1 HISTORICAL BACKGROUND

When Confidential Enquiries into Maternal Deaths (CEMDs) began in England and Wales in 1950, childbirth in the UK was entering a new era. The National Health Service (NHS) was two years old. The still-new colleges of midwives and obstetricians had just become 'Royal'. The age-old curse of puerperal sepsis had been lifted. Public protests about high death rates in childbirth and infancy had ended. Maternal mortality had begun to fall and the professions and the government were united in their resolve to make pregnancy even safer.

The task would not be easy. It would need the co-operation of midwives, general practitioners (GPs), obstetricians, hospital services and public health officials, and a controversial Act of Parliament. Each piece of that complex jigsaw has its own history, tacitly understood when the CEMD began making its recommendations but largely forgotten today. Some of those histories are mentioned in later chapters, but the background stories of midwives, doctors and hospitals are summarised here. They help to explain the conditions in which the new CEMD had to operate, and they may also make surprising reading.

The midwives

The word 'midwife' sounds feminine but actually it is gender neutral. It comes from the Middle English 'mid' (with) and 'wyfe' (woman) and simply means the person who is 'with the woman' at childbirth. For centuries, however, men were excluded from labour and birth, and the term 'midwife' came to cover a broad spectrum of birth attendants from trained professionals to the local 'handywoman'. The extremes are exemplified by two historical figures, one real and one fictitious.

Mrs Nihel and Mrs Gamp

Elizabeth Nihel was a leading midwife in the eighteenth century. She trained at the Hotel Dieu in Paris (one of the few midwifery schools of the time) before

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setting up in practice in London in 1749 and writing her own textbooks. She objected strongly to the rise of the 'man midwife' and has been immortalised by her picturesque comments about them.

Sarah Gamp appeared in Charles Dickens' novel *Martin Chuzzlewit*, published in 1843. Sloppy, ignorant and fond of gin, she combined the roles of midwife and nurse, and 'went to a lying-in or a laying-out with equal zest and relish'. Based on a real person a female friend had described to Dickens, she became a popular nineteenth-century stereotype.

Dickens' caricature, however, contained more than a grain of truth. In 1871 Florence Nightingale wrote, in her book *Notes on Lying-in Hospitals*:

> *Although every woman would prefer a woman to attend upon her in her lying-in, and in diseases peculiar to her and her children, yet the woman does not exist, or hardly exists, to do it. Midwives are so ignorant that it is almost a term of contempt.*

Figure 1.1 Mrs Elizabeth Nihel (1723–76)

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Figure 1.2 Sarah Gamp, as illustrated by Frederick Barnard

She had already turned nursing into a respected profession and she outlined the training required to do the same for midwifery. Her mission was taken up by others in the 1880s. The first step was to be a statutory register of midwives. The Medical Register had been established in 1858 to help people distinguish between professionals and quacks, and the Midwives Register would do the same. In 1890 a Midwifery Bill was presented to Parliament in the short-lived hope that it would pass with little debate.

The Midwives Act

The second reading was moved on 21 May 1890 by Liberal and Conservative Members of Parliament (MPs), who said their purpose was to ensure that the poor had access to the standards of midwifery that the rich already enjoyed. The bill was opposed, however, by a medically qualified MP who said he 'had received representations from medical men stating that the passage of this Bill

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would deprive them of much legitimate practice which they at present enjoyed'. It was talked out and 12 years of debate followed.

Doctors argued that there were no adequate facilities for midwife training. Some even formed the Committee to Oppose Midwives' Registration. Anti-female prejudice was rife at that time, but this argument was more about finance than feminism. Doctors and midwives were private practitioners competing for fees from people who could afford them.

When the Midwives Act was finally passed in 1902, the debate intensified. If a midwife called a GP to help with a difficult labour, did the husband have to pay both of them? And what about people who could not afford to pay at all? The Poor Law Act of 1834 had established Poor Law Guardians, and in 1908 the Medical Protection Society wrote to all 648 Boards of Guardians pointing out that they were obliged by law to pay a doctor summoned by a midwife. Some Boards did so, others refused, and many haggled.

