on the pattern of instruments selected by the Doctors'. The medical staff would have found it equally disconcerting to find comments in the correspondence columns of the local press to the effect, 'that it is, in all respects, mentally, morally and physically better for women to be attended by women' and calls for women to 'Go in and win', not only to train and certify as nurses and midwives but as consulting physicians to their sex and as lecturers to midwives. These views and those of some of the subscribers, that female doctors ought to have been appointed because women patients could relate more easily to them on matters of a delicate and emotional nature, were seen by the medical staff as an attack upon the status of medical officers.⁷¹

It is no surprise, therefore, that the Ladies' Committee radically changed in character after 1896 and that the appointment of the first female medical officer to the hospital was not until 1921, 15 years after a female was first appointed to a Liverpool hospital and 29

years after women students were first accepted at the maternity hospital.⁷² Following the resignation of some of the most ardent critics on the Ladies' Committee, the women's group became far more conciliatory and supportive of the medical staff's cause. Thus, the Ladies' Committee accepted single women into the hospital from January 1899, allocated two beds for the use of the Professor of Midwifery from the University Medical School in the same year and in 1901, provided a ward for the exclusive use of complicated cases.⁷³ All three issues had been habitual points of controversy between the Medical Board and the Ladies' Committee since the 1870s, but within five or six years of the Medical Board taking control, the Ladies' Committee had, to a greater or lesser extent, conceded on all of them. Also areas of hospital policy, such as midwifery appointments and instruction, which had been the province of the Ladies' Committee, soon came under criticism from the medical staff, who quickly took over the task of remodelling the structure of midwifery instruction and appointments.⁷⁴

All these incidents point to a complete collapse of female control over the birth process and account for the failure of the Ladies' Committee to promote the appointment of female practitioners who briefly appear in 1896, but do not return, despite demands by the Ladies' Committee for their appointment, until 1921.⁷⁵ Indeed, it was because of the medical staff's refusal to appoint an all-female body of pre-maternity officers to the city's ante-natal centres that the Liverpool Health Committee

withdrew the hospital's rights to appoint staff to these centres in December 1919.⁷⁶ The refusal to appoint women doctors long after they were accepted elsewhere, even to the point of public embarrassment, was no doubt the medical staff's way of responding to the events of 1896 and to practically 30 years of female control.

To conclude, the strong lay presence, which had thwarted the profession's attempts to augment their ranks, control admissions and fulfil teaching and research commitments, goes a long way towards explaining the Honorary Staff's unprecedented action in 1896 and their mad scramble, on returning to the hospital, to assert themselves at its helm. However, the actual timing of events and the mass support the hospital's medical staff received from local colleagues, cannot be fully accounted for without reference to issues of national significance: the Midwives' Registration Bill, the calls, by the medical profession, for great improvements in obstetric instruction and the emergence of professional unionism. Combined, the events highlight the beginnings of the medicalisation of childbirth, the consequences of which will be discussed in greater detail in the subsequent chapter.

Notes to Chapter 6

1. Liverpool City Record Office (hereafter as LCRO), 614 MAT 10/1, Newscuttings, 'Possible' (correspondence), *Daily Post*, 15 May 1896.
2. For an example of a specialist hospital where medical staff were highly influential, see: Lindsay Granshaw, *St. Mark's Hospital London: A Social History of a Specialist Hospital* (London, 1985), pp.22-24; idem, 'Fame and Fortune by Means of Bricks and Mortar: The Medical Profession and specialist hospitals in Britain 1800-1948', in *The Hospital in History*, ed. by Lindsay Granshaw and Roy Porter (London, 1989), pp.199-200 (p.201).
3. LCRO, 614 MAT 9/1, Annual Report 1869.
4. See Chapter 4.
5. LCRO, 614 MAT 1/1, Board of Management Minutes, 27 January 1874.
6. LCRO, 614 MAT 9/1, Annual Report 1880.
7. LCRO, 614 MAT 1/1, Board of Management Minutes, 27 January 1874.
8. The lack of opportunity to advance professionally within the ranks of the general hospital staff had, after all, been a principal reason why many doctors had defected and established their own specialist institutions, Brian Abel-Smith, *The Hospitals 1800-1948* (London, 1964), pp.19-21.
9. 'The medical officer in charge has frequently been absent from the hospital for weeks, and in some cases for months, when no special cases necessitated his attendance', President's remarks at subscribers' meeting', LCRO, 614 MAT 10/1, Newscuttings, *Liverpool Mercury*, 16 April 1896.
10. LCRO, 614 MAT 2/2, Medical Board Minutes, 8 June 1874.
11. H. H. Francis, 'The History of Obstetrics and Gynaecology in Liverpool', *Sphincter*, Summer (1955), 114-120 (pp.117-18).
12. LCRO, 614 MAT 10/1, Newscuttings, James Lister's correspondence, *Daily Post*, 23 May 1896.
13. O'Donel T. D. Browne, *The Rotunda Hospital* (Edinburgh, 1947), pp.261-262. LCRO, 614 MAT 9/2, Annual Report 1885. LCRO, 614 MAT 2/2, Medical Board Minutes, 24 April, 26 June 1889.

14. LCRO, 614 MAT 2/2, Medical Board Minutes, 6 August 1878, 13 February 1879.
15. LCRO, 614 MAT 2/2, Medical Board Minutes, 6 August 1878, LCRO, 614 MAT 1/1, Board of Management Minutes, 13 March 1879.
16. LCRO, 614 MAT 10/1, Newscuttings, Board of Management Minutes, 27 November 1895.
17. LCRO, 614 MAT 2/2, Medical Board Minutes, 27 November, 15, 23 December 1895; 9 January 1896.
18. LCRO, 614 MAT 10/1, Newscuttings, Board of Management letter to the Medical Board, 16 January 1896; Medical Staff circular to subscribers, 30 March 1896.
19. LCRO, 614 MAT 2/2, Medical Board Minutes, 24 January 1896.
20. Initially the request was for one medical representative, but when it became evident that the doctors were winning the dispute the request increased to four representatives, LCRO, 614 MAT 10/1, Newscuttings, Board of Management Letter to Medical Board, 24 February 1896; correspondence from Medical Board to the President of the Board of Management, 30 March 1896.
21. *BMJ*, 25 April 1896, p.1058.
22. LCRO, 614 MAT 10/1, Newscuttings, correspondence from the President of the Board of Management to the Medical Board, 15, 21, 29 April 1896; Correspondence from the Medical Board to the Board of Management, 20, 30 April 1896.
23. For example: LCRO, 614 MAT 10/1, Newscuttings, *Daily Post*, 15 April, 20 May 1896; *Liverpool Express*, 21 May 1896; *BMJ*, 4 April 1896, p.876; *Lancet*, 21 March 1896, p.308; 4 April 1896, p.957.
24. *BMJ*, 16 May 1896, p.1226.
25. Mitchell Banks was also President of the Lancashire and Cheshire Branch of the British Medical Association. The object of the newly formed Liverpool Medical Club was to promote professional unionism and discussion in ethical matters. Rallying local practitioners to support the medical staff at the Liverpool Lying-in Hospital proved one very effective means of promoting professional unionism, LCRO 614 MAT 10/1, Newscuttings, Mitchell Banks correspondence, *Daily Post*, 19 May 1896; 'Another M.D.' correspondence, *Liverpool Courier*, 17 May 1896. *BMJ*, 30 May 1896, p. 338.

26. LCRO, 614 MAT 10/1, Newscuttings, William Bartlett, correspondence, *Liverpool Courier*, 27 May 1896; James Lister, correspondence, *Daily Post*, 22 May 1896.
27. This letter to the subscribers of the hospital was first signed by Richard Caton, President of the Liverpool Medical Institution, then by William Banks, the President of the Lancashire and Cheshire Branch of the British Medical Association, followed by the signatures of the Chairman and Honorary Secretary of the hospital's Medical Board, T. B. Grimsdale and J. E. Gemmell, respectively. The fact that the signatures were set in this order highlights the importance of the local medical community to the hospital practitioners' cause. LCRO 614, MAT 10/1, Newscuttings, no date; *Daily Post*, 29 May 1896.
28. *BMJ*, 30 May 1896, p.1163. *Lancet*, May 30 1896, p.1509.
29. *Lancet*, June 13 1896, p. 631.
30. LCRO, 614 MAT 10/1, Newscuttings *Daily Post*, 4, 5 June 1896. See also Chapter 4.
31. LCRO, 614 MAT 10/1, Newscuttings, *Liverpool Mercury*, 6 June, 7 July 1896; *Daily Post*, 24 June 1896.
32. For accounts of the medicalisation of childbirth see the Introductory Chapter.
33. LCRO, 614 MAT 10/1, Newscuttings, Mitchell Banks, correspondence, *Daily Post*, 19 May 1896. Correspondence from the Board of Management to the Medical Board, 24 February 1896. H. Kyrke-Smith, correspondence, *Liverpool Courier*, 28 May 1896.
34. LCRO, 614 MAT 10/1, Newscuttings, H. Kyrke-Smith, correspondence, *Liverpool Courier*, 28 May 1896; Medical Staff Circular to the subscribers 11 April 1896; J. E. Gemmell, Chairman of the Medical Board, correspondence, *Daily Post*, 11 April, 22 May 1896; Correspondence from Medical Board to William Bartlett, 3 June 1896.
35. LCRO, 614 MAT 2/2, Medical Board Minutes, correspondence from Dean of Medical Faculty, University College, to the Medical Board, 31 May 1895. 614 MAT 9/2, Annual Reports, 1891-95.
36. Janet Campbell, 'Notes on the Arrangements for Teaching of Obstetrics and Gynaecology in the Medical School', *Report on the Public Health and Medical Subjects*, 15 (1923), p. 3.
37. LCRO, 614 MAT 2/2, Medical Board Minutes, 31 May 1895.
38. LCRO, 614 MAT 2/2, Medical Board Minutes, 31 May 1895.

39. LCRO, 614 MAT 2/2, Medical Board Minutes, 26 June 1895.
LCRO, 614 MAT 10/1, Board of Management Minutes, 27
November 1895.
40. LCRO, 614 MAT 10/1, Newscuttings, James Lister,
correspondence, *Daily Post*, 13 April 1896; a special
meeting of subscribers, *Daily Post*, 24 June 1896.
41. LCRO, 614 MAT 2/2, Medical Board Minutes, 29 March, 29
November 1893, 31 January 1894, 26 June, 30 May 1896.
42. LCRO, 614 MAT 10/1, Newscuttings, 'A Subscriber',
correspondence, *Liverpool Courier*, 29 April 1896;
Correspondence from President of the Board of
Management, William Bartlett, to the Medical Board, 29
April 1896.
43. LCRO, 614 MAT 10/1, Newscuttings, Subscribers' Meeting,
remarks by James Lister, *Daily Post*, 16 April 1896;
Mitchell Banks, correspondence, *Liverpool Courier*, 8
May 1886.
44. *BMJ*, 30 May 1896, p.1341.
45. LCRO, 614 MAT 10/1, Newscuttings, 'An Englishman',
correspondence, *Daily Post*, 30 May 1896.
46. LCRO, 614 MAT 10/1, Newscuttings, correspondence from
President of the Board of Management, to Medical Board,
17 February 1896.
47. Jean Towler and Joan Bramall, *Midwives in History and
Society* (London, 1986), p.168.
48. Jean Donnison, *Midwives and Medical Men* (London, 1977),
pp.139, 140.
49. *Lancet*, 30 June 1894, p.1647. Donnison, pp. 120, 140.
50. Mitchell Banks, correspondence, *BMJ*, 4 July 1896, p.43.
51. idem, correspondence, 4 July 1896. LCRO, 614 MAT 10/1,
Newscuttings, Mitchell Banks, correspondence, *Daily
Post*, 19 May 1896.
52. *BMJ*, 4 April 1896, p.859.
53. Norman R. Eder, *National Health Insurance and the Medical
Profession in Britain 1913-1939* (London, 1982) pp. 18-
21. For the impact of the 'battle of the clubs' on
professional unionism see also Jeane L. Brand, *Doctors
and the State: The Medical Profession and Government
Action in Public Health 1870-1912* (Baltimore, 1965) p.
197.

54. *BMJ* 1896: 4 April p.859; 25 April p.1059; 16 May p.1230; 30 May p.1340; 4 July, p.39; 18 July, pp.156, 196; 1 August p.301.
55. *BMJ*, 27 June 1896 p.1570; 30 May 1896, pp. 1341-2
56. LCRO, 614 MAT 1/2, Board of Management Minutes, 11 January 1898, 10 December 1901.
57. LCRO, 614 MAT 1/2 Board of Management Minutes, 13 January 1903. LCRO, 614 MAT 9/3, Annual Report 1900.
58. LCRO, 614 MAT 10/1, Newscuttings, President of the Medical Institute, correspondence, *Daily Post*, 25 May 1896. LCRO, 614 MAT 9/3, Annual Reports, 1898-1900.
59. LCRO, 614 MAT 1/2, Board of Management Minutes, 12 January 1897; 10 January 1899.
60. LCRO, 614 MAT 10/1, Newscuttings, Dr Glynn Whittle, Subscribers' Meeting, *Liverpool Mercury*, 16 April 1896.
61. LCRO, 614 MAT 1/2, Board of Management Minutes, 16 December 1901; 22 February, 23 March 1908.
62. LCRO, 614 MAT 2/3, Medical Board Minutes, 18 January 1918.
63. LCRO, 614 MAT 10/1, Newscuttings, *Liverpool Mercury*, 16 April 1896; *Liverpool Courier*, 31 December 1898.
64. LCRO, 614 MAT 9/4, Annual Reports, 1908. 614 MAT 9/5, Annual Reports, 1909, 1910.
65. LCRO, 614 MAT 9/5, Annual Reports, 1908-10. 614 MAT 1/3, Board of Management Minutes, 7 September 1909; 2 March 1910.
66. See Chapter 4.
67. LCRO, 614 MAT 1/2, Board of Management Minutes, 14 May 1901. LCRO, 614 MAT 9/4, Annual Reports, 1906-08. 614 MAT 9/5, Annual Reports, 1909-10.
68. LCRO, 614 MAT 1/2, Board of Management Minutes, 30 December 1898; 10 December 1901. 614 MAT 9/2 Annual Reports, 1892. 614 MAT 9/3, Annual Reports, 1897-1900. 614 MAT 9/5, Annual Reports, 1916-17. 614 MAT 9/6, Annual Reports, 1918-20.
69. Judith Leavitt, 'The Medicalisation of Childbirth in the Twentieth Century,' *College of Physicians of Philadelphia Transactions and Studies*, 21 (1989), 229-319.
70. *Lancet*, 4 April 1896, p.957.

71. LCRO, 614 MAT 10/1, Newscuttings, Circular to Subscribers by Medical Board and signed by the President of the Liverpool Medical Institute and the Cheshire and Lancashire Branch of the BMA. No Date; 'A Man', correspondence, *Daily Post*, 12 April 1896; 'A Subscriber', correspondence, *Liverpool Courier*, 29 April 1895; 'Another Subscriber', correspondence, *Liverpool Courier*, 30 April 1896.
72. The first hospital in Liverpool to appoint a female as an Honorary Medical Officer, was the Stanley Hospital in 1906, H. H. Francis, p.117. LCRO, 614 MAT 9/2, Annual Report 1892. LCRO, 614 MAT 9/6, Annual Report, 1921.
73. LCRO, 614 MAT 2/1, Board of Management Minutes, 30 December 1898; 10 January 1899; 14 May 1901.
74. LCRO, 614 MAT 2/1, Board of Management Minutes, 9 December 1902. 614 MAT 2/2, Medical Board Minutes, 2 December 1902; 6 January 1903.
75. LCRO, 614 MAT 1/3, Board of Management Minutes, 18 April 1913.
76. LCRO, 614 MAT 1/4 Board of Management Minutes, 10 December 1914.

Chapter Seven

Turning Professional

'The Medicalisation of Childbirth': Cause and Effect

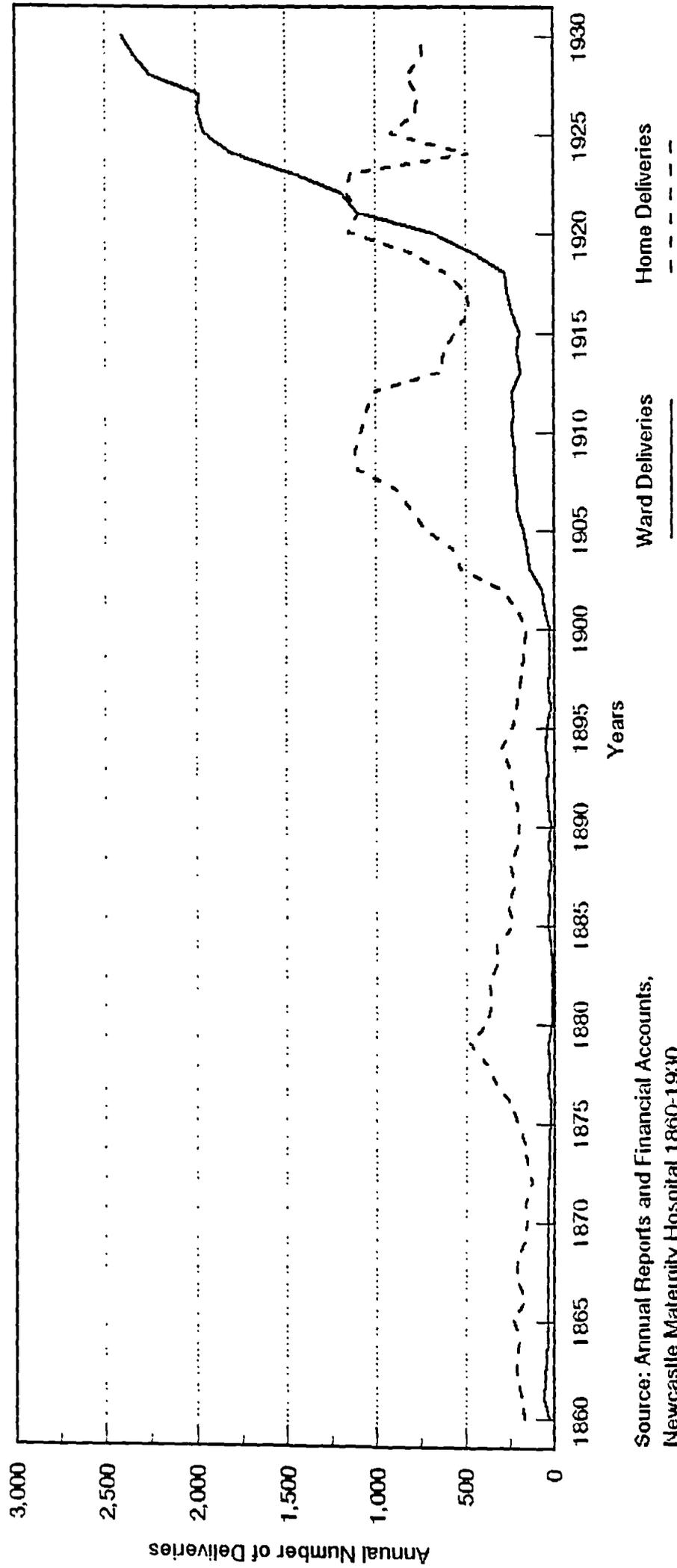
1900-1930

Every institution depends enormously upon its administration, and I think all voluntary institutions have a tendency to change: either to be on the upward grade or else to be deteriorating.¹

With the exception of the Newcastle Lying-in Hospital, a major characteristic shared by maternity hospitals during the nineteenth century, was the highly supportive but very modest role assumed by the medical staff in the birthing room, whether in the hospital or the woman's own home. Whilst it had always been 'clearly understood that the midwives have pre-emptory instructions never to proceed with a case involving certain clearly defined difficulties, without immediately calling in medical assistance', in reality, this meant the doctor attended no more than 4 to 8 per cent of district cases. Even in the hospital, at the Jessop, Sheffield, for example, the Superintendent of Midwifery, Kate Keslo, was obliged to call the duty Medical Officer only when a difficulty arose and conversely, the Medical Officer was only to 'give counsel and help, when required, to the Superintendent of Midwifery and to the midwives of the Hospital'. This meant attendance at about 20 per cent of cases because of the higher than average concentration of difficult labours.² Thus the strength of the maternity hospital lay in its use of trained and competent midwives for the overwhelming majority of women, but with access, when the necessity arose, to experienced and highly qualified medical personnel.

However, all these arrangements altered within the first two decades of the twentieth century. The widespread change of name from lying-in to maternity hospital itself reflected wider changes, as it became increasingly physician-led and placed far more reliance on junior doctors, medical students and pupil midwives to attend cases than on its own midwives, whose high profile in institutional practice and autonomy in the labour room diminished considerably.³ The first signs of this transition have already been documented for the Lying-in Hospital Liverpool, which resulted in the substitution of its lay Board by a body of honorary medical officers and less fervent lay members. Unlike their predecessors, they had no qualms about altering the charity's regulations and code of practice to meet the doctors' needs, personal as well as professional. This subject, the 'medicalisation of childbirth' now awaits further study. Its historiography to date has been marred by emotive, often sensational discourse, attributing the change to a nascent process of male misogyny, professionalisation and domination, without full reference to hospitalisation, 'the most important step on the road to "medicalising" childbirth'.⁴ Firstly, it is necessary to explain more fully the nature of, and the reasons for, the hospital's transformation from a lay to a professionally led institution and secondly, to evaluate the impact of these changes upon the quality of care and fate of the ever increasing number of women confined within a hospital.

**FIGURE 7.1: ANNUAL NUMBER OF DELIVERIES
NEWCASTLE MATERNITY HOSPITAL 1860-1930**



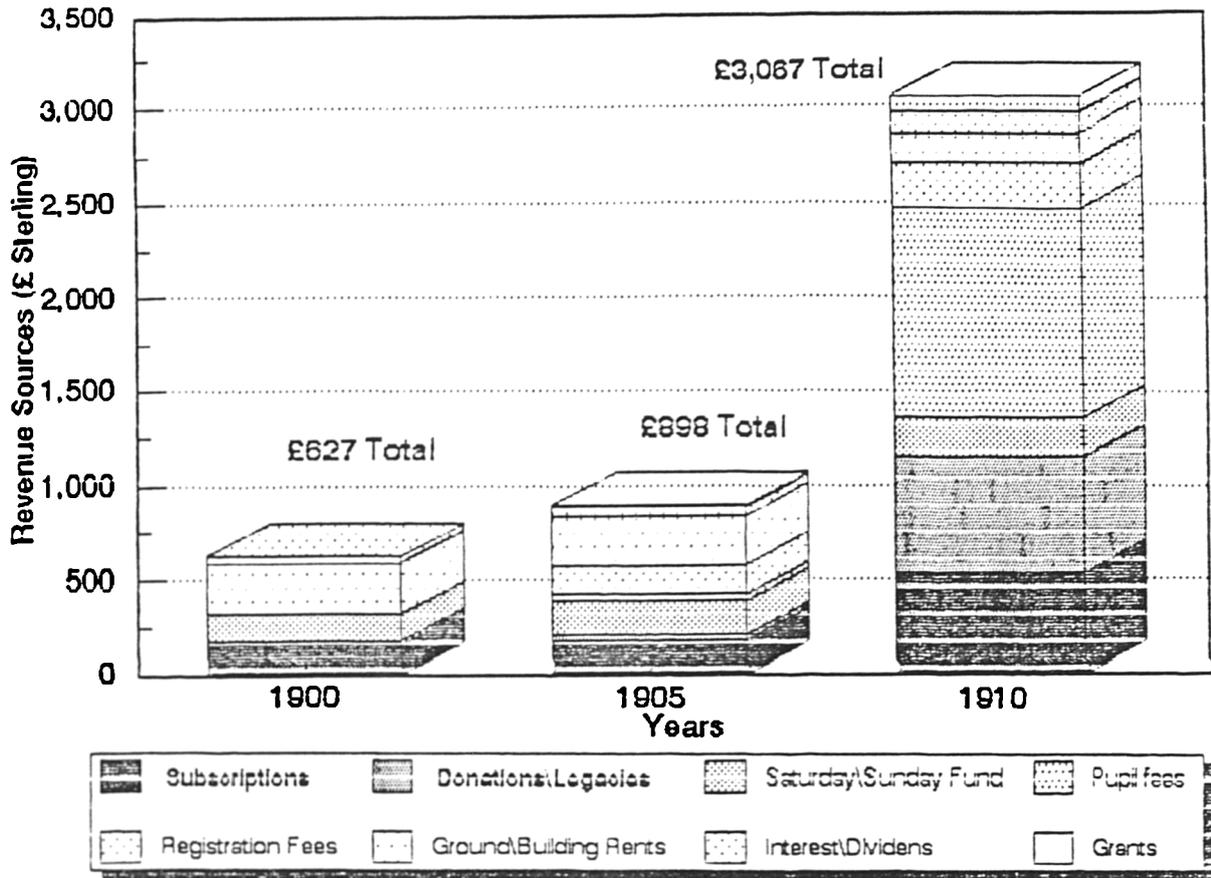
Source: Annual Reports and Financial Accounts,
Newcastle Maternity Hospital 1860-1930

The Nature of the Institutional Changes

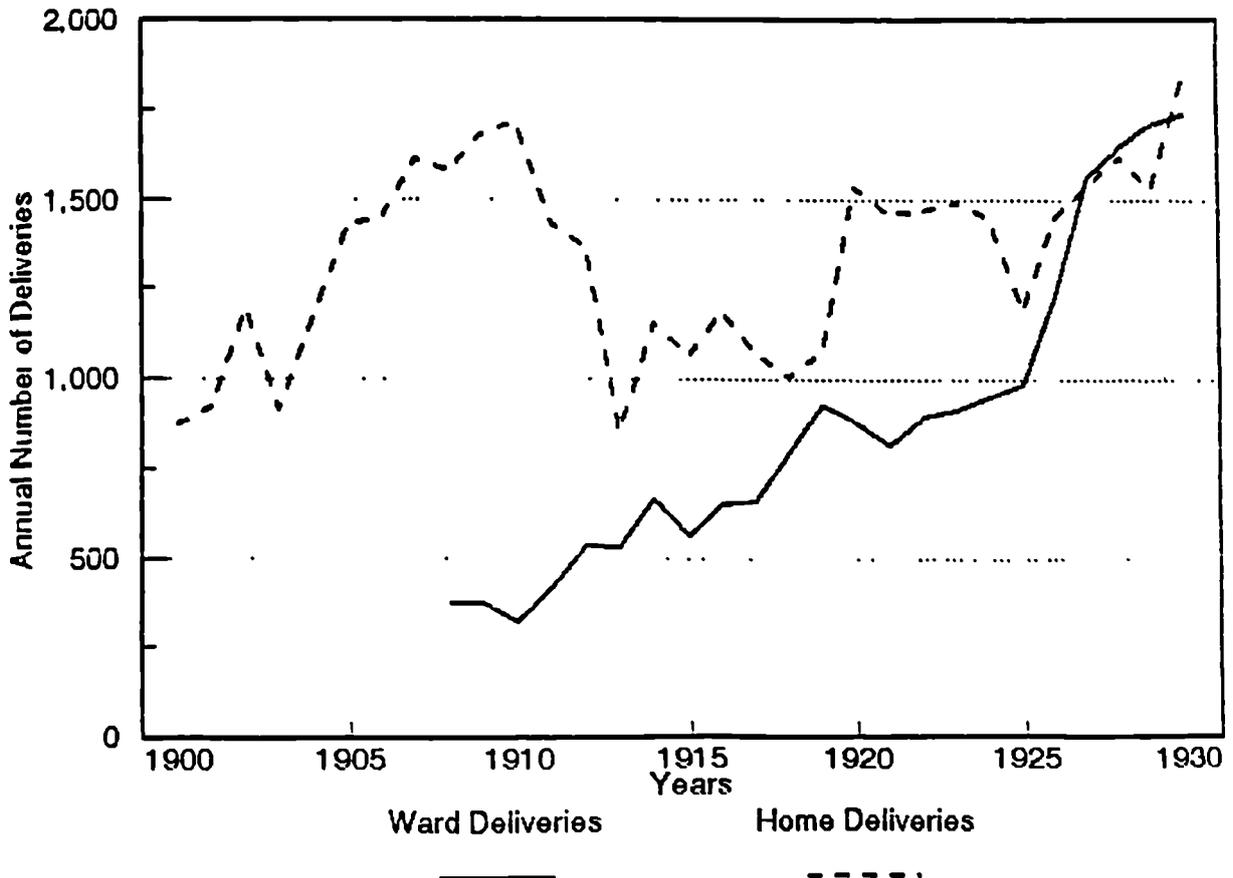
One of the most striking aspects of institutional change during the thirty year period was the unprecedented and rapid growth in the number of women attended by hospital staff. This is most notable, for example, at the Newcastle Lying-in Hospital which, reserving its services for 'poor married' and 'deserving women', who had borne at least one child, lived within a prescribed boundary and were recommended by a one guinea or more subscriber, attended on average, only 30 ward and 200 district confinements a year (1860-1900) (Figure 7.1).⁵ Once it was resolved, at a meeting led by the hospital's medical staff in October 1900, to abolish the system of admission by recommendation, relax the rules of admission of single women, enlarge its catchment area, double its bed capacity and finance the expansion largely from the increase in tuition fees, then the hospital's case total rose considerably. From fewer than 200 women a year in 1900, it increased to over 1,300 by 1910, and to almost 2,000 by 1920 (Figure 7.1).

Similarly, at the Birmingham Lying-in Charity, the situation remained static until 1901 when, after six years of campaigning by the medical staff, the decision was taken 'To provide and maintain a central home...and to train midwives and midwifery nurses'. Thereafter, the charity's district boundaries, unaltered since the 1860s, despite substantial city growth, were extended in 1903

**FIGURE 7.2: REVENUE SOURCES
BIRMINGHAM MATERNITY HOSPITAL 1900-10**



**FIGURE 7.3: ANNUAL NUMBER OF DELIVERIES
BIRMINGHAM MATERNITY HOSPITAL 1900-1930**



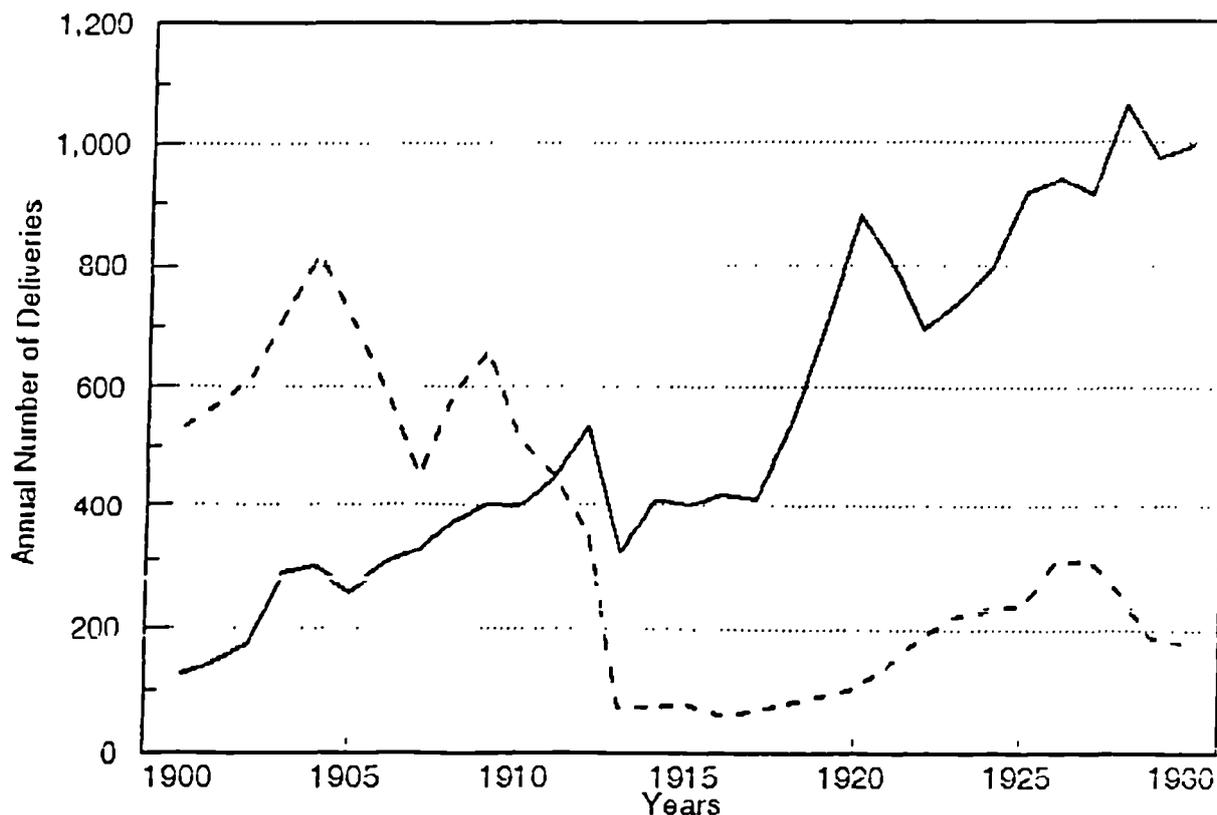
Source: Birmingham Maternity Hospital Annual Reports 1900-1930

'to make them commensurate with the boundaries of this city'. This was achieved by creating two more districts (complete with midwives), appointing six Honorary District Surgeons and two Honorary Physicians to Out-Patients and affiliating with the Nine Day Nursing Society. To sustain this expansion, the recommendation system was abolished because of the severe depletion in the number of subscribers eligible to recommend cases, which had fallen from 566 in 1864 to 144 by 1900. It was replaced in 1904 by a registration system, whereby women approved by an all-female Investigative Committee were registered and confined by the Charity, either in their own home or in a hospital ward, for a nominal fee of 2s 6d.⁶

By 1910, the new registration fee, combined with the collection of tuition fees from pupil midwives, neither possible in 1900, raised over £1,300 in income. In addition and despite the loss of recommendation privileges, there was virtually a seven fold rise in annual subscriptions and donations during the same period (Figure 7.2). This increase was undoubtedly due to the re-opening of the Charity's maternity hospital, which gave the philanthropic public a tangible asset and visible landmark on which to focus their charitable efforts. Consequently, the additional funding and increased accessibility resulted in a 99.4 per cent rise in the district case total (1900-10) and the establishment of a maternity hospital in 1908, confining a further 300 to 400 women a year (Figure 7.3). The

FIGURE 7.4: ANNUAL NUMBER OF DELIVERIES

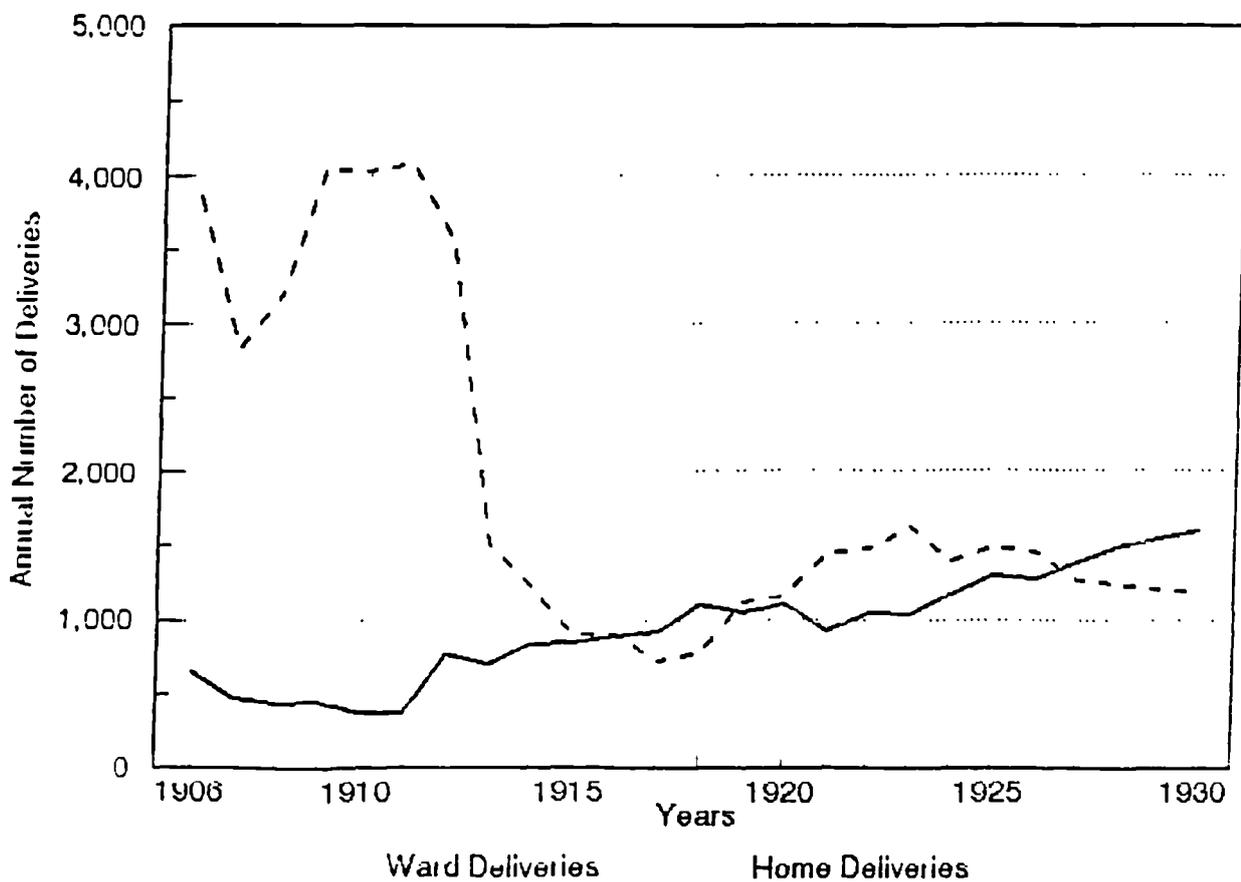
JESSOP'S SHEFFIELD 1900-1930



Source: Jessop Hospital Annual Reports 1900-1930

FIGURE 7.5: ANNUAL NUMBER OF DELIVERIES

ST. MARY'S MANCHESTER 1900-1930



Source: St. Mary's Annual Reports 1900-1930

problem of demographic relevance, which had hampered the Charity's role within the community ever since it had disposed of its first maternity hospital in 1867, was at last being solved.

Characterising this expansion, particularly in the case of the Jessop, was a change of emphasis, from a home to a ward delivery and from a midwife to a doctor or pupil-conducted birth. The Jessop had been delivering women since 1879, but suddenly the medical staff announced in 1906 that the ward service constituted the 'most valuable' and 'important part of hospital work' and were openly admitting to 'taking more cases for the "Hospital" which would otherwise go to the "attached" midwives...', by substituting district, with residential midwives.⁷ Thus, whilst admissions rose by 262 per cent (1901-12), from 148 to 536 ward deliveries a year, district figures fell by 38 per cent, from 571 to 354 home deliveries, which marked a complete reversal in hospital policy. Whereas ward deliveries accounted for 20 per cent of the case total in 1901, they accounted for 60 per cent in 1912 (Figure 7.4). Overall, however, the Jessop maternity case total rose by only 24 per cent, suggesting the increment in the number of hospitalised confinements was as much to do with the contraction of the hospital's domiciliary work as it was a response to the hospital's increased popularity, as the medical staff claimed.

The deliberate contraction of domiciliary practice in favour of ward deliveries was not a pattern readily

repeated elsewhere, or at least not before the National Health Insurance Act of 1911, which had a marked impact on district work generally, whatever the category of hospital.⁸ At Newcastle's maternity hospital growth was proportionate in both areas, for despite a much smaller base figure of 56 confinements a year, the in-patient department, which increased its case intake by 316 per cent (1901-11), grew no faster than the district service, which simultaneously increased its case total by 397 per cent (Figure 7.1). Similarly, at its peak in 1910, there were over 800 more women delivered each year in their own homes by Birmingham Maternity Hospital staff, than ten years earlier, despite the opening of a maternity hospital in 1907 (Figure 7.3). At St. Mary's, Manchester, burdened by financial difficulties, the only growth area following amalgamation with the Southern in 1905 was its district practice, at a time when the number of ward deliveries was virtually halved (Figure 7.5).