But money was not the main problem. Training had to be expanded rapidly and facilities were limited indeed. Formal midwifery training had been established in London in 1872, when the London Obstetrical Society introduced a diploma specifically for midwives. This had been a controversial step. A leading obstetrician, Sir Francis Champneys, later recalled that, as the president of the Society, he had signed the diplomas personally and some doctors had threatened to refer him to the General Medical Council for doing so. Champneys was intent on raising the status of midwives and he became a driving force behind the Midwifery Act.

Zepherina Smith

Among the first to receive the Society's diploma was a nurse, Zepherina Veitch, who had already published *A Handbook for Nursing the Sick*. In 1881, encouraged by the activist Louisa Hubbard, she and six other midwifery diplomates formed the Matron's Aid Society to improve the training of midwives. They chose that name because the word 'midwife' was rarely used in polite society.

Soon the Society gained the confidence to rename itself the Midwives Institute and in 1890 Zepherina (by then Mrs Smith) became its president. She attended meetings of the committee which framed the Midwives Bill but did not live to see it become law. She died in 1894, aged 58, but the Institute continued and became the College of Midwives in 1941.

By 1902 schools of midwifery had been established outside London, including one in Liverpool, where formerly 'students were compelled to take out their course of practical midwifery in Dublin'. Ireland was well ahead of England

Figure 1.3 Zepherina Smith (1836–94)

and midwifery training had existed in Dublin since 1745, when the Rotunda Hospital was founded there.

The Central Midwives Board

The Midwives Act established the Central Midwives Board (CMB) to regulate the new profession. It included representatives from the two medical Royal Colleges, the Society of Apothecaries, nurses, laypeople and midwives. Champneys was its first chairman and was re-elected annually until his death in 1930 at the age of 82. According to an obstetrician colleague, William Fletcher Shaw, 'it was his administrative ability, patience, firmness, and tact which made possible the implementation of the Act'.

Balance and tact were indeed essential. Florence Nightingale had taken a gradual approach to the transformation of nursing by establishing a school in London and then sending her nurses to other cities. In complete contrast, the CMB appointed 'inspectors of midwifery' across the whole country simultaneously in 1905. As Shaw pointed out, this could have gone badly wrong. 'To have removed from the register all who failed to conform to modern standards before new ones had been trained would have created chaos: to have been too lenient and weak would have failed to bring home to the profession the necessity of improvement if they were to retain their registration.'

Thanks to Champneys, chaos was avoided. Shaw recalled that most of those who were reported to the CMB were 'admonished by the chairman, and dismissed with a caution, always with good effect'.

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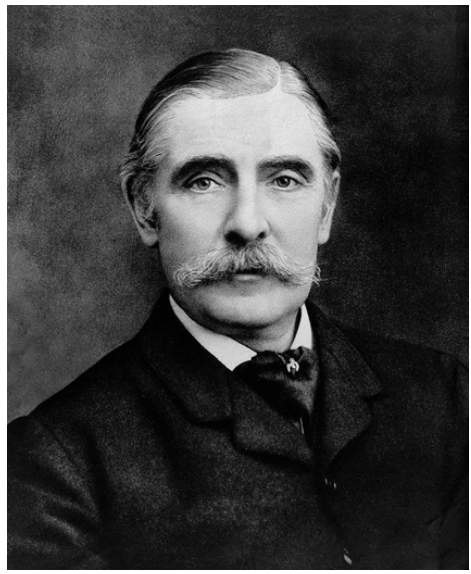

Figure 1.4 Sir Francis Champneys (1848–1930)

Gradually the length of midwifery training increased, standards were raised and better applicants were attracted. As midwifery became more autonomous the number of obstetricians on the Board reduced. In 1983 the CMB was replaced by the UK Central Council for Nursing Midwifery and Health Visiting, which in turn became the Nursing and Midwifery Council in 2002. By then midwifery was a graduate profession with (for better or worse) hardly any obstetric input into its degree courses.

The doctors

Obstetric teaching dates back to Hippocrates, but it almost disappeared in the Middle Ages when men were barred from childbirth and women were barred from universities. It re-emerged in Europe in the sixteenth century. Textbooks were printed in German and Latin, the surgeon Ambroise Paré founded a school for midwives in Paris, and accoucheurs (male midwives) appeared in France.