It is only in the wake of the National Health Insurance Act which came into force in 1913 that the maternity hospital's district practice began to decline. With a large proportion of hospital cases eligible for maternity benefit (an estimated 80-90 per cent of charity recipients at St. Mary's) and therefore private domiciliary care, there was an immediate and 'considerable falling off' in the number of district cases, by as much as 50 per cent (1912-13), which prompted, for reasons to be discussed, a shift of emphasis from a home to a ward confinement (Figures 7.1,

7.3 - 7.5).⁹ Thus, whilst a ward delivery still accounted for only 18 per cent of Newcastle Maternity Hospital's confinement total in 1911 (a mere two per cent increase since 1901) it accounted for 37 per cent in 1920 and 76 per cent in 1930. Whilst only 8 per cent of St. Mary's confinement total was conducted in the hospital in 1911, by 1920 it was 49 per cent and by 1930, 57 per cent.¹⁰ Similarly, at the Birmingham and Liverpool Maternity Hospitals (1911-30), the percentage of ward deliveries to the confinement total, increased from 23 and 25 per cent respectively, to 48 per cent. However, in both cases domiciliary practice still represented a substantial proportion of the case total, even by the end of the period. With perhaps the exception of the Jessop, there is no suggestion therefore, prior to National Insurance, that women were forced to go into hospital as a result of a deliberate reduction in district services, as Carter and Duriez allege. What contraction does occur, is in the wake, and as a result, of this legislation and women's reactions to it, and not primarily as a result of the actions of the hospitals' professional bodies, as will be explained.¹¹

As the number of hospitalised deliveries increased, so did the presence of medical staff, but not midwives, whose services were practically dispensed with at the Jessop and St. Mary's during this period. Whilst the Jessop medical staff doubled their ranks, including five more salaried appointments (1901-15), the number of hospital midwives were reduced to a point where they were

**TABLE 7.1: BOARD MEMBERS, MEDICAL OFFICERS & MIDWIVES
JESSOP'S SHEFFIELD 1901-1925**

	1901	1915	1925
Hon. Consulting Medical Officers	2	2	2*
Hon. Acting Medical officers	4	3	2*
Hon. Assistant Medical Officers		1	2*
Hon. General Physician		1	1
Registrar		1	1
Hon. Consulting Physician to Infants			1
Hon. Pathologist			1
Hon. Physiologist			1
Anaesthetist (Female/Total No.)		1/3	1/4
Pharmacist		1	1
House Surgeon	1	1	1
Assistant House Surgeon		1	2
Hon. Staff Total	6	8	11
Salaried Staff Total	1	6	8
Midwives	6	4	
Management Bd. (Female/Total No.)	0/13	0/12	4/12

* Medical Officer now known as Surgeon

Source: Jessop Hospital Annual Reports 1901-25

no longer listed in the annual reports, and the two or three that remained worked from the hospital rather than independently in the district (Table 7.1). Whereas 'Midwives Fees' amounted to £206 10s in 1904 (the year the 1902 Midwives' Act took effect), accounting for 3.6 per cent of expenses and 17 per cent of the wages and salaries bill, the amount by 1910 was only £30, or 0.4 per cent of total expenses and 2 per cent of wages and salaries. By 1915, the midwives' account did not even warrant a separate entry.¹²

Their demise had begun in 1901 with the substitution of the post of Superintendent of Midwifery (formerly the position of Kate Keslo who had resigned) by a Midwifery Sister, on £20 less than Keslo and with only the same authority as a sister in the gynaecology department, subservient to the hospital matron. It continued in 1904 with calls from the medical staff for the replacement of part time district midwives with full time employees, 'two or three at the most', resident in the hospital and assisted by pupil midwives, of whom there were about 20 enrolled in any one year (Figure 7.6A). The transition was gradual, for it was not until 1916 that the names of the remaining district midwives were removed from the annual reports. By this date, midwives were referred to as staff nurses, supervising rather than conducting deliveries, which were largely attended by pupil midwives and students.¹³

The pattern was repeated at St. Mary's, once it had amalgamated with the Southern. There was an immediate

loss of 13 midwives followed by a proposal to replace the remaining 15 with a system of pupil midwives living in hostels, each managed by a 'superior midwife'. These were to be self-financing and ultimately dispense with the need to pay midwives' fees altogether. Only one of these hostels was ever built, in the Oldham Road area of Manchester, which survived only three years (1909-12). The large number of pupil midwives (enrolled after 1916 for six months rather than three) and the ever expanding body of medical students (resident for *one month*) ensured a sufficient number of birth attendants for all its registered midwives to be dismissed in 1912 (Figure 7.6B). This left three CMB qualified nurses on call during the day, including the sister-in-charge and a CMB Staff nurse at night. The supervision of pupils and students, formerly the task of the midwife, was, after World War I taken over by the house surgeons, who were to be 'present at, or shortly after, all births', whether a ward or home delivery, abnormal or otherwise, 'as if he would be in general practice'.¹⁴

In contrast, at Birmingham Maternity Hospital, the early 1900s witnessed the reinstatement of midwives. This occurred firstly with the expansion of the district midwifery service, which even after 1913 was never so severely affected as the district practices at the Jessop or St. Mary's and which throughout the period, continued to rely on registered midwives to attend the majority of deliveries. Secondly, came the re-introduction of midwifery instruction in 1904, the responsibility of a

**TABLE 7.2: BOARD MEMBERS, MEDICAL OFFICERS & MIDWIVES
BIRMINGHAM MATERNITY HOSPITAL 1900-1920**

	1900	1910	1915	1920
Consulting Surgeons	4	3	2	3
Hon. Surgeons	4	1		
Hon. Physician to In-Patients		2	6	6
Hon. Physician to Out-Patients		2		
Hon. District Surgeons F/Total		1/6	1/5	
Hon. Ophthalmic Surgeon		1	1	1
Hon. Obstetric Registrar			1	1
Pathologist		1	1	1
House Surgeon F/Total		2/2	1/1	2/2
Consulting Staff Total	4	3	2	3
Hon. Staff Total	4	12	13	8
Salaried Staff Total		3	2	3
Midwives	4	8	7	
Management Bd: F/Total	2/15	10/19	12/26	

F/Total = The Number of Females as a Proportion of the Respective Total

Source: Birmingham Maternity Hospital Annual Reports 1900-1925

new official, a Lady Superintendent of Midwifery, and which until 1913 was unhampered by the presence of medical students (Figure 7.6C).¹⁵ Though medical students increased in number at Liverpool Maternity Hospital, following the reforms of the late 1890s, they never surpassed the numbers of pupil midwives taught at the hospital, except for a brief period in the 1920s. As the expense accounts show, midwives also continued to remain in the hospital's employ (Figure 6.1).¹⁶ This was never the case at Newcastle, which had, since the mid 1860s, taught only medical students and never employed midwives. Although pupil midwives were instructed there from 1907 their numbers rarely surpassed the number of medical students taught in any one year (Figure 7.6D). Consequently, during a period which witnessed a four-fold increase in the number of medical staff (1900-25), women at the Newcastle Maternity Hospital continued to be attended by doctors and medical students, as well as perhaps a pupil midwife, but seldom by one that was fully qualified, registered and in the hospital's employ.¹⁷

The nature, pace and extent of these institutional changes, which were inevitably professionally led, appear to have varied considerably between hospitals. Gender was another major issue of the medicalisation process which underlines this point. At Birmingham Maternity Hospital, the first two House Surgeon posts created when the hospital opened, went to women, as did one of the new positions of District Honorary Surgeon in 1909, at a time when half the Board of Management were women (Table 7.2).

JESSOP'S SHEFFIELD 1910-1930

	House Surgeon	Assistant House Surgeons	Anaesthetists	Pharmacist
1910	M		M	
1911	M	M	M M	M
1912	M	M	M M	M
1913	M	M	M M F	M
1914	F	F	M M F	M
1915	F	F	M M F	F
1916	F	F	M M F	F
1917	F	F	M M M	F
1918	F	F	M M M	F
1919	F	F	M M M	F
1920	F	F	M M M	F
1921	M	M M	M M	F
1922	M	M M	M M M	F
1923	M	F F	M M M	F
1924	M	M M	M M M F	F
1925	M	M M	M M M F	F
1926	M	M F	M M M M F	F
1927	M	M F	M M M M F	F
1928	M	M M M F*	M M M M F	F
1929	M	M M M F*	M M M M F	F
1930	M	M M M F*	M M M M F	F

M = Male F = Female

* Firth Vale Ancillary Hospital

Source: Jessop Hospital Annual Reports 1910-1930

On the other hand, at the Jessop, despite applications from women for the House Surgeon's post since 1899 and deputations from various pressure groups, including the National Union of Women Workers in 1911, women were not offered the position until World War I. Even then this proved to be only a temporary measure and it was not until 1918 that the first women were appointed to its Board of Management (Table 7.3).¹⁸ The principal characteristics of this overall change included greater professional involvement, an increase in numbers, improvements in accessibility and a new emphasis from a home to a ward delivery. These factors need to be explained, and also the anomalies between one institution and another, the consequences of which may well have influenced local maternal mortality variations, as considered in Chapter 8.

Guilty of Misogyny? The Reasons For Greater Professional Involvement and Hospitalisation¹⁹

With the obvious exception of St. Mary's and the Southern Hospitals, Manchester, the Victorian maternity hospital was on the whole, dormant, demographically irrelevant and quite indifferent to the needs of the medical profession and its host community. Yet without the demand for training facilities from prospective midwives and doctors and with little interest shown generally in midwifery work, there was no incentive, let alone funding, to promote change or initiate

improvements. However, in the mid-1890s, when Robert Boxall and William Williams first voiced their concern about the stability of the maternal mortality rate, the registration and instruction of practising midwives became a very real possibility.

As the puerperal fever mortality rate had diminished 'almost to vanishing point' in most lying-in hospitals, many doctors readily assumed that this was the case for the country as a whole. As puerperal fever was the single, most important cause of maternal mortality, it was assumed that the maternal mortality rate had also fallen sharply. Robert Boxall, a midwifery lecturer at Middlesex Hospital, was of the same opinion, until he consulted the Registrar General's Annual Reports (1847-91) and found that the death-rate from childbirth had not appreciably diminished, and in the case of puerperal fever, had actually risen. That there had been a decline in the puerperal fever rate in most lying-in hospitals, but not the country generally, and that antiseptic-aseptic procedures, the key to low puerperal fever rates, were widely known, but seldom applied, obviously reflected badly on the medical profession. To be sure, midwives, 'ignorant', 'untrained', 'lax' and 'half-hearted', were incriminated, but the problem of inept midwifery was at least being solved by proposals to register and train all practising midwives. The same could not be said of the medical profession.²⁰

It was a time for re-evaluation. Charles Cullingworth, newly-elected President of the London

Obstetric Society, still felt the medical profession was partly at fault. He made 'Undiminished Mortality from Puerperal Fever in England and Wales' the focus of his inaugural address in 1897 and attributed the cause 'mainly to the large number of confinements attended by ignorant and untrained midwives'. 'It is clear that something is wrong', remarked Cullingworth with reference to obstetric practice, 'We shall be most likely to find out what that something is by a process of self-examination, both on the part of the teacher and taught, however disagreeable that process may be'.²¹

Consequently, obstetric instruction and medical attendance at a confinement were rigorously reviewed by other distinguished obstetricians, including John Edgar, Milne Murray, John Byers and Elizabeth Garrett Anderson, all anxious to arrest maternal mortality and promote their specialty. None of them liked what they found: inexperienced and ill-informed tutors, midwifery courses 'squeezed into a few weeks', little or no supervision in the birthing room and once qualified, utter disregard for basic hygiene techniques and the principles of non-intervention. As a result, the maternity hospital and its training facilities, the inadequacies of which have been highlighted in Chapters 5 and 6, were inevitably called into question, with requests that special rooms for complicated cases be allocated, the bed capacity increased, in-house training provided and experienced house-surgeons appointed as student tutors.²²

This self appraisal, promoted by the revelations of Boxall and Williams, and fostered by the criticisms of Cullingworth, Garrett Anderson and others, was undoubtedly significant, but not it seems, sufficient to have promoted the great changes that followed. As Cullingworth remarked,

there seems good reason to think that the profession has not as yet realised the enormous importance and significance of the facts to which these writers have invited attention, and has not by any means laid to heart the lessons from them or the urgent necessity that exists for a radical alteration in our present midwifery practice.²³

More relevant to the profession in general than the convoluted discussions on maternal mortality trends, was the fear of losing income, autonomy and prestige to an emergent body of midwives, trained and regulated under the auspices of a Midwives' Act. This was proposed on eight separate occasions (1890-1900) before finally becoming law in 1902. Opposition to the proposed legislation by the medical profession was directed on two fronts. Firstly, there was resistance by general practitioners, who feared loss of earnings and professional status, to the very idea of a Midwives' Act, which if not rejected altogether, placed the training, organisation and regulation of midwives firmly under medical control. Secondly, leaders of the medical profession were criticised for having left obstetric instruction to midwives, claiming that their training was of a superior quality to that received by most medical practitioners.²⁴

It was apparent by the mid-1890s that midwife registration was to become a reality, but not along the lines envisaged by the medical profession, who originally aimed to place the registration machinery solely under their control. They were thwarted by 'women's organizations, Parliament, and the Government', as well as sudden pressure for improvements in midwifery and obstetric instruction.²⁵ Thus the letter from the Dean of the Medical Faculty, University College, Liverpool, in late May 1895, demanded that the local Lying-in Hospital enhance its training facilities (access to hospital wards, theoretical instruction, doctor and not midwife supervision and hospital accommodation during training) only days after the House of Lords had radically altered the Midwives' Bill and unleashed the proposed CMB, which was responsible for the practice and examination of midwives, from medical control.²⁶ Similarly, Newcastle Lying-in Hospital's Management Committee were threatened in October 1900, the year the Act became a virtual reality, with proposals by the local medical school to establish an alternative maternity hospital (as at Liverpool) unless obstetric instruction was improved and the hospital brought up 'to meet modern requirements'. This resulted in the appointment of the school's midwifery lecturer as an Honorary Physician, and the decision to offer students additional facilities, including ward instruction and an increased in-patient capacity, to ensure a ready supply of training material.²⁷ The prospect of a Midwives' Act, prompting an

expansion in training facilities for pupil midwives and stimulating long awaited reforms in medical education, clearly served as the principal catalyst for change, encouraging hospitals drastically to increase their patient totals and provide a service more compatible with midwifery instruction.

Yet ironically, the Midwives' Act, which was intended to enhance professional standing and vocational opportunities, provided the medical staff with the motive and means to divest their own midwife employees of their privileges, independence and status, and ultimately to dispense with their services altogether. The Act threatened the autonomy of the medical staff at the Jessop and St. Mary's, who had always formulated the rules and drafted the contracts concerning the employment of their own midwives, thus acknowledging and even encouraging their presence. At the request of the Local Government Board, voluntary and Poor Law hospital midwives were exempt until 1924 from section E of the CMB regulations governing the conduct and practice of registered midwives. However, the two maternity hospitals, perhaps in their eagerness to secure CMB approval (the first two provincial hospitals to do so) still submitted their own midwifery staff to the rigours of CMB jurisdiction, placing exacting demands on all concerned.²⁸

Under such jurisdiction, for instance, St. Mary's was obliged to dismiss those midwives who failed to meet certain criteria with regard to age, length of service,

acquaintance with the rules and their working practices. This resulted in April 1906 in the dismissal of five midwives including the competent but very old Mrs Pearson, who was 88 years of age and still practising. Under CMB regulations several hospital midwives were also suspended from time to time for their 'behaviour', though this was never described. The hitherto successful practice of admitting sick infants into St. Mary's had to stop, following the CMB's insistence that a sick child was first seen by a registered practitioner rather than alone by a midwife as had formerly been the case. Subject to greater scrutiny and more exacting demands, and in line with the salaries of other registered midwives, the midwifery fee at St. Mary's was increased from 3s 6d to 5s: initially the fee set by the medical staff was 7s but this was rescinded by the Management Board. Hospital midwives, therefore, proved increasingly expensive and to all intents and purposes, no longer under the hospital's direct authority.²⁹

The midwife's devaluation in every respect: status, authority, salary and even in name, referred to as a district or staff nurse rather than as a professional in her own right, went undisputed by the two Management Boards. Indeed, still all-male Management Boards and preoccupied with financial anxieties, they proved very responsive to the ideas of the medical staff, who after years of haggling for additional bed space, equipment and personnel, had learnt just how to turn such key managerial words as 'savings' and 'economy' to their

advantage and publicise them accordingly. At St. Mary's, the Medical Committee submitted the idea of substituting hospital midwives with self-funding hostels at the very time the annual deficit was almost £4,000 and when the maternity department's ward and district service capacities had been reduced by almost 50 and 25 per cent respectively.³⁰ Similarly at the Jessop, the medical staff presented their proposals at the very meeting summoned especially to deal with a financial crisis that threatened the closure of several wards. The medical staff's idea of charging pupil midwives 15 guineas for a three month course, on the understanding 'the Board would have their services' and forecasting a fall in midwives' wages from £207 to £90 a year, by reducing the number of midwives to two or three living in the hospital, was obviously a very attractive proposal to a beleaguered Board of Governors. As a result, the money spent on midwives each year fell consistently from £207 in 1904, to £146 a year later and to £30 by 1910. Tuition fees simultaneously rose from zero in 1904, to £137 the following year, to £233 five years after that.³¹

The midwives' re-location moving to, and working from hospital, as opposed to working independently from home, was also symptomatic of an even more significant change of emphasis, that from a home to a hospitalised delivery. This in turn, the most significant manifestation of professionalisation, is subject to a number of explanations, not all of which were a direct result of the policies and actions of male practitioners

as a number of historians would argue.³² The new teaching practices, for example, required for the first time, instruction in a hospital ward, initially for medical students and then, by the 1920s, for midwives also. The first directive from the General Medical Council in 1906 compelled students to perform part of their obstetric instruction in hospital. Students were then required to attend the indoor practice of a lying-in hospital or the lying-in wards of a general hospital for at least a month, to ensure they received practical instruction in the management of labour. Only after they had received such instruction were they permitted to conduct their 20 labours, either on the district, perhaps under midwife instruction, or in the hospital under medical supervision.³³ Thus, from February 1906, the Liverpool Maternity Hospital made arrangements for students in groups of six to visit the hospital, performing internal examinations when permitted by the Honorary Medical Officer.³⁴ Similarly, in October 1907, the Management Committee at St. Mary's, in a financial appeal to the City Council, estimated that 2,400 confinement cases were necessary to instruct 60 pupil midwives and an equal number of medical students. Of these, 600 would have to be conducted in the hospital to meet the requirements of the General Medical Council, at a time when only 450 women a year were delivered in hospital, and mostly by the honorary staff because of their complicated nature.³⁵

Initially the CMB had allowed pupil midwives to be instructed entirely in the district by a recognised

practising midwife, a district nursing association, a private practitioner or an approved institution, as long as they were given the opportunity to deliver 20 women and to attend to them during their lying-in period. However, the importance of experiencing a combination of hospital and district-based instruction, the former inculcating 'a high standard of surgical cleanliness and method', whilst the latter taught the midwife 'resourcefulness under adverse conditions', did encourage hospitals from a very early date to ensure a regular supply of normal ward confinements for midwifery instruction.³⁶ Indeed, the Management Board suggested in May 1903 that the Jessop concentrate solely on potentially complicated deliveries. Treating ordinary cases by the midwives as out-patients was rejected by the medical staff, on grounds that it was 'absolutely necessary [to admit normal cases] in order to train our midwives and students for the ordinary emergencies of practice...otherwise all training will have to be abandoned'.³⁷

Elsewhere, however, the hospital's district practice remained the midwives' principal training ground, as indeed for the doctors. St. Mary's, for example, by 1910 trained practically 80 midwives a year. It received over £1,500 as a result, three times the annual amount collected from medical students. The hospital relied on its 4,000 district cases to provide the bulk of instruction material; in the hospital there were less than 400 labours a year and most of them were abnormal

cases.³⁸ The turning point for most maternity institutions, transferring from a district to a ward-centred service, were not the changes in the medical syllabus or the CMB training manuals, but the introduction of a piece of national legislation. The National Insurance Act of 1911 was quite separate from, and unrelated to, obstetrics and engendered suspicion and hostility from the medical profession. From January 1913 it provided insured women or wives of insured men (earning less than £160 a year) 30s in maternity benefit, which doubled if both husband and wife contributed to the scheme.³⁹

At St Mary's, 80 percent of its district recipients were insured and their immediate reaction, partly to assert their new-found right and partly acting under the misapprehension that they would forfeit their benefit if they accepted hospital charity, was to seek independent domiciliary attendance at their confinement.⁴⁰ To ensure a future, the maternity hospital subsequently had to emphasize its role as a centre for abnormal pregnancies and complicated labours. Thus it was differentiated from the practice of independent birth attendants, whose solvency under the terms of the Act was now assured and who were much more willing to refer more complicated, and therefore expensive and time consuming cases, to the hospital. Whereas, for example, independent medical practitioners and midwives referred only 12 percent of the cases admitted to the Liverpool Maternity Hospital (1909-12), immediately following the Act they referred 22

percent (1914-17). Similarly, between the two periods, the proportion of abnormal labours to the case total rose from 34 to 43 percent.⁴¹

Moreover, in the light of the 30s maternity benefit, a hospitalised birth became a more viable proposition, for though the maternity hospitals initially assured women that 'no part of the Maternity Benefit is taken either for indoor or outdoor cases', by the end of the decade, largely due to financial problems, they requested all in-patients to contribute towards the cost of their maintenance. In the case of the Jessop, this amounted to all of the 40s maternity benefit (increased after the war) if confined in the hospital and 10s if confined in the district. Other hospitals followed. Whereas, on average, patient contributions to the Liverpool Maternity Hospital were £54 a year (1909-12) they amounted to £871 (1914-17) and whereas patients' payments were nonexistent at the Newcastle Maternity Hospital as late as 1920, by 1925 they amounted to £2,781, practically three times as much as any other single source of income and a third of the hospital's total revenue that year.⁴² Patient payments, however, were not intended to affect the charitable composition of admissions, for whilst the Liverpool Maternity Hospital instructed the Central Relief Society to take into account whether a woman received maternity benefit or not, they still had to report 'on the resources and moral character of the applicant to the Ladies Committee who shall decide whether the applicant shall be accepted'. At the newly

named Princess Mary Maternity Hospital (1924), one of its greatest attributes, according to the City's Medical Officer of Health, was its focus on 'most births in the poorest section of the community, including very many of the difficult and complicated labours'. The point is further emphasised at the Birmingham Maternity Hospital, which continued to provide material assistance to its more impoverished patients, including the issue of milk and meal tickets, the hire of perambulators at 1d a week and help with a personal predicament, including assistance in one case, to obtain artificial teeth and in another, financial support to help re-stock her shop.⁴³

What also encouraged the transition to a hospitalised birth in the wake of the Act, was the impact of the Child and Maternal Welfare Movement, which contrary to the conclusions of Dwork and Lewis was more than just a hygiene-education and prevention programme.⁴⁴ It actually wielded, as will be seen here and in the concluding chapter, a positive influence on medical provision, strengthening the responsiveness of the hospitals to maternal health and communal needs, which in the process increased their in-patient capacities. Fuelled by concerns, enhanced by the War, about the detrimental effect of a woman's health and child bearing experiences on the survival prospects of the foetus and her newborn and perceived primarily as a clinical problem, to be solved by enhancing the quality of professional attendance, the LGB encouraged the expansion of in-patient services from 1915 onwards. To do so, it