One of them was Peter Chamberlen, a Huguenot whose family fled to England in 1569. He became accoucheur to the Queen in 1616 and invented the obstetric forceps, which remained the Chamberlens' family secret for four generations. In the 1720s a great-grandson with no male heir divulged the design, and the use of forceps began to spread among the man-midwives who by then were becoming fashionable in England.

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William Smellie

The most influential of these was William Smellie, a Scots doctor who moved to London in 1738 to learn midwifery and went to Paris for further training. When he returned he gave courses of his own. The standard fee for a two-year course of lectures was 20 guineas (about £4,000 today), and he advertised that 'The Men and Women are taught at different hours.'

Smellie improved the forceps and wrote rules for using them which still apply today. His *Treatise on the Theory and Practice of Midwifery*, published in 1752, included the advice never to criticise a midwife but to become her 'real friend'. Not all midwives reciprocated. Smellie lacked social graces and Mrs Nihel memorably called him 'a great horse God-mother of a he-midwife'. In 1759 he returned to the peace and quiet of his home town, Lanark, but his reputation as 'the master of British midwifery' lives on.

Lying-in hospitals

Another of the early man-midwives, Sir Richard Manningham, established London's first lying-in beds in 1739 in the house next door to his home in Jermyn Street. In 1745 a purpose-built lying-in hospital was founded in Dublin and later became the Rotunda. Its founder was Bartholomew Mosse, and, according to his biography, 'The wretchedness of the circumstances of many of the women that Mosse attended moved him deeply and he decided in the early 1740s to establish a charitable lying-in hospital.'

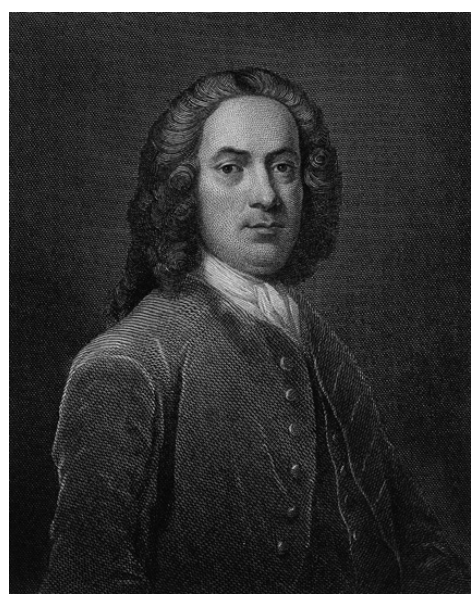

Figure 1.5 William Smellie (1697–1763)

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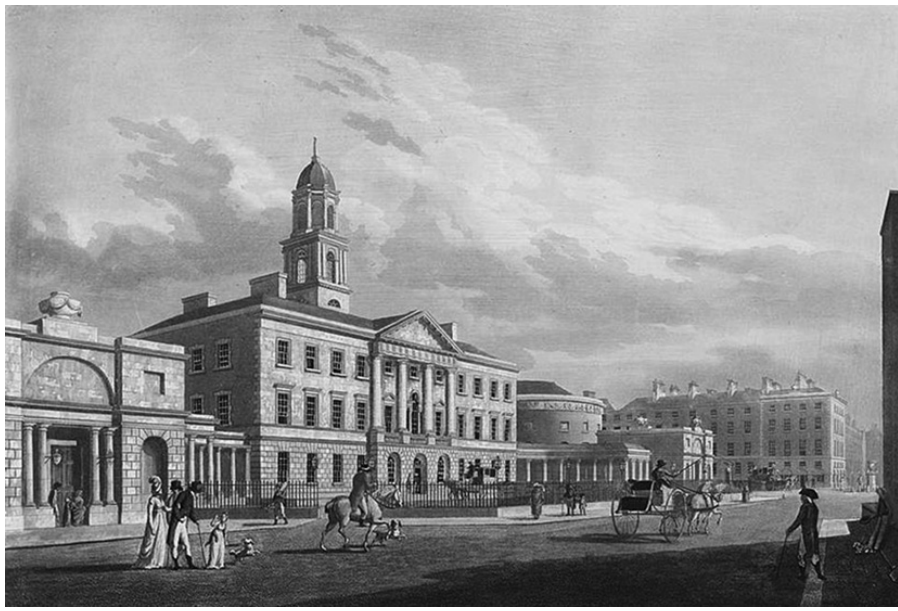

Figure 1.6 Rotunda lying-in hospital, Dublin, opened in 1757

London soon followed. The Middlesex Hospital added lying-in wards in 1747 and within five years there were five lying-in hospitals. They included the Bayswater Lying-in Hospital, which later became Queen Charlotte's and, like the Rotunda, offered midwifery training. As the Industrial Revolution progressed, other cities realised that their fetid slums were no place to have a baby. Lying-in hospitals were established in Newcastle, Manchester and Edinburgh, and later in Leeds, Liverpool and Sheffield.

The first medical schools

Until the eighteenth century Britain had no medical schools. Clinical teaching was available elsewhere in Europe or in one of London's two hospitals, St Bartholomew's and St Thomas', neither of which had a lying-in ward. Medicine in England was controlled by the Royal College of Physicians, which was founded in 1518 and did not regard midwifery as part of medicine. The surgeons had a trade guild that dated back to 1540 and would become a Royal College in 1800. They too eschewed midwifery, commenting that the only operation a man-midwife did was to cut the umbilical cord.

Britain's first medical school was founded in Edinburgh in 1726. Elsewhere in Scotland, Glasgow and Aberdeen followed in 1751 and 1786. In London, St

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George's Hospital offered teaching from its foundation in 1733 and the London Hospital Medical College was founded in 1785. Edinburgh had a professor of midwifery from the start but London had no university until 1826, when University College was founded. In 1842 it appointed a Dublin-trained obstetrician as its first professor of midwifery.

Nineteenth-century innovation

During the nineteenth century the name 'man-midwife' was replaced by 'obstetrician', which comes from the Latin (*obstetrix* ('midwife')) and therefore has more gravitas. The century brought major innovations. Ether anaesthesia was discovered in 1846 by an American dentist, and chloroform anaesthesia was discovered in 1847 by the professor of midwifery in Edinburgh, James Young Simpson. The idea of pain relief in labour was briefly resisted on religious grounds, but when Queen Victoria asked John Snow for chloroform during her eighth labour in 1853 she set a trend that would continue into the twentieth century.

Joseph Lister pioneered aseptic surgery in the 1870s. It enabled abdominal operations and ushered in the specialty of gynaecology. The first successful hysterectomy in Europe had been performed in 1863 in Manchester, and in the 1870s a vogue developed for gynaecological procedures, many of them ill-advised by modern standards. Caesarean section remained rare, but isolated reports appeared from 1835 onwards. In 1894 a review of 160 caesarean sections in Britain and the USA reported mortality rates of 32–40%. *The Lancet* commented that it was 'still an operation attended with much danger'. This may have been because it was performed only as a last resort in the most difficult cases.

Undergraduate obstetrics

Between 1824 and 1834 seven new medical schools were established in quick succession across England but not all of them taught midwifery. Medicine was still dominated by the physicians and surgeons and was still an all-male profession. Women were excluded from the UK medical register until 1876 and from British universities until 1878. In such an atmosphere it is not surprising that the schools gave midwifery low priority. Later the honorary surgeon to Liverpool Maternity Hospital wrote: 'Obstetrics has always been the Cinderella of the Medical Faculty. It was considered a branch of the profession hardly respectable. The College of Physicians precluded practitioners of midwifery from their Fellowship; the College of Surgeons would not allow such a one to sit on its council until 1828.'

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But the influence of obstetricians was growing. In 1824 they founded their own society, which became the Obstetrical Society of London in 1858, the year of the first Medical Act regulating medical education. In 1881 the Society's president, James Matthews Duncan (an Edinburgh alumnus), called for more curriculum time to be given to obstetrics and for the subject to have equal status with medicine and surgery.

Obstetrics finally became a statutory part of medical training in 1886, when a new Medical Act decreed: 'No person shall be registered under the Medical Acts who has not passed a qualifying examination in Medicine, Surgery, and Midwifery.' Ironically, four years later doctors were blocking the statutory training of midwives.

The birth of a specialty

By the 1870s the Obstetrical Society of London had about 600 members. It disapproved of the fad for gynaecological surgery and a breakaway group formed the British Gynaecological Society in 1884, but both became part of the Royal Society of Medicine in 1907. Regional societies were formed, such as the North of England Obstetrical and Gynaecological Society which was founded in 1889, and their proceedings were published in national journals.