**TABLE 7.4: MATERNITY HOSPITALS AND LOCAL
AUTHORITY SUBSIDIES: CASE EXAMPLES 1927**

Maternity Hospital located in...	The terms of the financial Subsidy...
Birmingham	20 maternity beds reserved by the City Council for £86 10s a bed, a year
Leeds	30 maternity beds reserved by the City Council for £3,000 a year, with a view to extending facilities, pending a grant from the Ministry of Health
Liverpool	20 maternity beds reserved by the City Council for £1 11s 6d a case, a week
Newcastle	10 maternity beds reserved by the City Council for £1,000 a year. Also, £2 a case, a week, for those referred by Gateshead, Bedlington and Wallsend and Northumberland Councils, and £250 a year from Durham County Council to maintain two maternity beds

Source: Janet Campbell. 'The Protection of Motherhood'.
Reports on Public Health and Medical Subjects,
48 (London, 1927), p.61.

used local authority grants and made direct payments to hospitals.⁴⁵ From July that year, Sheffield City Council maintained two beds at the Jessop purely for cases of puerperal sepsis and paid the hospital 50s a week for every abnormal pregnancy or confinement that the council referred to them. St. Mary's assigned five beds to the City Council from October 1920 and the Birmingham and Liverpool Maternity Hospitals reserved beds for their fee paying councils in even greater numbers (Table 7.4). At Newcastle Maternity Hospital, the greatest part of its ward expansion (1918-22) seems to have been funded by the City Council, which provided most of the £3,850 necessary to provide 20 more maternity beds, in addition to reserving ten beds for Council referred cases for £1,000 a year.⁴⁶

To what extent doctors openly manipulated or exploited these external influences to their advantage and seized on the opportunity to confine more and more women in hospital, is difficult to say. Clearly, for example, at the Jessop, the focus on the Maternity Department, at the cost of its district practice, happened some time before the effect of national legislation. Doctors undoubtedly stood to gain from attending confinements in a hospital as opposed to a home environment. Hampered by the '"gossips"...offering well-meant but ignorant suggestions', and 'forced by the importunity of the patient and her friends to interfere unduly with the natural course of labour', the doctor's task at a home confinement was often made a difficult one

and his position frequently compromised.⁴⁷ In this sense there was a clear attempt to assert authority over the management of the birth but more for therapeutic and practical purposes than out of any conscious decision to control birth for its own sake. As one general practitioner put it, though somewhat exaggeratedly,

The private doctor is driven from pillar to post by the patient's relatives. He receives an urgent summons, and on arrival he finds that the patient has been in labour for barely half an hour. On the staircase he trips over the husband who is seated there with his head between his knees, groaning and unshaven. In the bedroom he will be confronted by the mother-in-law who wants to know when something will be done. There, too, he will meet the woman from next door who is pouring scent on the victim's forehead and saturating the room with noxious vapours. He finally runs up against the patient's own mother who has come up from the country especially for the confinement, and, who, having had children herself, of course, "understands things". Under such circumstances is it to be wondered at that sometimes we do things contrary to our better judgement and contrary to what we teach and have been taught?⁴⁸

It was, as another practitioner noted, a case of 'too many cooks stirring the broth', but uninformed and inexperienced private practitioners were, as has been shown, as much to blame for the confusion in the woman's home as an anxious parent or relative, and it was from both groups that the hospital doctor was escaping, to the supposed 'atmosphere of calm routine' at the hospital.⁴⁹ This accounts in part, for the transition at St Mary's from a home to a hospitalised birth. Despite strong objections, the Management and Medical Boards were forced by the Corporation's Supervisory Committee of Midwives

and the Manchester and Salford Branch of the BMA to dissolve the district medical officer system in 1907, because, these organisations argued, it restricted the woman's choice of aid and constituted a loss of earnings to the general practitioner who received payment from the council every time he was summoned by a midwife. St. Mary's, which had hoped to expand its system of Honorary District Medical Officers, now had to allow the woman's general practitioner to be called. It was, as one Board Member, Mr H. Smith-Carrington, remarked, 'an evil day for the Hospital when only medical men can be called in by a midwife without reference as to whether he is the best man in the neighbourhood for the special work required', and one more reason for performing such 'special work' in the hospital under their direct control.⁵⁰

Also, in the wake of diminished puerperal fever in 'all properly conducted Lying-in Hospitals' and in the light of a greater and more successful array of therapeutics, the hospital staff genuinely believed that they had much more to offer the parturient woman. Of direct benefit, the hospital was 'an untold blessing' for 'severe and difficult cases of labour which cannot be adequately dealt with in the homes of poor women'. It was never really disputed that a home confinement could be conducted 'satisfactorily, and with little or no maternal mortality, even in the humble and insanitary dwellings of the very poor' as Birmingham's Lying-in Charity's own figures testify. However, it was argued

that the same insanitary conditions 'may and do spell disaster in the event of an obstetric operation being necessary'.⁵¹ As Campbell explained:

The average working class mother is able to make provision for an ordinary confinement as commonly conducted, but few would be able or willing to spend money in providing that more thorough attention which experience is teaching us to regard as desirable.⁵²

In addition, a number of obstetric techniques, such as caesarian section, internal version and induction and the treatment of severe complications, namely eclampsia and haemorrhaging, had been developed for use in the hospital, not the home. Under these circumstances, the Final Report on Maternal Mortality concluded, 'the greatly enhanced prospects of safe delivery in a well conducted institution are generally recognised', and with regard to those hospitals 'properly built, equipped, and managed', added Henry Jellet, 'a positive factor in the reduction of maternal mortality'.⁵³

This, however, as Lewis explains, concerned only abnormal labours and not natural cases, which a number of leading obstetricians and policy makers still adamantly believed 'should be carried out [at home] by well-trained midwives while the obstetric surgeon is called in for emergencies'.⁵⁴ Both the Interim and Final Reports on Maternal Mortality, for example, published in 1930 and 1932 respectively, found the home to be 'in ordinary circumstances a safe place for normal confinement even under the usual conditions of working class life', which often produced 'excellent results'.⁵⁵ There were, to be

sure, a growing number of dissenters amongst the obstetric profession, including Bonney, Lackie and McAllister, who believed that all births should take place in the hospital under 'medical expertise'. However, as Kerr explained, this was a minority opinion and of little influence at the time, either on official government policy or the admission practices of maternity hospitals.⁵⁶ From the outset, Birmingham Maternity Hospital reserved its beds for 'cases of eclampsia...of albuminuria...of bleeding before delivery; abnormal presentations, contracted pelvis, excessive distension and various complicating affections'. Meanwhile, St. Mary's concentrated on the admission of anticipated difficulties and primiparae cases and left only slight perineum tears and medical ailments to be attended in the district.⁵⁷

Accepting that doctors, vis-à-vis the hospital, could now offer a safer environment, with all the ancillary support necessary for a complicated delivery, women, particularly in those institutions which had a strong tradition of female voluntary effort and management, fervently supported the idea of a hospitalised confinement. As documented at the Liverpool Maternity Hospital, at the instigation of the Ladies' Committee in May 1901, 'a special room for bad cases' was assigned, furnished and fitted, to receive patients referred by the district staff or general practitioners.⁵⁸ Similarly, at Birmingham, the decision to build a maternity hospital in 1901 came soon after two

women had been appointed to the Board of Management and the Charity's female subscribers, providing 30 per cent of the subscription revenue, had become full governors, no longer requiring their husbands to represent them at subscribers' meetings. By the time the maternity hospital was fully operational in 1908, when Clara Eglinton was appointed House Surgeon and single women still refused admission, testifying to the extent of the women's influence, the Charity's female supporters had gained more than half of the nineteen seats on the Board of Management (Table 7.2). Whilst in the absence of Board minutes, the nature and extent of women's influence on the re-opening of the Birmingham Maternity Hospital remains uncertain, the fact that there was a strong female presence at the time and that it was the Ladies' Canvassing Committee which raised most of the £16,500 necessary to open the hospital, leaves little doubt that middle class women were instrumental in realising the doctors' notion of a hospitalised birth.⁵⁹

At this period, the middle class were being told that it was safer to give birth in Shoreditch or Whitechapel, the poorer areas of London, than in the more affluent parishes of Hampstead and Islington. Ladies were equally affected by 'the shadow of maternity' as their poorer sisters and just as anxious about the persistently high death rate in childbed as any obstetrician or government official.⁶⁰ In view, therefore, of debilitating home conditions, impeding rest and recovery as much as the labour itself, the offer of

medical expertise and greater access to anaesthesia to relieve the pain, 'articulate women's groups', as Lewis observes, 'supported the hospitalisation of childbirth', and as Leavitt adds, women's 'eagerness to put themselves more completely in the hands of obstetricians and medical institutions'.⁶¹

The expansion of ward services to a point where 'overflow' patients were being re-directed to other hospitals because of the lack of bed space, even at a time when district practice was expanding, attests to their popularity. In addition, calls from working-class as well as middle-class women for hospitalised births, were expressed via such organisations as the Women's Co-operative Guild, the Standing Joint Committee of Industrial Women's Organisations, the International Council of Women, the National Birthday Fund, the Fabian Women's Group and the Unofficial Maternal Mortality Committee.⁶² Thus, embodied in the Guild's National Care of Maternity Campaign, amidst calls for maternity centres, material relief for expectant and nursing mothers, greater access to skilled medical assistance and supervision of all labours by a doctor (as happened at St. Mary's), were demands for the hospitalisation of difficult obstetric cases and women from homes deemed unsuitable for delivery. By 1933, the Women's Co-operative Guild was demanding a maternity hospital, complete with an operating theatre and ambulance service, in every town with a population of more than 4,000.⁶³ Similarly, one of the principal demands of the Unofficial

Maternal Mortality Committee, led by 'titled' and 'well-connected' females, was increased hospitalisation for maternity cases, facilitated by the provision of home helps, as a means of encouraging them to enter hospital and at the same time, address the social and environmental problems facing parturient women.⁶⁴

'Unhygienic and Interventionist': No Redeeming Features?⁶⁵

The transition seems on the whole, therefore, to have been met with a general consensus and encouraged by both provider and recipient. The maternity hospitals continued to reduce barriers to access, finally accepting single women 'upon the same footing as married women' at Liverpool Maternity Hospital from March 1920 and abolishing the recommendation system at the Jessop the following year, whilst more and more women displayed their approval by entering these institutions. Such was the demand at the Jessop, by September 1919, despite the re-vitalisation of its district practice, that maternity in-patients were having to be accommodated on tables, couches and trolleys. At Newcastle Maternity Hospital the demand for hospital beds increased from an average of 30 ward confinements a year (1896-1900) to almost 30 a week (1921-25), in addition to a ten-fold rise in the number of district confinements.⁶⁶

Moreover, the maternity hospital of the 1920s, albeit under greater professional control, was, as will

be shown in the conclusions, a far more dynamic and relevant force than its Victorian predecessor, no longer a place where women were simply confined. Re-located along City Road, in a thickly populated area, the Newcastle Maternity Hospital was, for example, in the opinion of local health officials, the primary form of maternity provision in the city, fulfilling 'a function that is absolutely vital to Newcastle': attending to a third of the city's annual confinement total, providing one of the largest training schools for midwives in Britain and constituting a major, local force in ante-natal care.⁶⁷ In Birmingham, 90 per cent of the city's midwives had received no formal instruction nor qualification as late as 1906. There, the maternity hospital soon identified 'the need...in this city and the surrounding counties for a larger supply of trained and certified midwives' and from 1904, began to train midwives for the second time, but on a much more systematic and successful footing. By 1920, the proportion of untrained midwives to the total number registered, had been reduced to 47 per cent and by 1930, to 9 per cent. This was due in no small part to the efforts of the maternity hospital, which at its peak (1922) was training over 100 midwives a year and had, as early as 1913, been recognised by John Robertson, the City's Medical Officer of Health, to be of 'special advantage in improving the training of nurses'. The same institution, influenced by the maternal and child welfare movement, was also responsible for establishing an Infant

TABLE 7.5: PRINCIPAL COMPLICATIONS
ST. MARY'S MANCHESTER 1906\10-1921\25

	Case Total	Mat Deaths	% of Cases	Case Total	Mat Deaths	% of Cases
	1906-10			1921-25		
Haemorrhaging						
Accidental	62	1	0.2%	197	11	5.6%
Post-Partum	24	1	0.4%	58	10	17.2%
Placenta Praevia	154	14	0.9%	280	11	3.9%
Mal-Presenting						
Breech	93	0	0%	358	5	1.4%
Transverse	58	1	0.2%	137	4	2.9%
OccipitoPosterior	13	0	0%	417	8	2.0%
Brow & Face				87	7	8.0%
Prolapsed Cord	59	1	0.2%	133	2	1.5%
Albuminuria	99	3	3.0%	320	6	2.5%
Eclampsia	81	28	34.6%	181	32	17.7%
Contracted Pelvis	395	16	4.0%	794	20	2.5%
Heart Disease	16	9	56.2%	109	5	4.6%
Case Nos	1,054	74	7.0%	3,071	123	4.0%
Total Nos	2,007	74		5,504	123	
Case % of Total	49%	3.5%		56%	2.25%	

Source: St. Mary's Maternity Department Annual Reports 1906-1925

Welfare Committee in April 1913. This made a significant contribution (vis-à-vis infant health visits, maternal instruction and milk distribution) to the city's own efforts in this direction. It also proposed a School for Mothers, for which the land was purchased, plans drawn up and £3,340 raised, but which was ultimately thwarted by the war effort.⁶⁸

As has been shown, these increasingly professionally led institutions were also highly regarded as places of safety and centres of expertise for women enduring a complicated pregnancy or labour, and to a degree, this was reflected in the returns. At a glance, for instance, the mortality rate for complications dealt with at St. Mary's appears to have fallen from 7 per cent of the total number of complications (1906-10) to 4 per cent (1921-25) (Table 7.5). However, what was being diagnosed as a complication in this later period, increasingly by young and inexperienced house surgeons, may have been treated as a natural birth by a midwife in the former. In particular, the point may be made about women who endured an occipito-posterior presentation or a contracted pelvis, for in the majority of cases spontaneous delivery was possible and as will be shown with regard to the former, the problem was quite harmless if not unduly rushed or interfered with, which seemed to be increasingly the case.⁶⁹ However, with regard to certain complications, where diagnosis was less ambiguous, there appears to have been a genuine fall in the mortality rate. Eclampsia and heart disease, which

were admitted in highly concentrated numbers (it was estimated that 1 in 600 women confined would experience eclampsia, which was endured by one in 30 at St. Mary's) are a case in point. Both conditions were able to benefit from the advances in ante-natal provision and in-house treatment, ensuring, in the case of the former, early admission, a strict milk diet, hot packs, saline infusion and morphine to control the frequency and severity of the fits, a major cause of death. In the case of the latter, the woman could be made as comfortable and relaxed as possible prior to confinement and the stress endured during labour relieved, where necessary, by the use of forceps.⁷⁰

In many ways, however, the institutional initiative had, by the 1920s, been lost. Firstly, by employing qualified nurses to assist rather than midwives to deliver, the hospital was losing a highly acclaimed professional, renowned for obtaining 'excellent results' and adding 'greatly to the safety and comfort of the mother...whether a doctor is in attendance or not'.⁷¹ The maternal mortality returns continued to illustrate this point. John Fairbairn, Consultant Obstetrician at St. Thomas's, demonstrating the value of a well-trained corps of midwives, showed that the maternal mortality rate amongst women attended by midwives of the Queen Victoria's Jubilee Institute was, even after the necessary computational adjustments, 'under half that of the general rate for England and Wales' (1905-25). At the East End Maternity Hospital, London, 'where the bulk

of the cases are conducted by midwives, and abnormal cases by [honorary] medical practitioners...', as in Manchester 30 years earlier, James Young found that it had 'a mortality rate standing a little over 1 per 1,000 cases', which he believed to be an 'admirable result' and well below the national average.⁷² A similar result was achieved amongst Liverpool Maternity Hospital's own district midwife-conducted deliveries, where the maternal mortality rate was considerably below the national average, at 1.42 (1901-10) and 1.75 (1911-20) per 1,000 live births compared with national averages of 4.00 and 3.84 respectively. This was significant at a time when many complicated cases attended by hospital staff were seen in the woman's own home.⁷³

Indeed, so highly regarded was the well-trained midwife, that in the move towards a National Maternity Service in the 1920s, it was envisaged by government officials and leading obstetricians, as well as voluntary bodies, that the domiciliary midwife would play a key role in its development, supported by the medical profession only in the cases of abnormal labour.⁷⁴ Yet ironically, the maternity hospitals in Sheffield and Manchester, which had led the way in highlighting the importance of using well-trained midwives and skilled practitioners, relinquished the successful partnership in favour of a second rate, professional affair, at the very time the country as a whole was beginning to value the domiciliary midwife and incorporate her services into a national maternity scheme.

Secondly, by transferring women from home to hospital, without a proportional rise in bed space, professional personnel and ward facilities, the medical staff placed undue strain on institutional resources and put the patient at unnecessary risk. At Liverpool Maternity Hospital in-patient numbers rose from 174 in 1895, to 322 in 1905, to 590 by 1910, and continued to rise thereafter, despite fears that the patients' health was adversely affected by 'the evil of the overcrowding' and despite having to refuse women 'almost daily' and re-direct them to the workhouse. By 1916, the average, daily occupation of the 23 maternity beds was 22.95, 'a most emphatic testimony of the urgent need for more hospital accommodation'.⁷⁵

Similarly, at the Jessop, Sheffield, having accepted LGB and city council sponsored in-patients from June 1914 and private cases from October 1917, whilst insisting on retaining a 50:50 ratio of in-patients to residential staff (servants, nurses and medical officers), the hospital faced an acute accommodation crisis by 1918. So acute was the crisis, that by September 1919, the year 700 women were confined in the hospital, practically six times the ward total twenty years earlier, parturient women were being accommodated on tables, couches and trolleys. The Management Board, concerned that the provision of more beds would mean the appointment of more staff nurses and ancillary personnel, demanded that the medical staff restrict admissions. There was no agreement between them; one had control of admissions,

the other, the purse strings, and it was this fundamental failure to synchronise that caused the problems.⁷⁶

The first to fall victim were the women who took advantage of the fortnight's convalescence. Their residential stay was reduced from 14 to 12 days at the Liverpool Maternity Hospital in 1908 and at the Jessop, from a fortnight to less than ten days, between the early 1890s and late 1920s, despite the pledges to prohibit a practice, which, 'in the interests of the patients', was 'considered unwise'. Others were more seriously neglected. Between 1921 and 1924, the Liverpool Maternity Hospital faced so many litigations concerning claims of wrongful medical and surgical treatment that the Board of Management was forced to seek insurance cover. In one instance a 'poorman's lawyer' defended a Mrs T whose baby was the subject of an accident at the hospital. The Board denied any liability, but offered 'without prejudice a sum of £5 towards out of pocket expenses'. Three years later, in 1924, solicitors were representing a woman whose operation had been wrongly performed; she too settled out of court for £30.00. Given the frequency and variety of complaints that the hospital was facing, it was no surprise that the Board could not find one insurance company willing to offer cover against such litigation proceedings.⁷⁷

A small number of hospital fatalities too, could in all probability, be attributed to increased levels of overcrowding and subsequent loss of control and supervision. As with the litigation reports, details of

such fatalities were hardly ever recorded, but it would be fair to assume that insufficient supervision lay behind the death of an infant whose body was severely burnt by a running hot tap and also the death of a maternity patient, again at the Jessop, but seven years later, in 1914, who fell from a first floor window 'whilst suffering under some delusion, or by mistake'; the hospital staff could not even be exact about the woman's mental state or chose purposefully not to be. In a highly publicised case in September 1934, 19 year old Molly Taylor, who had enjoyed a normal, problem-free pregnancy, died soon after being confined in the out-patient department of St. Mary's and transferred to Crumpsall hospital due to the lack of bed space. Though the verdict of a Public Enquiry on the matter was inconclusive, the incident nonetheless exposed the lack of co-ordination between the voluntary and municipal hospitals and moreover the problems arising from being overcrowded and under-resourced.⁷⁸

Thirdly, by placing the hospital's salaried doctors in charge of 'All cases, both normal and abnormal, treated in their own homes', as well as in-patients, the responsibility was transferred from a competent midwife and a renowned obstetrician to a body of young, inexperienced and insufficiently trained graduates, altogether ill-qualified to do the job. A sample review of St. Mary's medical staff in 1922 illustrates the point. Both House surgeons for the maternity Department, W. D. Saltern and J. W. Smith, had graduated only the

year before. The obstetric officer, F. S. Horrocks, who had 'absolute responsibility' for all district cases and supervision of ward admissions, had graduated only two years earlier. None could compare to Kate Keslo or Louisa Gosling who, appointed with a great deal of previous experience, ran the maternity wards at the Jessop and the Liverpool Maternity Hospital respectively, for over 20 years and knew more about the rudiments of maternity, the delivery of a normal child and identifying potential complications, than their male counterparts could ever have hoped to achieve in a lifetime of private practice. Yet the three young graduates, assisted only by students, pupil midwives and trained nurses, were expected to be the first to attend over 2,500 labours a year, 41 per cent of them in hospital, compared to 2,900 and 6 per cent in hospital in 1900, attended by the same number of residential but more experienced staff and 16 district midwives. In 1922 far more of the case load, therefore, fell on the students and pupil midwives who, inexperienced and often unsupervised, exacerbated the problem of incompetent attendance.⁷⁹

The combined result was increased intervention at deliveries. At the Jessop, with five anaesthetists by 1926, a yet further encouragement to intervention, the number of ward deliveries rose five fold from 685 cases (1891-95) to 3,529 (1921-25) (Table 7.6B). The number of operative cases rose 12 fold, from 74 to 869, and accounted for a quarter of all ward deliveries, compared to one tenth, three decades earlier (Table 7.6B).⁸⁰ The

forceps rate alone accounted for a greater proportion (11.1 per cent) of ward deliveries in this latter period, than the total number of operative cases (10.8 per cent) did in the former (Table 7.6B). Despite claims of a decline in methods destructive of the foetus, craniotomy and decapitation were just as frequent as they were 30 years earlier. Whereas caesarian section and version accounted for two and three cases respectively (1891-95), collectively they accounted for 10 per cent of the total number of ward deliveries (1921-25) (Table 7.6B). Clearly, the experience at the Jessop is at total variance with Shorter's conclusion 'that before the 1930s there was little overall increase in the amount of operative interference'; the reality was quite the contrary.⁸¹

Whilst the increase in interventionist measures is not so discernible at St. Mary's, for ward figures are available only from 1906, the rate of intervention was nonetheless very high, accounting for about a third of all ward deliveries (1906-10 to 1921-25) (Table 7.6A). Decapitation techniques and inducing the birth diminished in importance and forceps and version simply maintained their proportion of the ward total, about 13 and 6 per cent respectively. However, the number of caesarian sections rose seven fold, from 18 (1906-10) to 127 a year (1921-25), or from 4 to 12 percent of the total number of deliveries (Table 7.6A). In comparison with other hospitals, these rates were high. Both Henry Jellett, former Master of the Rotunda, Dublin (1910-19), and Munro

Kerr, Regius Professor of Midwifery, University of Glasgow, estimated that between 5 and 8 per cent of all labours required forceps. At the Rotunda (1919-26) the rate was 6.7 per cent, at the Jessop and St. Mary's it was 11.2 and 13.3 per cent respectively (1921-25). Similarly, the caesarean rate which was 1 in 104 at the Rotunda (1919-26), 1 in 100 at York Road Lying-in Hospital, London (1918), was 1 in 25 at Newcastle Maternity Hospital, 1 in 18 at the Jessop (1921-25), 1 in 16 at the Birmingham Maternity Hospital (1920), where there were female house surgeons, and 1 in 9 at St. Mary's (1921-25).⁸²

The medical staff at these provincial institutions justified such high rates of intervention by their 'peculiar position', accepting: 'all primiparae and multiparae with a bad obstetric history', 'cases of difficult or complicated labour occurring in the district' and all urgent cases recommended by a general practitioner or a midwife, often after their attempts at delivery had failed. At St. Mary's, 53 per cent of admissions (1921-25), as opposed to 40 per cent (1907-10), were primiparae cases. In addition, all women who required more than low forceps were brought into the hospital and no urgent case refused 'no matter how far she may be living away'.⁸³ There was also an increasing problem with 'FFO' cases ('Failed Forceps Outside'), where a doctor had failed to deliver the baby with forceps at home and as a result had to rush the mother into hospital. According to Shorter, 'it was the large

**TABLE 7.7: CAMERON'S SURVEY OF 'MATERNAL MORTALITY
...IN MATERNITY HOSPITAL PRACTICE' 1914**

	No. of Women Delivered	Deaths Among Deliveries	Deaths Per 1,000 Live Births	Total Maternity Deaths	Deaths Per 1,000 Live Births
Hospital A 1910-14	4,714	28	6.2	32	7.1
(pa)	943				
Hospital B 1910-12	5,491	13	2.5	16	3.0
(pa)	1,930				
Hospital C 1905-13	2,553	103	39.1	145	59.1
(pa)	510				
Hospital D 1911-14	1,722	37	25.4	51	25.0
(pa)	430				
District E 1910-14	9,476			10	1.1
(pa)	1,896				
District F 1911-14	4,818			2	0.4
(pa)	1,204				
England and Wales					3.53

A/B = Two Metropolitan Maternity Hospitals

C/D = Two Provincial Maternity Hospitals (St. Mary's & The Birmingham Mat. Hosp)

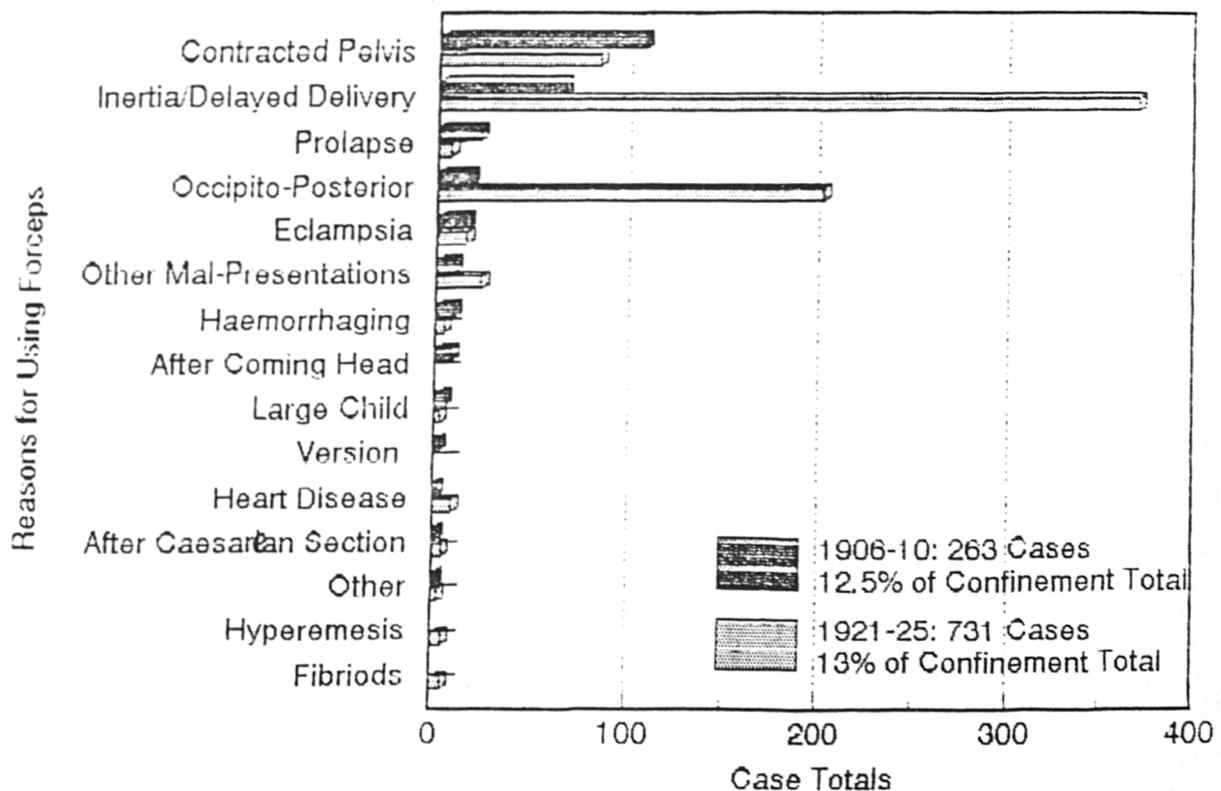
E = District Practice of Hospital A F = District Practice of Hospital D

Source: Arthur Newsholme, 44th Annual Report of The Local Government Board 1914-1918: Supplement Containing a Report on Maternal Mortality in Connection With Childbearing (London, 1915) pp.106-7.

TABLE 7.8: FORCEPS CASES
ST. MARY'S MANCHESTER 1906\10-1921\25

	Forceps/Delivery	Forceps as % of	1 in X Deliveries	1 Mat/Chld Death
	Totals	Delivery Total	= Forceps	In X Deliveries
				from Forceps
1906-10	263/2,097	12.5%	9	24/4
1911-15	380/3,517	11%	9	
1916-20	484/5,081	9%	10	
1921-25	729/5,504	13%	8	28/3
1926-30	1,092/7,309	15%	7	

FIGURE 7.7: REASONS CITED FOR USING FORCEPS
ST. MARY'S MANCHESTER 1906\10-1921\25



Source: St. Mary's Maternity Department Annual Reports 1906-1925

number of FFOs that sounded the death knell of home deliveries in general'. Whilst this perhaps was an exaggeration, there was a very real problem of cases 'sully'ing' the maternity hospital's mortality returns that had 'been allowed by delay to develop into grave emergencies before their admission'. In the case of at least two provincial maternity hospitals, these mortality rates were much higher than the national average and the rates of some London hospitals because of this very reason (Table 7.7).⁸⁴

Regardless, however, of the large and various number of complicated deliveries, there was still no justification, even in the eyes of their contemporaries, for hospital staff to intervene on the scale they did. Forceps were a case in point, for though inevitable and often helpful for women too weak and too exhausted to continue labour unassisted, they were, by the 1920s being applied to cases where manual manipulation, if not natural forces, would have sufficed and where more problems were being created than solved. At St. Mary's, for example, the three-fold rise in forceps deliveries (1906-10 to 1921-25), was due to a six-fold rise in the number of forceps cases involving delayed labour and malpresentation (namely, occipito-posterior presentations), which were diagnosed and performed by junior medical staff, but which according to a number of esteemed obstetricians need never have taken place (Table 7.8 and Figure 7.7). Whereas these two particular conditions accounted for 92 forceps deliveries and 4.4 per cent of

the confinement total (1906-10), they accounted for 595 forceps deliveries and 10.8 per cent of the total (1921-25) (Figure 7.7). With regard, however, to other major obstetric complications, involving forceps (haemorrhaging, contracted pelvis, eclampsia and prolapse cord), all cases involving consultation with an Honorary Medical Officer, there was a proportional decline in the use of forceps, from 171 cases or 8.1 per cent of the confinement total (1906-10), to 136 or 2.5 per cent of the total (1921-25) (Figure 7.7).

At first sight, the three-fold rise in forceps deliveries and the focus upon delayed and mal-presented labours appear immaterial, for maternal deaths actually declined from 4.2 per cent of the total number of forceps deliveries (1906-10), to 3.6 per cent (1921-25). Further examination, however, reveals that the stillbirth and infant death rate amongst forceps cases remained very high: 30 per cent of all infants, whose mothers were delivered by forceps (1921-25), died in the process, most probably as a result of cranial injuries. If, as Shorter argues, the medical profession strengthened their control of the birth process and intervened more readily in order to produce a healthy baby as well as a living and undamaged mother, these figures suggest they failed miserably. Such deaths, maternal as well as infant, were largely due to the use of forceps in cases of delayed labour and mal-presentations. Had there been no maternal deaths from these causes, as was the case fifteen years earlier, then the maternal death rate would have been

only 1.1 per cent of forceps deliveries as opposed to 3.6 per cent. The hospital was not, therefore, by this latter date, the 'controlling force on forceps abuse' that Shorter portrays it to be.⁸⁵

All 18 maternal deaths and many of the 163 infant and still-birth losses, where forceps were applied to mal-presentations and delayed labours, would, according to such eminent obstetricians as Comyns Berkely, Eardley Holland, Munro Kerr and Henry Jellett, have been quite unnecessary had the doctor refrained from using forceps. Occipito posterior cases were a common abnormality of the vertex presentation. There were 417 cases of these and 8 maternal deaths at St. Mary's (1921-25), including 202 forceps cases, five of whom died. Comyns Berkely observed that 'In nearly every case...it is possible to rotate the head and shoulders with the hands', in short, forceps were rarely required. Where they were used, Berkely argued, then 'The child certainly is more likely to be injured by rotation with the forceps, and I have seen most serious lacerations following such attempts on the mother', at worst, 'bringing the patient to the point of death', at best, causing 'life long suffering from injury or infection', including immobility, prolonged ill-health and sterility. As further evidence of the futility of using forceps in such cases, Munro Kerr pointed to the York Road and East End Maternity Hospitals, London, which admitted 176 and 729 occipito posterior cases, respectively (1928-31), but encountered no maternal deaths, because all were attended by midwives

who could not have used forceps and would have been much more willing to allow spontaneous delivery than their more anxious, perhaps over zealous, medical counterparts.⁸⁶

This too would have been the case in Manchester 30 years earlier, where it has already been seen that major complications aside, forceps were applied only to women who had been given every opportunity to deliver naturally, without undue haste or interference on the part of the attendant. In the first instance, 'the attendant' would have been a midwife, in the second, a notable figure, such as Japp Sinclair at the Southern and Lloyd Roberts at St. Mary's, the 'ruling spirits' of their respective institutions, whose denunciations of the horrors of 'meddlesome and mischievous' midwifery were widely publicised and firmly enshrined in hospital practice. Now the attendants were young and inexperienced, no more qualified than a general practitioner, yet attending six times the number of ward deliveries than were admitted at the end of the nineteenth century and without the autocratic, but guiding influence of such characters as Roberts and Sinclair; the chaotic state of private obstetric practice had finally been unleashed on the hospital and it was beginning to show.

The increasing and unnecessary acts of intervention by young and inexperienced house surgeons during the 1920s, supports both Loudon's and Oakley's views, that the hospitalised birth was characterised by 'greater use

of surgery' and 'excessive obstetric intervention'.⁸⁷ The evidence, with reference to the dangers of forceps and the mal-effects of a caesarean, fails to support Shorter's opposing view that a hospitalised birth was a positive and life saving experience that promoted only 'safer', 'gentler' and 'pleasanter' childbirth.⁸⁸ However, whilst the hospital clearly had its drawbacks because of its growing dependency on student help and young doctors, it would be quite wrong, as Lewis observes, to draw comparisons between a hospitalised and a home delivery and categorically state one was safer than the other. The difficulty with this approach is the inability to distinguish, from the mortality returns, between the place of delivery and the place of death, for as it has been shown, women in a grave, almost moribund condition (often the result of prior attempts at delivery) were frequently admitted into the hospital.⁸⁹

Where tentative conclusions may be made, is in drawing a distinction between the treatment of a complicated and a normal delivery. Where a woman was faced with a complication such as heart disease, eclampsia, haemorrhaging or a mal-presentation, which could be identified at an early point in labour, then the hospital would have been the most suitable place for her confinement. As in the Victorian period, the advantage for such severe cases was attendance by highly competent, experienced and senior medical staff, who often had to treat women enduring difficulties caused by malpractice outside the hospital. Yet where a woman had every hope

of delivering naturally and without any undue complication, there was no real advantage to being delivered in the hospital as opposed to her own home. All the more so in the wake of the National Insurance Act, which began to address the financial burden imposed by a confinement and the improvements in midwifery training, first in 1902 then in 1916 and 1926, which ensured greater attendance by perfectly competent and well trained independent midwives.⁹⁰

Where the opinions of Oakley, Tew, Branca and other feminist historians are challenged, is with regard to the explanations for the transition, which cannot simply be attributed to the doctors' quest for professional gain.⁹¹ There were more pragmatic and influential reasons underlying the transition, namely the 1911 Insurance Act which forced a change of approach by the hospital, and the Child and Welfare Movement, which via the Local Government Board, directly sponsored hospitalised births. Fulfilling educational demands and commitments was also a contributory factor, but one that considered the training of the midwife as much as the doctor, even to the detriment of the latter. The transition was also as much a response by women themselves, who showed their support by entering maternity hospitals in ever increasing numbers and actively supporting their development, as by doctors, who were far from being alone in their promotion of hospitalisation, as Oakley would lead us to believe.⁹³

Notes to Chapter 7

1. Evidence submitted by Thomas Ainsley, Honorary Surgeon of Hartlepool Hospital and Medical Officer of the Hartlepool Union Infirmary. Appendix, Vol V. Evidence (with Appendices), oral and written, of witnesses from South Wales and North East Counties, BPP, 1909, (4888) xli, 983, p.173.
2. Jessop Hospital Archive, Sheffield (hereafter JHA Sheffield), Annual Report, 1884. See also Chapters 3 and 5.
3. For example, Newcastle Lying-in becomes Newcastle Maternity Hospital in 1907 and Birmingham Lying-in Charity the Birmingham Maternity Hospital in 1908.
4. Jane Lewis, 'Mothers and Maternity Policies in the Twentieth Century', in *The Politics of Maternity Care: Services For Childbearing Women in Twentieth Century Britain*, ed. by Jo Garcia, Robert Kilpatrick and Martin Richards (Oxford, 1990), pp.15-29 (p.90). For full review of sources and the discussion on this subject, see Introduction.
5. Tyne and Wear Central Archive (hereafter Tyne and Wear CA) HO/PM/1/11, Lying-in Hospital Management Board Minutes, 25 October 1900. Newcastle Central Reference Library (hereafter Newcastle CL), L362.1, Annual Reports of Newcastle Lying-in Hospital 1880, 1900, 1901.
6. Birmingham Central Library (hereafter Birmingham CL), L46.24, Annual Reports of the Birmingham Lying-in Charity 1895-1904.
7. JHA Sheffield, Annual Report, 1906, Minute Book No.8, 8 August 1909.
8. Brian Abel-Smith, *The Hospitals 1800-1948* (London, 1964), p.246. Bentley Gilbert, *The Evolution of National Insurance in Great Britain* (London, 1966), p.137.
9. St. Mary's Hospital Archive, Manchester (hereafter MHA Manchester), Management Board Minutes, 30 January 1913, JHA Sheffield, Annual Report 1912.
10. For examples of similar changes in London Maternity Hospitals see: Jane Lewis, *The Politics of Motherhood* (London, 1980), pp.132-33. John Ryland's University Library, Manchester (hereafter, JRUL Manchester), Manchester Medical Collection, Jb6, St. Mary's Annual

Reports, 1911-30, Newcastle CL, L362.1, Annual Reports, 1911-30. Birmingham CL, L46.24, Annual Reports, 1911-30, Liverpool Central Record Office (hereafter LCRO), 614 MAT 9/5-7, Liverpool Maternity Hospital, Annual Reports, 1911-30.

11. Jenny Carter and Thèrèse Duriez, *With Child: Birth Through The Ages* (Edinburgh, 1986), p.143.
12. JHA Sheffield, Annual Reports, 1901-15.
13. JHA Sheffield, Minute Book No.7, 26 March 1901, Minute Book No.8, 28 November, 13 December 1904, Minute Book No.12, 26 September 1916.
14. MHA Manchester, Board Minutes, 28 January, 25 February 1909; 21 March 1912, Medical Board Minutes, 16 April, 18 December 1906; 17 April 1923, JRUL, Manchester, Jb6, St. Mary's Maternity Department Report, 1919. John Bride, *A Short History of the St. Mary's Hospitals Manchester and the Honorary Medical Staff* (Manchester, 1922), pp.125-26.
15. An application by a medical student was first made in 1912, 'but the application could not be entertained, owing to lack of residential accommodation', Birmingham CL, L46.24, Hospital Annual Reports, 1901, 1904, 1912-13.
16. In November 1919, District Midwives or Sisters as they were referred to, were receiving £60 a year with an increment of £10 after three years service and £12 a year uniform allowance, LCRO, 614 MAT 1/4, Management Minutes, 12 November 1919.
17. For one month only, in anticipation of the National Insurance Act and acting in the belief that certified midwives would be required to attend the confinement if the woman was to be awarded her maternity benefit, midwives were appointed in February 1913, until the hospital's position with regard to the Act was better understood. Tyne and Wear CA, HO/PM/1/11, Management Minutes, 20 January 1913.
18. For the struggles to secure female appointments to medical posts, see JHA Sheffield, Minute Book No.7, 7 June 1899; 26 March 1901, Minute Book No.8, 28 November 1904, Minute Book No.10, 14, 28 March, 11 April 1911; 9 January 1912, Minute Book, No.11, 24 July 1913; 12 May, 9 June, 14 July 1914, Minute Book No.13, 25 June 1918.
19. Ann Oakley, in particular, holds the opinion that greater professional involvement and hospitalisation was 'symptomatic of the transition to male control' and 'a logical continuation of the male medical profession's misogyny', a point to be disputed. Ann Oakley, 'Wise

- Woman and Medicine Man: Changes in the Management of Childbirth', in *The Rights and Wrongs of Women*, ed. by Juliet Mitchell and Ann Oakley (Middlesex, 1976), pp.17-58 (pp.48, 52). A similar viewpoint is expressed in a more recent publication by Marjorie Tew, *Safer Childbirth? A Critical History of Maternity Care* (London, 1990), p.44.
20. Robert Boxall, 'The Mortality of Childbirth', *Lancet*, 1 July 1893, pp.9-14 (p.11). William Williams, 'Puerperal Mortality', *Transactions of the Epidemiological Society of London*, 15 (1895-96), 100-33 (114).
 21. Charles Cullingworth, 'Undiminished Mortality from Puerperal Fever in England and Wales', *Transactions of the Obstetrical Society of London*, 39 (1897), 91-114 (pp.107, 108).
 22. John Edgar, 'Is There Room for Improvement in our Present Mode of Clinical Instruction in Midwifery?', *Glasgow Medical Journal*, 50 (1898), 174-84. Milne Murray, *Transactions of Edinburgh Obstetric Society*, 26 (1900-01) 5-23 (pp.21-23). John Byers, Mortality from Puerperal Fever in England and Wales, *American Journal of Obstetrics*, 64 (1901), 435-41 (pp.437-41). Elizabeth Garrett Anderson, 'Death in Childbirth', *British Medical Journal*, 24 September 1898, p.927.
 23. Cullingworth, p.93.
 24. *Lancet*, 1890, p.1144, *Medical Press and Circular*, 26 November 1890, p.556.
 25. Jean Donnison, *Midwives and Medical Men* (New York, 1977), p.174.
 26. LCRO, 614 MAT 2/2, Medical Board Minutes, 31 May 1895. Donnison, p.139.
 27. Tyne and Wear CA, HO/PM/1/11, Management Board Minutes, 25 October 1900.
 28. Central Midwives Board Annual Report, 1908. MHA Manchester, Medical Board Minutes, 16 April 1906. JHA Sheffield, Management Board Minutes, 28 November, 1904.
 29. MHA Manchester, Management Board Minutes, 29 March 1906. Medical Board Minutes, 5 December 1905; 20 February, 13 March, 16 April, 14 August 1906.
 30. MHA Manchester, Medical Committee Minutes, 16 April 1906.
 31. JHA Sheffield, Annual Reports, 1904-10, Minute Book No.8, 28 November, 13 December 1904, 10 January 1905.
 32. For example, Ann Oakley, p.48. Marjorie Tew, p.7.