In 1902 the specialty got its own journal. It had been suggested by Sir William Sinclair, an Aberdeen graduate who was a professor of obstetrics and gynaecology in Manchester. The first issue of the *Journal of Obstetrics and Gynaecology of the British Empire* devoted 30 pages to summaries of papers from abroad – 17 from France, 13 from Germany and 2 from the USA. This reflected the major sources of research in the specialty (and indeed in all medicine and surgery) at that time.

In 1911 William Blair-Bell of Liverpool formed the Gynaecological Visiting Society (GVS) with leading specialists from across Britain and Ireland. Blair-Bell had achieved national prominence because of his own research, but he is now remembered for founding the British College of Obstetricians and Gynaecologists in 1929. Among the other founding members were Sir Francis Champneys and William Fletcher Shaw.

Breaking away from the two established colleges was a bold step which needed a visionary leader. Blair-Bell was such a man: he became the College's first president and asked to be buried in the presidential robe he himself had designed. He died in 1936 and the College was granted its 'Royal' title in 1938, though it did not receive its charter until after the war.

In 1949 Dame Hilda Lloyd, Professor of Obstetrics and Gynaecology in Birmingham, became the Royal College of Obstetricians and Gynaecologists'(RCOG) first woman president. She had formed the Women's

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Gynaecological Visiting Club in 1936 because women were excluded from the GVS and other national clubs. In 1949 Dame Hilda became the first woman to sit on the General Medical Council.

The RCOG quickly became an examining body like the other two colleges, with exacting standards in its membership examination. Candidates, however, had to rely on standard textbooks and local teaching. It was not until the 1990s that the RCOG began issuing its own guidelines on clinical practice.

Twentieth-century teaching

Although the 1886 Act had mandated midwifery teaching in medical schools, the subject struggled for curriculum time. In 1926 Sir Comyns Berkeley, a leading teacher and co-founder of the RCOG, inveighed against attitudes in London, where hospitals had far too few maternity beds for obstetric teaching, and he linked the neglect of midwifery teaching to the rate of maternal mortality, which was still scandalously high.

In 1930 the *Report of the Committee on Maternal Mortality and Morbidity* devoted a full chapter to medical education in obstetrics, and recommended improvements (see Chapter 2). In 1939 Sir John Fairbairn, another RCOG co-founder, called for a broader approach including preventive medicine. Commenting on the standards set by the CMB, he ended: 'Surely we teachers of medical students will not allow them to go into practice with a more restricted outlook than the midwives who will be their assistants.'

The General Practitioner Obstetrician

Medical school training was important because a newly qualified doctor could go directly into general practice. Before 1950 most births took place at home and maternity care was given by the midwife and GP. Who was 'assisting' whom is unclear. If pain relief was needed the midwife had to call the GP because the British Medical Association (BMA) had resisted calls to allow midwives to give any form of sedation.

Fairbairn pointed out that the GP saw his duty as relieving distress, usually by 'anaesthesia and a speedy and artificial end to labour'. This meant chloroform and forceps delivery, both of which carried risks, especially in the pre-antibiotic era. Postgraduate training in obstetrics or anaesthetics was not available and the GP obstetrician had to rely on his undergraduate teaching and then learn by experience.

When the NHS was set up in 1948 it proposed an 'obstetric list' of GPs with appropriate experience, who would receive extra remuneration. The BMA reluctantly agreed but then changed its mind. Throughout the 1950s its members repeatedly voted to abolish the list, arguing that all doctors learned

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enough at medical school to qualify for inclusion. Early signs of pregnancy complications continued to be missed, with fatal results.

The hospitals

St Bartholomew's and St Thomas' Hospitals were founded in the twelfth century, and London gained another hospital, Guy's, in 1721. The first general hospitals outside London were established in Bristol and York in 1735 and 1740, respectively, and over the next 50 years the expanding cities of the north of England did the same. Some of the cities also had lying-in hospitals. In the nineteenth century the term 'lying in' became obsolete and was replaced by 'maternity'.