33. Janet Campbell, 'Notes on the Arrangements for Teaching of Obstetrics and Gynaecology in the Medical Schools', *Reports on Public Health and Medical Subjects*, 15 (London, 1923), p.3.
34. LCRO, 614 MAT 1/2, Management Minutes, 22 February 1906.
35. MHA Manchester, Correspondence from St. Mary's Management Board to the local Medical Officer of Health, Dr Niven, October 1907. See also JRUL Manchester, Manchester Medical Collection, F41xii, Report of Committee on Teaching and Examination in Midwifery, Owen's Medical College, 24 January 1907.
36. Janet Campbell, 'The Training of Midwives', *Reports on Public Health and Medical Subjects*, 21 (London, 1923), p.3; idem, *Report on the Physical Welfare of Mothers and Children, England and Wales*, 2 vols (Liverpool, 1917), II, p.51.
37. JHA Sheffield, Minute Book No. 7, 10 May 1903.
38. MHA Manchester, Annual Report 1910.
39. Norman R. Eder, *National Health Insurance and the Medical Profession in Britain, 1913-1939* (London, 1982), pp.31-45. JHA Sheffield, Minute Book No. 10, 8 April 1912.
40. MHA Manchester, Management Minutes, 30 January 1913. LCRO, 614 MAT 9/5, Annual Report 1913.
41. So concerned was Liverpool Maternity Hospital's principal sponsor, W. P. Hartley, that the National Insurance Bill would alter 'the whole complexion of Voluntary Hospitals' and even invalidate the need for such an institution, that he reduced his financial pledge for the new hospital from £15,000 to £10,000 in July 1911 along with a proposal that the anticipated bed compliment of 75 was reduced to 50. Once law, he called for a suspension of hospital building altogether. LCRO, 614 MAT 1/3, Board of Management Minutes, 2 July, 14 November 1911. LCRO, 614 MAT 9/5, Annual Reports, 1909-17. Janet Campbell, 'The Protection of Motherhood', *Reports on Public Health and Medical Subjects*, 48 (London, 1927), p.39.
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53. Final Report, p.53. Jellett, p.127.
54. Lewis, *The Politics of Motherhood*, p.313. Ethel Cassie, 'Maternal Morbidity and Allied Problems', *Public Health*, 42 (1928-29), 329-33 (p.330).
55. Interim Report, p.38. Final Report, p.37.
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76. Residential Staff-Patient Ratios, September-November 1912
- | | <u>Patients</u> | <u>Nurses</u> | <u>Servants</u> | <u>Officers</u> |
|--------------|-----------------|---------------|-----------------|-----------------|
| 10 September | 67 | 37 | 25 | 4 |
| 8 October | 66 | 36 | 25 | 4 |
| 12 November | 68 | 37 | 26 | 4 |
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77. JHA Sheffield, Annual Report, 1922. LCRO 614 MAT 1/4, Board of Management Minutes, 12 May, 14 June, 11 October 1921, 12 April, 8 July, 14 October, 4, 9 December 1924; 13 January, 10 March, 10 May, 7 April 1925.
78. JHA Sheffield, Minute Book No.9, 13 August 1907, Book No. 12, 12 January, 1914. Judith Emmanuel, 'The Politics of Maternity in Manchester 1919-1939: A Study From Within a Continuing Campaign' (unpublished master's thesis, University of Manchester, 1982), pp.26-33.
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80. 'The increasing employment of analgesics and anaesthetics', as Eardley Holland remarked, 'in a certain proportion of cases...slow down labour and lengthen it, weaken the natural forces and so lead to an increase in the forceps-rate', Eardley Holland, 'Maternal Mortality', *Journal of the Royal Sanitary Institute*, 55 (1934-35), 674-83 (p.678).
81. Edward Shorter, *A History of Women's Bodies* (New York, 1982), p.162.
82. Jellett, p.195, Kerr, p.113. O'Donel Browne, p.206. Philip Rhodes, *Doctor John Leake's Hospital: A History of the General Lying-In Hospital, York Road, Lambeth 1765-1971* (London, 1977), p.205. Trevor Davies, 'Review of Recent Clinical Reports of Maternity Hospitals', *Journal of Obstetrics and Gynaecology of the British Empire*, 29 (1929), 155-60 (pp.159-60). Newcastle CL,

L362.1, Annual Reports 1924-25.

83. JRUL Manchester, Manchester Medical Collection, Jb6, Annual Reports of the Maternity Department of St. Mary's Hospitals, 1906-08. JHA, Annual Reports of Maternity Department, 1921-25.
84. A number of hospital deaths, particularly from sepsis, were frequently attributed to poor obstetric care prior to admission, to the effect: 'patient admitted with bruising and laceration of vulva and vagina after several attempts at delivery with forceps' and woman 'admitted in a moribund condition after forceps had been ineffectually applied four times outside...A rent 2" long was discovered in the posterior wall of the uterus, which packed with gauze, and the patient died of shock 17 hours later'. JRUL Manchester, Manchester Medical Collection, Jb6, Annual Reports of the Maternity Department of St. Mary's Hospital, 1913. JHA Sheffield, Maternity Department, Annual Report, 1921. Final Report, p.58. Campbell, Cameron and Jones, p.12. Shorter, p.153. Jellet, p.196. Walker, p.138.
85. JRUL, Manchester, Manchester Medical Collection Jb6, Annual Maternity Department Reports, 1906-10, 1921-25. Shorter, pp.140, 153.
86. Comyns Berkeley, 'Discussion on the Use and Abuse of Obstetric Forceps', *British Medical Journal*, 6 October 1923, 600-09 (p.602). Jellet, pp.197, 205.
87. Loudon, p.222. Oakley, p.47.
88. Amongst 190 on whom a caesarean was first performed at St. Mary's (1912-18), whose uterus remained intact and whose post-operative history was investigated, 66 (35 per cent) were diagnosed sterile. Of the 94 (49 per cent) who became pregnant again, only four delivered naturally, one of whom died from a ruptured uterus and 13 aborted. J. W. Bride, 'Caesarean Section in Manchester', *Journal of Obstetrics and Gynaecology*, 28 (1921), 463-68 (pp.465-68).
89. Lewis, *The Politics of Motherhood*, p.121.
90. Campbell, *Training of Midwives*, p.3. *Protection of Motherhood*, p.41.
91. For the references and views of Oakley, Tew and others of a similar mind, see the Introduction.
92. Oakley, p.48.
93. Janet Campbell stresses that maternity hospitals were primarily shools for midwives, which took priority over the teaching of medical students. Whilst the latter, Cambell wrote, 'see a great deal they actually do very little', for they were not,

unlike midwifery pupils, legally obliged to deliver their full quota of twenty women. Campbell, 'Notes on the Arrangements for Teaching of Obstetrics', p.46.

Conclusions...A Final Review

The Princess Maternity Hospital fulfills a function that is absolutely vital to Newcastle.¹

A Review of the Major Findings

The objectives of this thesis have been two-fold. Firstly, to challenge current historical opinion about the voluntary hospital's role as a contributory factor to improved local, maternal health and mortality profiles, which for the most part has been very negative. Secondly, to re-evaluate, from an institutional perspective, the medicalisation of childbirth debates and question whether or not the hospitalisation of birth can simply be attributed to the economic, personal and professional desires of medical men (as argued by Oakley, Versluysen and others), and fulfilling no more useful purpose than subordinating midwives and their patients to medical authority.

The preceding research has made a contribution to both important fields of study. Focusing on St Mary's and the Southern, Manchester, it has been found that the Victorian maternity hospital not only played a demographically significant role, attending to a large number of parturient women, many of whom were economically impoverished and living in the poorest quarters of the city, but also made a positive contribution to their chances of survival. Both

institutions offered women what Loudon considered was a crucial factor in the maternal mortality equation, attendance by a midwife who, 'had received some training or at least took reasonable precautions against infection, interfered as little as possible, and was able to obtain medical assistance if complications arose'.²

This commentary by Loudon, who has been quick to dismiss the work of the maternity hospital, aptly describes those women in its employ. Recipients of three months instruction, arguably to higher standards prior to the Midwives' Act than after it, midwives appointed to the Southern or St. Mary's became part of a structured, supervised framework, aimed at minimising the risk of infection and curbing intervention.³ This latter task, only if absolutely necessary and in consultation with colleagues, was performed by a competent, often senior member of the medical staff, who was able to draw from 'a fund of experience' and personal research as well as from the ideas exchanged at obstetrical meetings in which he and other leading men in the field regularly participated. The provision of maternity wards augmented the hospital's position, not only by guaranteeing those admitted, regular nourishment, attention and isolation from domestic strife, but also by providing a whole range of clinical services, including an aseptic environment, ante-natal care, a central reserve of staff and resources, and the use of the latest improvements in obstetric methods, especially caesarean section. The result was a maternal mortality figure for late Victorian

and Edwardian Manchester, considerably below the national average, at a time when the city had one of the highest general death rates in the country (Figure 8.2).

Other provincial maternity hospitals, namely those in Liverpool and Sheffield, were unable, through a lack of professional and public interest, to attend the same high proportion of women in their respective localities as in Manchester. Nonetheless, they employed the successful combination of trained midwife and skilled doctor to attend maternity cases both within the hospital and its district. At the Jessop, a strong professionalism influenced many aspects of its development, from the drafting of the original constitution to issuing the bye-laws governing the behaviour of both staff and patients. Yet the Superintendent of Midwifery, Kate Keslo, was obliged to call a doctor only when a difficulty arose. This meant, in the overwhelming majority of cases, that women who received the hospital's charity, rarely, if ever, saw a doctor in the birthing room. Contrary to the opinions of Versluysen and Oakley, for most women under the auspices of the hospital, midwifery remained very much a female affair.⁴

Indeed, such was the extent of the midwives' influence at Liverpool Lying-in Hospital that it provoked an eight-month, professional debate in 1896 on a scale hitherto unwitnessed, including the mass-resignation of the hospital's honorary medical staff and a boycott of the institution by colleagues throughout the city. They

returned only when they were assured ' sole and entire medical charge of all the patients in the hospital' and were offered three seats on the Board of Management. They soon consolidated their position thereafter, ensuring on a personal level that they were no longer re-elected by the Board but by the subscribers, and had their period of office extended from a maximum of twelve months to a general retirement age of sixty. On a professional level, the medical staff radically improved the quality of obstetric instruction and greatly increased accessibility to the wards, which prior to 1896 were operating at half capacity due to the lack of demand.

The events described at Liverpool Lying-in Hospital, provide an original insight into the reasons behind the medicalisation of childbirth in which the maternity hospital played an integral role. Equally, a study of the same institution before 1896, when professional involvement in its management was minimal and women wielded a considerable influence over the management of resources as well as the birth itself, has provided an interesting counter-balance to the norm. The norm was male-governed hospitals, with a professional bias, and nowhere more so, feminist sociologists and historians would argue, than in the maternity hospital, a supposed bastion of male-medical control. The Liverpool Lying-in Hospital (1869-1896) is at least one exception to the rule.

To suggest, however, that women managing women's affairs was to the greater good of their gender, because they shared 'the same biological experience of femaleness' and "knew" instinctively what was best for women in labour', is to overlook class interest.⁵ For example, midwifery instruction at the hospital was largely developed and influenced by the Ladies Committee. It was conducted with a view, not of providing competent, working-class women who could relate to the needs and circumstances of the impoverished, but 'respectable gentlewomen' who intended to make a lucrative living from delivering the children of suburban ladies. Class-interest and the Victorian emphasis on self help also influenced the women's decision, over who was and who was not to be given maternity relief, and this in many cases took precedence over the 'shared experience of womanhood'. Many single mothers, the wives of alcoholics and women whose husbands were permanently unemployed, invariably had their maternity applications rejected by the Ladies' Committee, regardless of their personal plight. This was not before, however, being subjected to a 'severe and humiliating labour test', which was applied 'to all indiscriminately and without regard to the fitness or capacity of the applicant'. Means testing would have been all the more distressing for the highly stressed and expectant mother.⁶

When such 'undesirables' were admitted, it was often due to the defiant efforts of the medical staff, who from the 1870s, rigorously campaigned for the admission of

single women, and once admitted, for their acceptance 'upon the same footing as married women'. It was also the same body of men who thwarted the Ladies Committee's proposals to substitute a perfectly competent group of midwives with a 'younger', 'better trained' set. The practitioners also campaigned against female efforts to elevate the occupation of midwifery to a higher social plane at the cost of depriving working-class midwives of the opportunity to receive instruction, 'for whether instructed or not they may still continue to practise'.⁷ Factors explained in Chapter 4 make credible the doctors' involvement in these particular issues. They had a genuine desire to safeguard the patients' interests which served on occasion to compensate for the women's orthodox and sometimes negative approach to the care of their impoverished sisters.

To be sure, the doctors' quest for professional unity, strength and consolidation, partly accounts for the increase in hospitalisation and greater professional involvement, as so readily illustrated by events in Liverpool in 1896, but this by no means provides a full explanation. This has to be sought with reference, firstly to the National Insurance Act of 1911, which radically altered the balance between the hospital's district and in-patient services, as former charity recipients sought private midwifery attendance and the maternity hospitals concentrated on the admission of women with a problematic pregnancy or labour. Secondly, there was greater government support and direct funding

of hospital beds. This was itself a result of increasing anxieties over the survival of the infant at birth, the campaigns of women's groups, the reports of government officials and the efforts of a wartime administration which initiated the Local Government funding of maternity beds. Finally, midwifery instruction for both midwife and doctor also influenced the hospitalisation of women, for it had the effect, on the one hand, of putting pressure on the hospital to increase the number of women available for instruction and, on the other, to ease the strain, by providing a free and abundant supply of labour, reducing the reliance on salaried midwives.

These effects, however, were not altogether positive. Whilst the maternity hospital was able to enhance its relevance to its host community by increasing the numbers confined and the range of services offered, with the exception of treating severe complications it was unable to sustain a clear advantage over other forms of maternity provision, such as a well organised body of municipal midwives. This was primarily due to the transfer of responsibility from the combination of a competent midwife and a renowned obstetrician, to a body of young and inexperienced graduates, hampered by inadequate resources and a growing dependency on medical students and pupil midwives to assist and even deliver women unsupervised. The consequences of this transition were increased intervention and unnecessary loss of life, thus confirming Loudon's conclusions about maternity hospital practice in the 1920s.

The Maternity Hospital and Other Clinical and Socio-
Economic Considerations

Contemporaries would argue, however, with few reservations, that the maternity hospital despite such disadvantages, still played an 'absolutely vital' role and one that 'may be regarded as a positive factor in the reduction of maternal mortality'. In Newcastle, for example, where the maternal mortality rate was 'considerably below that for the country as a whole', and it was found to be 'undoubtedly a safer thing for a woman to be confined in Newcastle than in most other places', the City's Medical Officer of Health, Harold Kerr, attributed this

largely to the presence of the Princess Maternity Hospital, which deals with an enormous number of severe or complicated cases of parturition among the poorer classes, and indeed supervises about one third of all the births notified in the city.

Similarly, prior to the opening of the Birmingham Maternity Hospital in 1908, the City's Medical Officer of Health, John Robertson, felt that, 'had proper hospital treatment been available for the [maternity] patients, useful lives might have been saved'. As it was, 'the only hospitals admitting such cases are those in connection with the (Birmingham Parish) workhouse, and it is scarcely reasonable', he added, 'to accept that persons of the artisan class would under any condition

avail themselves of this provision'. This would explain the confinement, on average, of only 171 women a year (1901-05) at the Workhouse Infirmary and no district confinements. Once the maternity hospital was opened, Robertson was soon testifying 'to the extraordinary work done in the Hospital', and indeed found it astounding 'that Birmingham did not have a maternity hospital long ago'. Robertson's counterpart in Manchester, James Niven, referring to the Southern and St Mary's, also felt his city was endowed with 'excellent hospitals for maternity work...available for all poor in Manchester and district'. In the opinion of Dr Margaret Smith, the city's first Executive Officer of Midwifery Services, this was where the strength of the maternity hospital lay, in its focus on the impoverished. 'It is much easier', she explained, 'for these midwives backed up directly by the authority of the Hospital, to cope with the problems incidental to midwifery among the very poor than it is for an isolated midwife to do so'. The maternity hospital's contribution to their host communities' maternal mortality rates, which were below the national average, seems to have gone unquestioned by the respective Medical Officers of Health, who were more informed than most about deaths in childbed.⁸

Eulogies and subjective interpretations by interested parties (Harold Kerr served on the Committee of Management of the Princess Mary Maternity Hospital as a consulting physician) provide insufficient grounds however to assume, like other contemporaries, that the

maternity hospital played a positive, if not leading role in the determination of maternal mortality.⁹ A more searching approach is required, and one which considers the role of other variables, however exploratory. This is perhaps best achieved by re-considering the maternal mortality rates of Lancashire towns, two with specialist maternity hospitals (Manchester and Liverpool), and some without, for it was a tentative review of their profiles (1919-21) that first initiated interest in the role of provincial maternity hospitals.¹⁰

Lancashire provides an ideal case study area, because in spite of the county's high maternal mortality figure, exceeded by only one other English county, Westmorland, the maternal mortality rates of Lancashire towns displayed such 'remarkable variations' that they provide an opportunity to explore a whole range of possible determinants of maternal deaths. Thus, while the administrative county of Lancashire returned a maternal mortality figure of 5.33 per 1,000 live births (1911-14), compared with an average of 4.00, for England and Wales during the same period, and five of its seventeen county boroughs were featured among the country's worst nine county boroughs with 'strikingly excessive' maternal mortality rates, there was an equally large number of Lancashire towns with low maternal mortality rates. Amongst these were Manchester, Liverpool and Bootle (Table 8.1). The second major study on maternal mortality by Janet Campbell (1919-22) confirmed the range of variations amongst Lancashire

**TABLE 8.3: THE ADMINISTRATIVE COUNTY OF LANCASHIRE
MATERNAL MORTALITY RATES AND OTHER REEVANT DATA
1923-1929**

	Maternal Mortality 1923-1929	Infant Death Rate Per 1,000 Births 1923-1929	Still-Birth Rate 1923-1930
Rochdale	6.96	82	47
Bury	6.80	83	54
Oldham	6.79	104	62
Blackpool	6.61	73	57
Wigan	6.44	109	59
Blackburn	6.42	87	54
Preston	5.86	104	57
Bolton	5.23	87	56
Burnley	4.90	103	50
Manchester	4.48	92	47
St. Helens	4.42	100	44
Warrington	4.42	82	40
Salford	4.02	105	46
Liverpool	3.60	99	39
Barrow	3.58	77	43
Bootle	2.75	93	41
Southport	2.60	64	46
Lancashire	5.33	79	52
England and Wales	4.11	71	40

Source: Janet Campbell, Isabella Cameron and Dylis Jones
High Maternal Mortality In Certain Areas (London, 1932) pp.62-66.

towns, from as low as 3.25 and 3.49 per 1,000 live births in Bootle and Liverpool to as high as 7.05 and 7.55 in Blackpool and Rochdale (Table 8.2).¹¹

The third major report reviewing Lancashire (1923-30), this time as its core subject, not only illustrates the remarkable variation between one county borough and another, but also a variation over time within the same county borough (Tables 8.1-8.3). Thus, whilst St Helen's had the second lowest maternal mortality rate in the county (3.39 per 1,000 live births) 1911 to 1914, it had the seventh highest in the county (5.13), 1919 to 1922 (Tables 8.2 and 8.3). Conversely, Southport had the tenth and eighth highest maternal mortality rate in the county, 1911 to 1914 and 1919 to 1922 respectively, but the lowest in the county, 1923 to 1928, when the rate was 2.75 per 1,000 live births, which was well below the national average (Tables 8.1-8.3).¹²

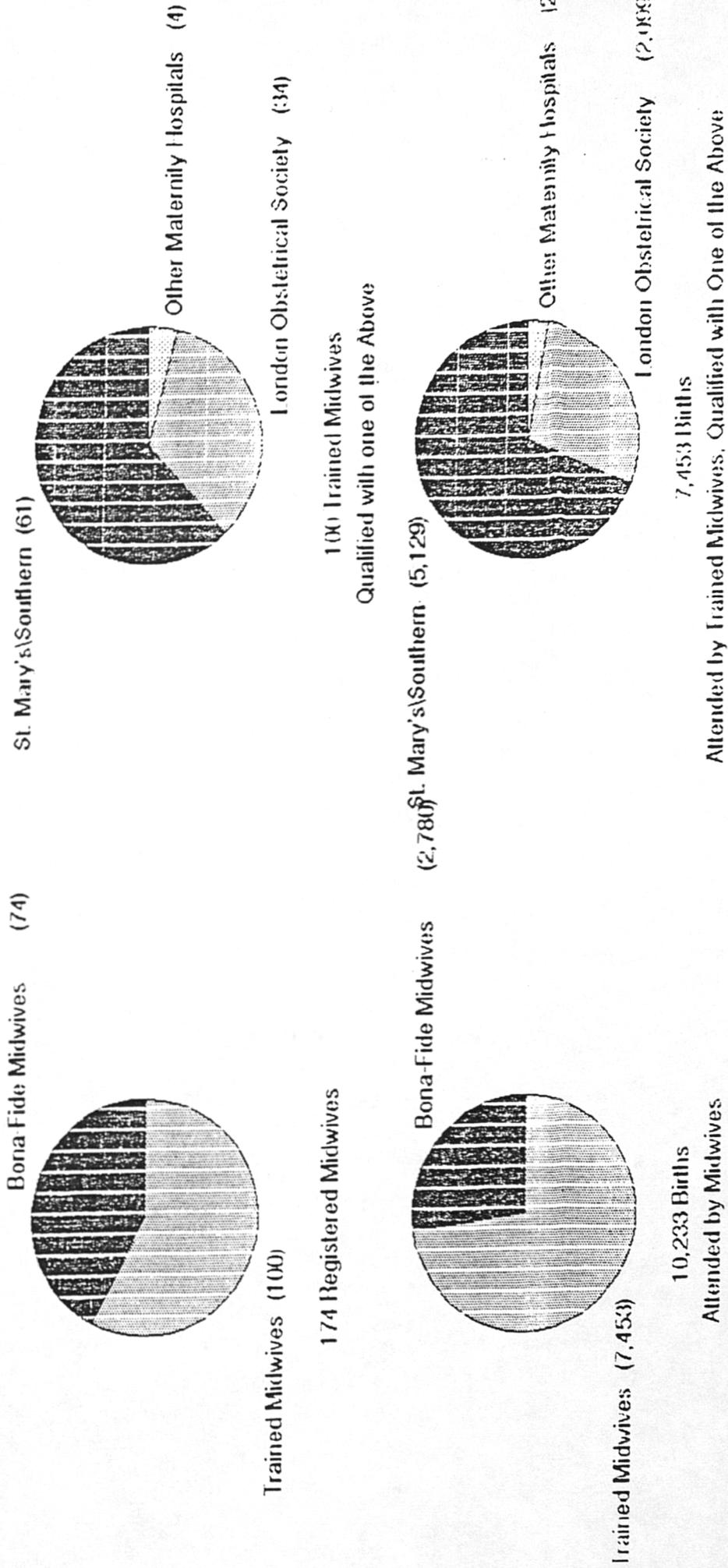
The authors of all three reports were unable to draw any conclusions about the geographical distribution of maternal deaths or find a 'statistically demonstrable' relationship between any one factor and the maternal mortality variations. Whilst a number of towns shared the same characteristics, they all displayed different mortality rates. Thus, whilst general housing and sanitary conditions, as illustrated by high infant mortality rates, were very poor in Burnley, Preston, Blackpool, Wigan, St Helens, Liverpool and Bootle, it was only in the case of the first three towns that maternal deaths were high. In the remainder they were well below

the national average and consistently so in the case of Liverpool and Bootle (Tables 8.1-8.3). Similarly, little information can be drawn from the birth-rates, not only because of the inconsistencies of correlation between them and maternal mortality rates in the different boroughs, but also because without information about the fertility rate, both a high and low birth rate could have had an adverse effect on the maternal mortality rate, in proportion to the number of births.¹³ Where Cameron feels there might have been some consistency, is between the still-births and maternal mortality rates (1923-30), for theoretically, as she explains, a high still-birth rate was indicative of a large number of complications and therefore maternal deaths. However, the figures are accurate only after the Notification of the Still-Births Act in 1922 (Table 8.3).¹⁴

Whilst no 'completely consistent' relationship was found nationally, either between mortality from childbearing and the rate of midwifery attendance, or between mortality from childbearing and the occupation of married women, with respect to Lancashire (1911-14), this is where the strongest correlation between the various factors and maternal mortality existed (Table 8.1).¹⁵ With regard to the rate of midwifery attendance, amongst the seven Lancashire towns with a maternal mortality rate below the national figure, over 80 per cent of the annual births were attended by midwives and 70 per cent of them were qualified (Table 8.1). Compare this with an average attendance of 55 per cent by midwives, only 40 per cent

FIGURE 8.1: QUALIFICATIONS OF PRACTICING MIDWIVES

MANCHESTER, 1905



Source: Manchester Medical Officer of Health, Annual Report 1905

**TABLE 8.4: 'QUALIFICATIONS OF MIDWIVES ENROLLED
IN LIVERPOOL UP TO END OF 1905'**

Midwifery Qualification Awarded By...	Total Number of Midwives	As a % of Total
Liverpool Maternity Hospital	153	42.4%
The London Obstetrical Society	124	34.3%
Rotunda Hospital, Dublin	8	2.2%
Glasgow Maternity Hospital	5	1.4%
Queen Charlotte's Hospital	4	1.1%
Manchester Southern Hospital	3	0.8%
National Maternity Hosp. Dublin	3	0.8%
Coombe Lying-in Hosp. Dublin	2	0.6%
Dundee Maternity Hospital	1	0.3%
Royal Maternity Hospital	1	0.3%
St. Marv's Hospital, Manchester	1	0.3%
Total Number Qualified	305	84.5%
Bona-Fide Midwives	56	15.5%
Total	361	

Source: Liverpool Medical Officer of Health, Annual Report 1905

of them qualified, amongst the eight Lancashire towns with maternal mortality rates above the national average (omitting Rochdale and Bury due to lack of data), and there does appear to be something of a relationship between the two factors (Table 8.1).

In Liverpool and Manchester, the high proportion of trained midwives, more so than in any other locality in Lancashire, except for Bootle, which closely bordered Liverpool, was primarily due to the training provided by their respective maternity hospitals (Table 8.1). Of the 174 midwives that first registered in Manchester in 1905, 100 were already trained; of this latter figure, 61 held training certificates from St. Mary's and the Southern, and a further 34, from the London Obstetric Society, which in the majority of cases were awarded after receiving training at one of the two hospitals (Figure 8.1). In terms of the numbers actually confined by these women, the figures were even more revealing about the importance of the two hospitals. Of the 10,233 births performed by midwives in Manchester in 1905, only 27 per cent were conducted by 'bona-fide' midwives; the remainder were attended by trained midwives, well over 70 per cent of whom had received their training at St Mary's or the Southern (Figure 8.1). Indeed, over 3,000 of the births conducted by trained midwives were by midwives still in the hospitals' employ.¹⁶

Similarly, in Liverpool, over 80 per cent of the 305 registered midwives in 1905 had already received a formal training before it was compulsory to do so (Table 8.4).

This was largely due to the collective efforts of the Liverpool Maternity Hospital and the London Obstetric Society. The Society examined midwives only, it did not train them, which, as in Manchester, was primarily the task of the maternity hospital. Where women held training qualifications other than from the two institutions, it invariably meant that they too had received a maternity hospital training from such institutions as the Rotunda in Dublin, St Mary's in Manchester and the Royal Maternity Hospital in Edinburgh (Table 8.4). Moreover, the Liverpool Maternity Hospital was very much involved in the subsequent development of the city's midwifery services. The hospital loaned its matron-midwife, for, example, for six months to become the city's first Inspector of Midwives. It also abolished fees for practising midwives who attended a course of lectures at the hospital and charged them a reduced rate for the CMB qualification. A loan scheme was also launched by the hospital for 'women unable to pay their fees in advance, but otherwise suitable for training', which fulfilled a proposal first raised by the medical staff in the 1870s to see midwifery training become much more accessible to working-class women.¹⁷ By the 1920s 'with very rare exceptions', Liverpool midwives were 'fully trained women' and of the 193 qualified in 1916, 149 had received some form of qualification (an Obstetrical Society Diploma, a Maternity Hospital Certificate or a CMB qualification) from the Liverpool Maternity Hospital.¹⁸

The presence of the maternity hospital was not the only reason that the midwifery services in Liverpool were far in advance of neighbouring localities. This in part was due to the zeal of local health officials who were overseeing the activities of local midwives, particularly with regard to the spread of infection, a decade or so before any national legislation compelled them to do so. There was also a well organised local Association of Midwives which involved 'all, if not quite all, of the midwives in the city', and in conjunction with the maternity hospital, served as a focal point for the dissemination of new ideas and practices.¹⁹

However, the tradition of midwifery instruction at St Mary's, the Southern and the Liverpool Maternity Hospital, was certainly important, particularly in light of the situation in Birmingham. There, midwifery instruction had by 1905 been available for only a year and consequently only 9 per cent of the 121 registered midwives had received any form of formal instruction, compared to a national average of 44 per cent. Further investigation showed that 52 per cent of these women could neither read nor write and those who could, were often dependent on a cheap translation of the work of Hippocrates as their only guide to midwifery.²⁰ Similarly, in Sheffield, where the Jessop instructed only two probationers a year, for fear of providing competition for local practitioners, the Medical Officer of Health found that when the midwives first began to register, that many were engaged in illicit and Sarah-Gamp-style

**Maternal Mortality: Quinquennial Averages
(per 1,000 live births) 1885-1930**

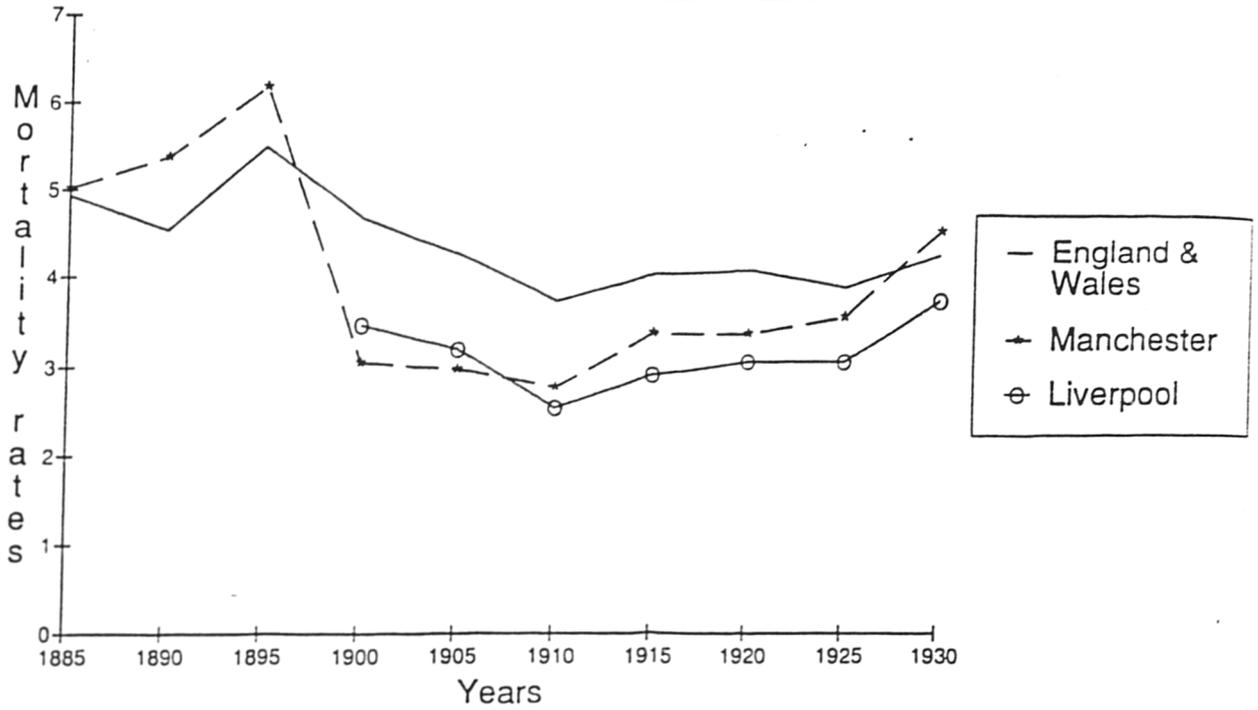
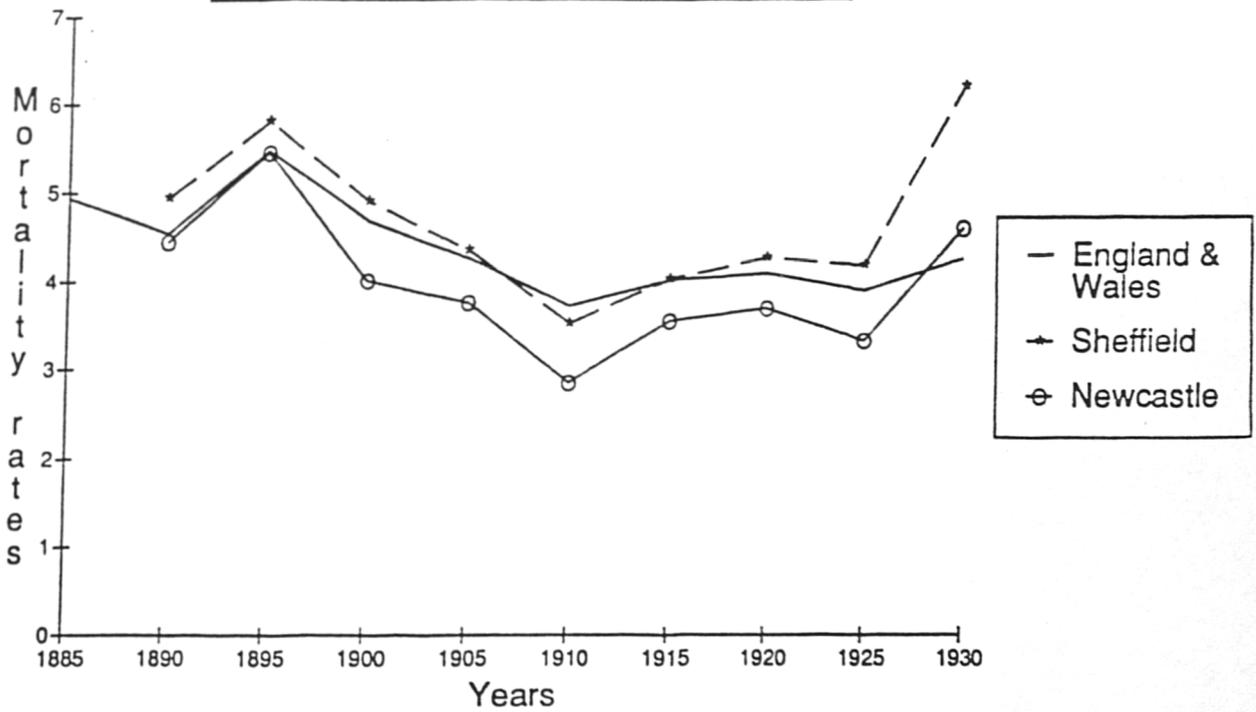


FIGURE 6.2

**Maternal Mortality: Quinquennial Averages
(per 1,000 live births) 1885-1930**



Source: Annual Reports of the Medical Officer of Health
for the County of Lancashire, 1885-1930

practices. One registered midwife, for example, was imprisoned for three months for sending for burial, a still-birth which was in fact born alive. Another woman served for 12 months with hard labour for selling lead pills. So inadequate was the education of the 'bona-fide' midwives that a simpler set of rules had to be drawn up because the CMB rules proved to be too difficult to follow.²¹ Where maternity hospitals were firmly established with a long tradition of midwifery instruction, namely in Liverpool and Manchester, the midwives which municipalities inherited in 1905 were of a much higher standard than elsewhere, a point perhaps underlined by the low maternal mortality rates in Manchester and Liverpool than, for example, in Newcastle or Sheffield (Figure 8.2).

To return to the Lancashire study, and in view of what has been said throughout the thesis, there does appear to be some correlation between the quality and quantity of provision by midwives and the local maternal mortality rates. This would not, however, be the case if the figures for the Lancashire county boroughs were consulted for the two succeeding periods (Tables 8.2 and 8.3). The favourable maternal mortality rate for St Helens (1911-14), for example, may be attributable to a 96 per cent attendance rate by midwives, over 60 per cent of whom were trained. However, this was only temporary, for the maternal mortality rose from 3.39 maternal deaths per 1,000 live births to 5.13 (1919-21) and placed St. Helens amongst the top seven boroughs in the county

with the highest maternal mortality rate as opposed to the bottom three (Tables 8.1 and 8.2). Similarly, Manchester with its general and high infant mortality rates, which surprised officials by having such a low maternal mortality rate in the first two case studies, was, during the latter case study, averaging 4.43 per 1,000 live births (1923-29), higher than in St Helens (Tables 8.1-8.3).

One plausible explanation for these increasing rates was the decline in the autonomy of midwives relative both to the medical profession and to institutions. Contrary to Oxley's comments in 1934 that the general practitioner was 'squeezed out' of midwifery practice in Manchester (hence, he claims, the increasing maternal mortality rate), their presence was more pervasive than ever before.²² Whereas, for example, one in 11 births attended by a midwife required medical attention in Manchester (1906-10) (which was about the rate at which genuine complications arose and genuinely required attendance by a doctor), by the end of the period (1926-30) it was one in four (Figure 8.3). This latter figure was largely as a result of doctors attending a greater number of tedious labours and stitching torn perineums, a common injury of childbirth, but also a prime source of infection and even disability if dealt with incompetently.²³ Similarly, in Liverpool, where one in 20 women attended by a midwife was seen by a doctor (1906-10), it was one in five (1926-30) and in Birmingham, where one in 21 midwife cases was

attended by a doctor in the former period, it was one in five by the latter.²⁴

This is partly attributable to the payment general practitioners began to receive for attending complicated labours. In the case of Birmingham, from 1 January 1908 they were paid by the Board of Guardians (£2 for every complication) and then, under national legislation, by the local authority, encouraging midwives to use the services of the doctor much more freely. Whilst the payments enticed the doctor to attend, it was, as John Fairbairn claimed in 1927, 'a lack of experience and a failure to take responsibility on the part of the midwife' which encouraged them to call a doctor. This was not helped, Fairbairn adds, by the issue of regulations by the CMB and local health department regulations which constantly extended the conditions for which a medical practitioner was called. The Birmingham Medical Officer of Health, for example, required all midwives from the early 1920s to call a doctor for every primipara birth, regardless of whether their presence was necessary. It was not just in the hospital, therefore, that childbirth was being medicalised. Midwives also faced pressure from the woman's anxious and impatient relatives to call in the doctor and it appeared to Fairbairn that the midwife was more affected by such pressure than in former years. As in hospital cases, there was a greater tendency to apply forceps and intervene, exacerbating the parturient woman's difficulties.²⁵