Maternity hospitals

Between 1834 and 1842 maternity hospitals were established in Glasgow, Liverpool and Birmingham. In 1846 Edinburgh Lying-in Hospital changed its name to Edinburgh Royal Maternity Hospital. In 1865 Bristol Maternity Hospital was founded as The Temporary Home for Young Girls Who Have Gone Astray (later shortened to The Temporary Home). By 1875 maternity hospitals had been established in Sheffield, Aberdeen and Nottingham. Like the general hospitals, these were charitable institutions.

Maternity hospitals were bedevilled by outbreaks of puerperal fever (see Chapter 5), but infection was a problem in general hospitals too. Sir James Young Simpson coined the term 'hospitalism' for the complications that increased institutional mortality rates after amputations. Because sepsis was such a scourge it was suggested that all maternity hospitals should be closed down, but women were willing to take the risk and the hospitals expanded. In 1869 Glasgow Maternity Hospital reported that its births 'exceeded 1000 annually'.

Workhouse infirmaries

The poorest of the poor gave birth in workhouses, which had their origins in the fourteenth century. The Poor Law Act of 1834 entitled inmates to free medical care. Workhouses had a medical officer and, after another Act in 1867, they employed trained nurses. Many built their own infirmaries. In 1913 workhouses became 'Poor Law Institutions' and in 1929 the Boards of Guardians were abolished. The system ended with the National Assistance Act of 1948, but buildings repurposed as hospitals remained and, for the local people, so did the stigma.

A typical example was Leeds Workhouse, which opened in 1861. It added a block with lying-in beds to its infirmary in 1904. About 70 babies were born

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each year and the birth certificates carried a fictitious address. In 1925 the infirmary was renamed St James' Hospital. In 1934 it had 941 births but no resident obstetrician. In 1939 the government decided that the old Poor Law Infirmaries should have permanent medical staff but St James' did not get its own consultant obstetrician until 1953. He also covered one of the city's many maternity homes.

Maternity homes

Municipal maternity homes had been suggested in 1907 by Sir William Sinclair of Manchester, who had been a strong supporter of the Midwifery Act. In 1902, the year of the Act (and his new journal), the overwhelming majority of births were at home. Sinclair saw a need for maternity homes to which midwives' cases could be admitted if complications arose.

In 1919 the new Ministry of Health replaced the Local Government Board, and Janet Campbell (later Dame Janet) was appointed as the senior medical officer in charge of maternity and child welfare (see Chapter 2). By 1921 the Ministry had recognised 60–70 maternity homes in England and Wales and more were planned. Britain's maternal mortality rate was still high and Dame Janet believed that most maternal deaths could be prevented 'if proper facilities and reasonable skill were to hand'. She wanted maternity homes of 10–20 beds for 'normal and slightly abnormal cases' with good links to the local hospital, midwives and GPs.

She assumed these maternity homes would be well run, but the reality fell far short. In 1923 Beckwith Whitehouse (later Sir Beckwith), a Birmingham obstetrician and CMB examiner, drew attention to the poor standards in 'the types of maternity home which are springing up like mushrooms throughout the country, especially in the poorer areas of the large cities . . . the small dirty house presided over by a woman frequently covered by the diploma of the CMB but without the experience needed to equip and manage a maternity home'.

In 1926 Parliament introduced registration making maternity homes liable to inspection by the supervising authorities established under an earlier Midwives Act. Complaints continued, however, particularly over the critically important issue of infection control. This is discussed in Chapter 5.

Another major issue was haemorrhage, which can occur suddenly at home or in a maternity home and needs immediate treatment. In 1929 Professor Farquhar Murray of Newcastle suggested that rather than rushing a shocked woman to hospital, a specialist and nurse should be rushed to the patient. The development of the 'obstetric flying squad' and its eventual demise are discussed in Chapter 6.

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Summary

The eighteenth century gave Britain man-midwives, medical schools and hospitals. In the nineteenth century the medical profession became organised, anaesthesia was discovered, the germ theory of infection was proved and the specialty of obstetrics and gynaecology was born. In the twentieth century midwifery was transformed from a craft into a profession, the Ministry of Health was established and maternity homes were created.

Throughout all this, however, a woman's risk of dying in childbirth never changed. Maternal mortality in 1930 was as high as it had been in 1730. What did change was the public mood. Someone had to do something, and that is the subject of the next chapter in this story.

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