FIGURE 8.3: REASONS THE MIDWIFE CALLED DOCTOR TO THE DELIVERY: MANCHESTER 1906\10-1921\25

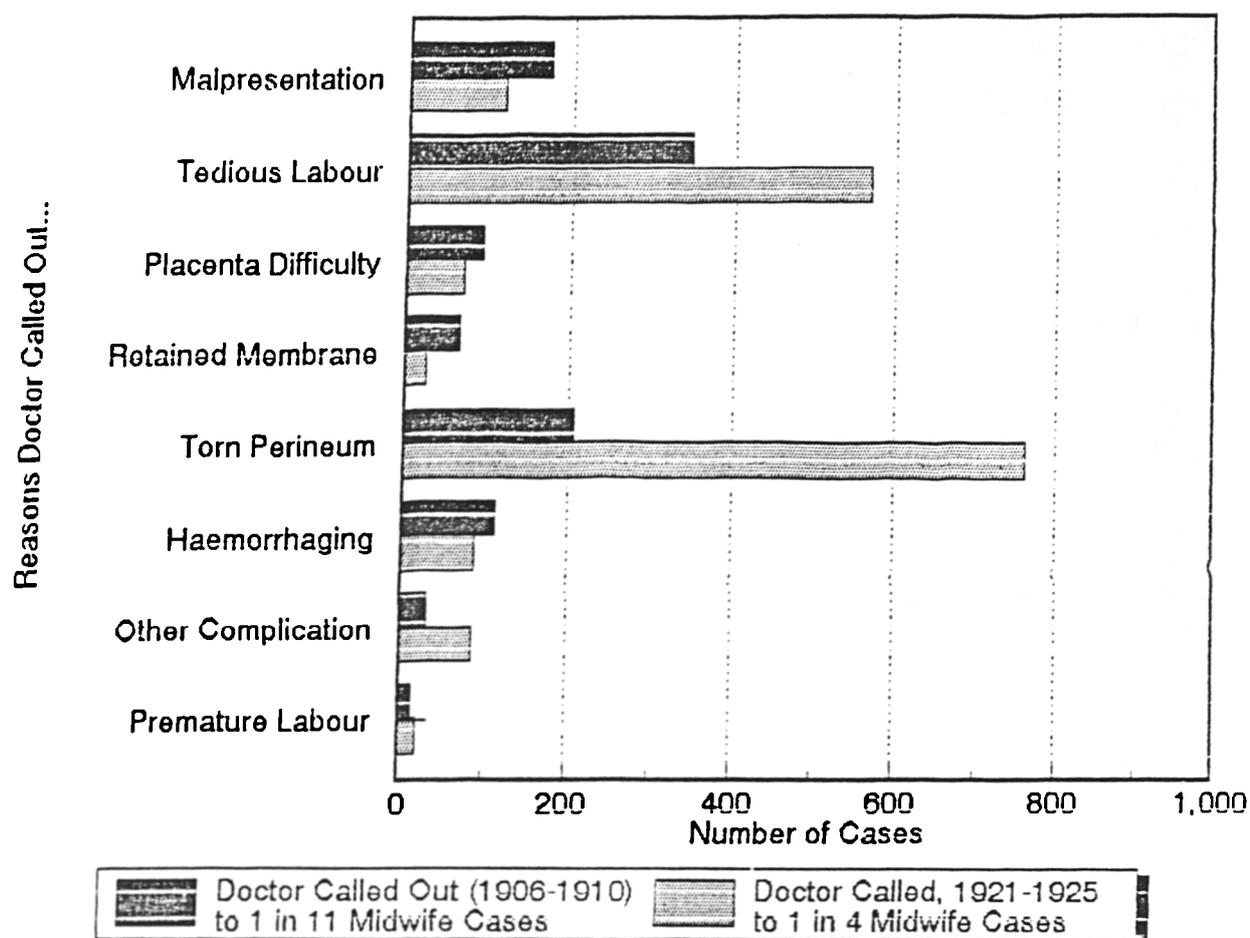


TABLE 8.5: NUMBER OF BIRTHS CONDUCTED BY MIDWIVES, INSTITUTIONS AND DOCTORS: MANCHESTER 1928-1930

Births were Attended By The Following...	1928	1929	1930	Average
	12,990 Births	13,032 Births	13,696 Births	13,239 Births
Midwives	8,375 (64%)	7,854 (60%)	7,244 (53%)	7,824 (59%)
Conducted in Institutions	3,492 (27%)	4,748 (37%)	5,318 (39%)	4,519 (34%)
General Practitioners	1,123 (9%)	430 (3%)	1,134 (8%)	696 (7%)
St Marys Confinement Total	1,489	1,551	1,604	1,548
as % of Institutional Total	43%	33%	30%	34%
as % of City Birth Total	11%	12%	12%	12%

(%) as a % of the city birth total

Source: Manchester Medical Officer of Health, Annual Reports 1906-1930

During this period, the midwife was not only losing autonomy to the general practitioner but also part of her practice to the various institutions which confined women in their own wards. Whereas institutions, namely the Southern and St Mary's Maternity Hospitals and Withington and Crumpsall Poor Law Infirmaries, were responsible for confining 4 per cent of Manchester's annual birth total in a hospital ward (1901-05), an institutional confinement accounted for 27 per cent in 1923, 39 per cent in 1930 and 50 per cent in 1933. Consequently the proportion of births conducted by midwives fell from 64 to 35 per cent (1928-33) (Tables 2.2, 8.5). The rise in institutional deliveries was not, as Judith Emmanuel remarked, matched by a corresponding decline in the maternal mortality rate, which actually increased. However, this cannot be entirely attributed to the maternity hospital, which by the late 1920s was no longer the prevalent form of institutional confinement, accounting for only a third of the total number of institutional deliveries (1923-30) and 12 per cent of the city's birth total (Table 8.5). The more significant form of institutional delivery by this latter date was the maternity home, of which there were 23 registered in 1923 and an additional 12 unregistered, which left those who entered vulnerable to unregulated practices.²⁶

A tentative connection may also be made between a high proportion of working women and a high maternal mortality figure. Where a quarter or more of married women in Lancashire towns worked, including Blackpool,

Preston, Oldham, Blackburn and Rochdale, the towns were amongst the fifteen county boroughs with the highest maternal mortality figures in the country. Where, in contrast, the maternal mortality rates were 'exceptionally low', the proportion of working mothers was only 6 and 10 per cent respectively (Table 8.1). The relationship was not, as Newsholme points out, an exact one, for towns outside Lancashire like Methyr Tydfil had a 'strikingly excessive' maternal mortality rate but a very low percentage (6 per cent) of working mothers, whilst towns like Birmingham and Worcester had maternal mortality figures well below the national average, yet a very high percentage of working mothers: 21 and 22 per cent respectively. The variations between Birmingham and Rochdale, Bury and Worcester, may, in part, be due to differences in the type of female employment, for in a lot of instances, the work such as retail and light factory tasks was no more arduous than washing, mangling, lifting tubs and countless other domestic tasks. In the textile towns, the work was more exacting, leaving women poorly prepared for ante-natal care and facing a delayed and often difficult labour. Whilst there was, as Newsholme concludes, 'no completely consistent relationship between excessive mortality from childbearing and a high degree of employment...it can scarcely be doubted that a close association exists between the two factors'.²⁷

An association between working women and infant mortality had been made as early as 1859 by John Simon.

Making claims about the detrimental effects of working mothers, which was regarded by many as 'unnatural dereliction of maternal duty', and a threat to male employment, was as much a political statement as a genuine health concern. There were those such as Evelyn Brown and Janet Campbell who found from their detailed research that female employment was not entirely the detrimental force that it was considered to be and even Arthur Newsholme, who was amongst those with an instinctive predisposition to condemn the working wife, had his doubts; but none could deny the relationship altogether. Evelyn Brown's study dealt with the incidence of puerperal sepsis only and said nothing of working women's vulnerability to death 'by other accidents of childbirth'. Whilst Janet Campbell found that women's work in the woollen industry, a major employer of women in the West Riding, was relatively light and therefore 'in itself...not likely to be harmful to the pregnant woman', thus work, if combined with the strain of housework and perhaps the inconvenience of keeping regular hours and travelling to and from work under uncomfortable conditions, could have led to problems. Combined, the double strain of housework and factory work could have left the woman weak and exhausted, with little opportunity for ante-natal supervision and even predisposed to abort the pregnancy because of the 'sheer inability to cope with the claims of a growing family while continuing her employment'.²⁸

Whilst subject to further research, consideration of this variable suggests that a possible explanation lay beyond mere clinical influences, on which Loudon and this thesis, because of its focus on the maternity hospital, have concentrated. The next stage of the research into maternal mortality might well consider a locality such as Lancashire, going beyond the general presentation of statistics and bland, often prejudicial commentaries of health officials, to consider a number of localities in detail.

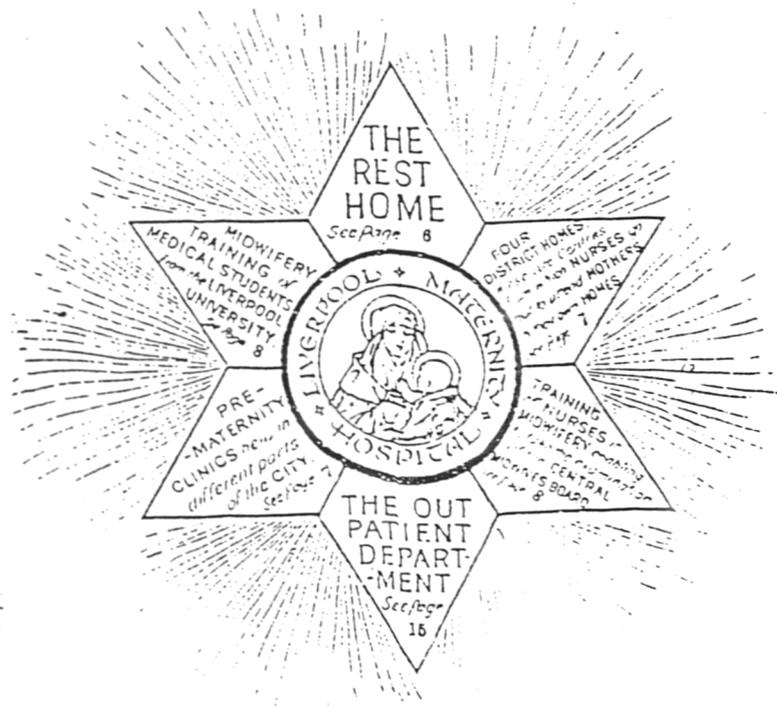
Yet even with regard to the hospital, its contribution to local maternal mortality and health profiles in the post-Victorian period cannot simply be seen in terms of bed totals, patient returns and mortality figures. There were, as illustrated by the hospitals' involvement in midwifery instruction, far more variables than these at play, acting in a much more subtle but nonetheless influential way. Printed in bold, dark print to set it apart from the rest of the text, Kerr's statement about the Princess Mary Maternity Hospital's 'absolutely vital' role, was more than just a reference to the 'x' number of cases it confined. It was an unqualified approbation of the hospital's participation in all facets of maternity care in Newcastle. So intimate was the association between the Princess Mary Maternity Hospital and the City, that the staffs of each respective body attended each other's Board meetings and considered themselves part of the other's staff.²⁹ Similarly, Dr Hope considered the

Liverpool Maternity Hospital to be of 'supreme importance' and 'perhaps the most important of all charities', despite its responsibility for only 12 per cent of the city's birth total and when, by the end of the period, the Poor Law institutions were responsible for confining a far greater number of women.³⁰

Once maternal mortality was considered an issue in its own right and funding was forthcoming from local authorities, so the maternity hospital, at both a consultancy and practical level, turned its attention to all expectant and parturient women within the community, not just the hospital. The Jessop, for example, appears to have been one of the most active in the field of consultancy, appointing members of its own staff to serve on the Boards of the Central Ante-Natal Clinic and the city's two municipal hospitals, which by 1930 collectively accounted for 62 maternity beds, twice the number at the Jessop. Hospital staff, also in an advisory capacity, worked closely with the Medical Officer of Health, particularly in cross-examining maternal mortality returns and acting as consultants in difficult obstetric and puerperal fever cases, regardless of the patient's charity status. Such was the close relationship between the Jessop and its local authority that it was a point of special note by maternal mortality analyst, Janet Campbell, who found it to be 'an advantage which cannot be overestimated' and one that made a significant contribution to the city's maternity services.³¹

LIVERPOOL MATERNITY HOSPITAL

BROWNLOW HILL.



FIFTY-SEVENTH ANNUAL REPORT

FOR THE YEAR 1925.

Sample Text 8.1: An Illustration of the Multiple Uses of the Maternity Hospital of the 1920s, Front Cover of the Annual Report of the Liverpool Maternity Hospital 1925

On a practical level, the maternity hospitals were the first organisations to provide and later promote ante-natal facilities, which as a result developed much more rapidly in their host communities. Initially, the Liverpool Maternity Hospital, which had provided the city with its first ante-natal clinic in 1914, developed and managed all subsequent clinics opened in the city, which by 1919 totalled nine and involved 12,225 ante-natal visits and attendance of over 800 new cases a year. The understanding was that whilst the Liverpool Health Committee provided and maintained suitable premises for ante-natal care, the Maternity Hospital staffed them, placing a doctor and midwife in each and managed them from day to day. Even when this understanding collapsed because of the hospital's refusal to appoint female doctors on grounds of gender alone, 14 of the 24 pre-maternity clinics opened in Liverpool by the mid-1920s were still under the direct control of the maternity hospital. A further two clinics were held at the Royal Infirmary and two were run by the Child Welfare Association, leaving only six under the auspices of the city's Health Committee; despite being hailed as a major step in improving maternal health and survival chances, voluntary effort was still very much the backbone of ante-natal care.³²

The hospital's multi-faceted role is further illustrated on the front cover of the Liverpool Maternity Hospital, Annual Report for 1925 (Sample Text 8.1). The hospital was more than a clinical centre, it also

addressed women's material needs, providing in Liverpool, 'The Rest Home', thus making Liverpool one of the first centres in the country to establish a rest home for 12 post-natal cases, at any one time, extending care to women after their confinement as well as before. As with the pre-maternity centre, 'the fact cannot be too strongly emphasised', the Board of Management wished to point out, 'that such services were not restricted to women assisted by the Charity but also those engaging a private midwife'. Underlying its importance to the whole community rather than a select few, the rest home was fully occupied within a year of opening in July 1916.³³

To conclude, the maternity hospitals' significance to maternal health and mortality varied over time and from location to location, but it was nonetheless significant. If, without underestimating the role of socio-economic factors, a clinical interpretation is to be taken of maternal mortality, then the hospital can no longer be overlooked as a variable of importance. Its contribution lay not simply with the number it confined, but also with its notable input into the changing ethos of maternity provision, training ever increasing numbers of birth attendants, nurturing new techniques and playing a leading role in the development of local maternity services, 'the pivot round which the whole maternity and child welfare scheme revolve[d]'.³⁴

Notes to Conclusions

1. Annual Report of the Medical Officer of Health, Newcastle-upon-Tyne, 1928, p.32.
2. Irvine Loudon, 'Maternal Mortality 1880-1950: Some Regional and International Comparisons', *Social History of Medicine*, 1 (1988), 183-228 (p.222).
3. To obtain a Diploma at St. Mary's prior to 1905, the pupil midwife had to achieve a pass rate of 50 per cent or more in the written examination. After 1905 this was abolished. Of the 18 exam candidates in 1905 for the CMB Diploma, there were no failures, yet only four gained over 40 per cent in their written examination. For high failure rates amongst pupil midwives prior to 1905, see Chapter 3. St. Mary's Hospital Archive (hereafter MHA) Manchester, Management Board Minutes, 12 May 1905. John Ryland's University Library, (hereafter JRUL), Register of Pupil Attendance, 1893/4-1909, March 1905.
4. For the views of and references for, Oakley and Versluysen and others, see Introductory Chapter.
5. May Chamberlain, *Old Wives Tales* (London, 1931), p.115. Ann Oakley, 'Wise Woman and Medicine Man: Changes in the Management of Childbirth', in *The Rights and Wrongs of Women* (Middlesex, 1976), pp.17-58 (p.55).
6. See Chapter 4.
7. See Chapter 4.
8. Annual Reports of the Medical Officer of Health for: Newcastle, 1923, p.27; Birmingham, 1904, p.47; 1907, p.64; Manchester, 1908, p.254; 1909, p.239.
9. Arthur Newsholme, 44th Annual Report of the Local Government Board 1914-1915, Supplement Containing a Report on Maternal Mortality in Connection with Childbearing (London, 1915), p.9. Andrew Laird, 'Maternal Mortality', *Public Health*, 34 (1930-31), 328-31, p.1. Henry Jellett, *The Causes and Prevention of Maternal Mortality* (London, 1929), p.127.
10. See Introductory Chapter.
11. Newsholme, Tables 2.7, 2.13, p.33. Janet Campbell, 'Maternal Mortality', Reports on Public Health and Medical Subjects, 25 (London, 1924), Appendix A.

12. Janet Campbell, Isabella Cameron and Dilys Jones, 'High Maternal Mortality in Certain Areas', *Reports on Public Health and Medical Subjects*, 68 (London, 1932), pp.55-68.
13. Newsholme, p.54.
14. Cameron, p.64.
15. Newsholme, pp.52-59.
16. Annual Report of the Medical Officer of Health in 1905, p.246.
17. Liverpool City Record Office (hereafter LCRO), 614 MAT 1/2, Board Minutes, 14 March 1905; 12 June 1906, 614 MAT 1/3, Board Minutes, 12 May, 8 June 1909.
18. Annual Report of the Medical Officer of Health, Liverpool, 1914, p.84; 1916, p.39.
19. *Report on the Departmental Committee to Consider the Working of the Midwives Act, 1902*, evidence by Medical Officer of Health for Liverpool, pp.96-97. Annual Report of the Medical Officer of Health, Liverpool, 1914, p.84.
20. Annual Report of the Medical Officer of Health, Birmingham, 1905, pp.53-55.
21. Annual Report on the Medical Officer of Health, Sheffield, 1906, p.54.
22. W. F. Oxley, contribution to the discussion of Veitch Clark's paper, Vietch Clark, 'Maternal Mortality', *Journal of the Royal Sanitary Institute*, 55 (1934-35), 684-95, p.693.
23. Clark, p.691. Campbell, 'Maternal Mortality', p.52.
24. Annual Reports of the Medical Officer of Health: Birmingham, 1906-30; Liverpool, 1906-30.
25. Annual Report of the Medical Officer of Health, Birmingham 1909, p.66; 1924, p.43. John Fairbairn, 'Observations on The Maternal Mortality in the Midwifery Service of the Queen Victoria's Jubilee Institute', *BMJ*, 8 January 1927, pp.48-49.
26. In the opinion of Lewis, the middle class nursing home 'was a much more uniformly risky place to give birth in the inter-war period' than a hospital. Jane Lewis, 'Mothers and Maternity Policies in the Twentieth Century', in *The Politics of Maternity Care*, ed. by Jo Garcia, Robert Kilpatrick and Martin Richards (Oxford,

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Appendix 1: Liverpool Maternity Hospital
and Ladies' Charity

Rules for Single Girls.

Except as hereinafter provided in Rule 8, the conditions of admission of Single Girls shall be as follows:-

Rule 1 A single girl must apply personally at the hospital with her references, if possible two months before requiring the Charity, after which her application will be investigated by a Lady on the Sub-Committee.

Rule 2 In no case can a patient be admitted without having been passed by one of the Ladies on the Sub-Committee.

Rule 3 Only first cases are admitted. No patient over 25 years of age can be admitted, unless the circumstances are very unusual, and the Sub-Committees agree to accept the case after it has been laid before them.

Rule 4 Each patient must be in a Single Ward, and may be visited only by members of the Single Girls Sub-Committee. When the girl is admitted the matron

will notify the Lady who investigated the case,
whose duty it shall be to visit her.

Rule 5 No case will be admitted unless a home can be
provided for the mother and child after they
leave the hospital.

Rule 6 Patients who are in a position to pay are not
admitted.

Rule 7 No application can be entertained unless the
applicant has for the past three months, either
had her home within 20 miles of Liverpool, or
been resident within the same limit.

Board of Management Committee
Minutes, 11 April 1912

Appendix 2: 'The Life of the [Newcastle Medical] School'

W.D.Arnison (Medical Student, 1882-6)

In the summer of 1886 I took out my midwifery - a very objectionable job. The town was then for easy working, divided into two areas, East and West. Dr J. R. Baumgartner looked after the East end and Dr. Clarke Newton to the West. I chose the East End. Our work lay chiefly about Pilgrim Street, City Road and Ouseburn district. It was a most hair-raising experience going to one's first 'Mid'. We usually got a fellow-student who had done the course to help, but there came a day when you were left "all alone in your glory" and the test came. We had no Princess Mary Hospital with all its staff at our backs. It is true that there was the Lying-In Hospital in New Bridge Street, but it was under the charge of Dr. Nesham, who had nothing to do with our patient work. I was never-in the place until long after I had qualified. We fortunately at that time had only to be signed up for attending twenty cases, so it soon got over.

The Newcastle-Upon-Tyne School of
Medicine, 1834-1934 ed. by Grey Turner
(Newcastle-Upon-Tyne, 1934) p.17.

Appendix 3: 'The Life of the [Newcastle Medical] School'
Grey Turner (Medical Student, 1893-98)

But Practical Midwifery was the most unique experience. We had to conduct twenty confinements in the homes of the people, and these we did entirely alone and in most cases without having seen a woman in labour. We registered our names in a book at the Lying-In Hospital in New Bridge Street and reported to one of the medical officers who was on outside duty. At that time I lived in the West end of Newcastle, which I was told was too far out of the district, but it was allowed to pass, and I fixed up a temporary night-bell and retired to rest in fear and trembling .

The first call came in the daytime, but it was not long before a messenger had to trudge all the way from the City Road and I had to accompany her back in the middle of the night. There was several experiences of that sort, and I blush to think of some of the experiences for which my ignorance was responsible.

Only twice did I disturb the medical officer; once he refused to come and on the second occasion he accompanied me to a cellar dwelling and removed an adherent placenta. It was a crude performance, and the recollection of the illness of that poor woman before her

death from septicaemia is still a terrible nightmare. With the advent of Dr. Lyle all this was changed, and the school cannot be sufficiently grateful to him for the wonderful training which is now available.

The Newcastle Upon-Tyne School of Medicine,
1834-1934 ed. by
Grey Turner (Newcastle-Upon-Tyne, 1934)
p.138-39.

Appendix 4: Local Advertisement for Pupil Midwife

Jessop's, Sheffield, October 1898

Wanted Probationer to be trained in the
Midwifery Department for District Work,
married, age 20 to 35, must be strong and
healthy. Apply with Testimonial to the
Superintendent of Midwifery at the Hospital
(Victoria Street entrance) in the mornings.

Jessop Hospital, Letter Book 1897-99,
19 October 1898.

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