

# «You worked on your own, making your own decisions and coping on your own»: Midwifery knowledge, practice and independence in the workplace in Britain, 1936 to the early 1950's

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## SUMMARY

1.—Introduction. 2.—The occupational structure. 3.—The nature and practice of midwifery knowledge. 4.—Conclusion.

## ABSTRACT

Midwifery knowledge is a complex entity-comprising of training and experiential elements-not fixed but mutable, both informed and altered by practice. This study uses oral history accounts to explore how midwives viewed themselves and how they interacted with midwifery knowledge in an attempt to gain a greater understanding of their power and independence in the workplace and, as a result, of their professional status. Midwifery knowledge cannot simply be defined as the technical skills taught in training; it was also shaped by the environment in which practice took place and the midwife's relationships with women and with doctors.

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## 1. INTRODUCTION

Historians have tended to focus on the professionalisation of midwifery through an examination of the struggle for registration and by exploring the inter-relationships between midwives and other medical health care professionals (1). Few have been informed by the work of sociologists, who have begun to explore and redefine theoretical frameworks through which to study the professions (2). Traditionally, female/female-dominated groupings have been dubbed semi-professions (3), a theory which clearly reflects notions of gender and power in society by insisting that «because women are not men, then “semi-professions” are not professions» (4). Historians therefore have tended to accept such models uncritically instead of exploring new theoretical frameworks. Simply put, a profession has been defined as an occupation usually requiring some advanced learning/specialist training, where those involved have a large degree of autonomy in the workplace and are regarded as «owning» knowledge and/or skills, access to which is controlled by the group. As an entirely female workforce, midwives were generally denied full professional status and were also excluded because they have did not have complete control over their own training programmes or rules and regulations. However, definitions of the professions which rely on the notion of complete autonomy have been challenged and recent research has suggested that «knowledge based groups have never been characterised by a total autonomy» (5).

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- (1) DONNISON, Jean. *Midwives and Medical Men: A history of the struggle for the control of childbirth*, London, Historical Publications Ltd., 1988.
  - (2) See for example: BURRAGE, Michael; TORSTENDAHL, Rolf (eds.). *Professions in Theory and History: Rethinking the study of the professions*, London, Sage Publications, 1990 and *The Formation of Professions: Knowledge, State and Strategy*, London, Sage Publications, 1990.
  - (3) ETZIONI, Antonio. *The Semi-Professions and Their Organisation: Teachers, Nurses, Social Workers*, New York, The Free Press, 1969.
  - (4) WITZ, Anne. *Professions and Patriarchy*, London, Routledge, 1992, p. 60
  - (5) TORSTENDAHL, Rolf. Introduction: promotion and strategies of knowledge-based groups. In: Michael Burrage and Rolf Torstendahl (eds.), *The Formation of Professions: Knowledge, Sate and Strategy*, London, Sage Publications, 1990, p. 5.

Given such problems of definition, the key to understanding the development of professional identity and status lies in the relationship between specialist knowledge and the power such knowledge accorded an occupational group. However, the relationship between knowledge and power is not straightforward as bodies of knowledge receive different levels of esteem at different points in history. Furthermore, knowledge and power cannot be regarded as one-dimensional, simplistic notions with a causal relationship. Whilst Foucauldian analysis relates power and knowledge firmly together (6), some researchers have challenged this apparent link and argue that although «Knowledge can confer power ... it does not automatically do so» (7). This is particularly apparent in midwifery, whose knowledge base in twentieth century Western societies has not been held in as high a regard as the «superior» knowledge of the obstetrician. By identifying hierarchies of knowledge and power, historians can begin to explain how different professional groupings were awarded different status and thus avoid the (gendered) labels of semi-/full profession.

Anthropology can also inform historical research into power relations and knowledge systems. For those concerned with the history of medicine or gender, much can be gained from the work of Brigitte Jordan who has discussed the notion of authoritative knowledge in relation to childbirth. Jordan argues that

«for any particular domain several knowledge systems exist, some of which, by consensus, come to carry more weight than others, either because they explain the state of the world better for the purposes at hand or because they are associated with a stronger power base and, usually both» (8).

Such an approach has important implications for the study of midwives in history as it outlines more clearly the complex nature of the relationship

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- (6) McNAY, Lois. *Foucault: A critical introduction*, Cambridge, Polity Press, 1994, p. 64.  
 (7) CORFIELD, Penelope. *Power and the Professions in Britain 1700-1850*, London, Routledge, 1995, p. 250.  
 (8) JORDAN, Brigitte. Authoritative Knowledge and Its Construction. In: Robbie, E. Davis-Floyd and Carolyn, F. Sargent (eds.), *Childbirth and Authoritative Knowledge: Cross-cultural perspectives*, Berkeley, University of California Press, 1997, pp. 55-79 (p. 56).

between power and knowledge. The application of such notions to historical enquiry, suggests that the knowledge/power nexus may not necessarily be a prerequisite for professional status, or at least that this relationship can have a range of results depending on whether it is the relationships within an occupational group, those with the clientele or those with outside agencies (themselves involved in a range of power and knowledge structures) which are being examined.

Recently, medical historians have been concerned with exploring the nature and impact of medical knowledge through the examination of practice, policy and patient experiences (9). However, the knowledge systems of mostly/completely female professional groupings (for example, midwives, nurses and health visitors) have received less attention in the British literature—although researchers (particularly within the history of nursing) are beginning to explore the issue of nursing knowledge (10). Traditionally, the history of midwifery has tended to either chart the development of the profession as a discipline (11), or explore inter-professional relations (12). However, the popularity of oral history as a research tool has led to some researchers (many of them midwives themselves) to begin to identify the changing nature of practice (13) and to explore the historical dimension of specific policy changes within their profession (14). Despite this activity, little attention has been paid to the creation of midwifery knowledge itself and its role in helping to form professional identity through training (15), or to the individual's

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- (9) For recent research and the current state of medical history see: the journal *Social History of Medicine* and BYNUM, William F.; PORTER, Roy (eds.). *Companion Encyclopaedia of the History of Medicine*, London, Routledge, 1997.
- (10) See for example: RAFFERTY, Anne Marie; ROBINSON, Jane; ELKIN, Ruth (eds.). *Nursing History and the Politics of Welfare*, London, Routledge, 1997 and RAFFERTY, Anne Marie. *The Politics of Nursing Knowledge*, London, Routledge, 1997.
- (11) See for example: TOWLER, Jean; BRAMALL, Jean. *Midwives in History and Society*, London, Croom Helm, 1986, which provides an excellent introduction to the development of midwifery.
- (12) DONNISON, note 1.
- (13) LEAP, Nicky; HUNTER, Billie. *The Midwife's Tale*, London, Scarlet Press, 1993.
- (14) ALISON, Julia. *Delivered at Home*, London, Chapman and Hall, 1996.
- (15) See: RHODES, Maxine. Births, Bedpans and Bugs: The contribution of professional education and training to becoming a midwife. In: *Health, Welfare and Oral History*, London, Routledge, 1999 (forthcoming).

interaction with her professional knowledge and the consequences of this for her role (for example, for the care she gave mothers) and her status within the maternity services. Moreover, there is much scope for research into the relationships between midwives and medics within institutions (such as hospitals and clinics), in the domiciliary setting and at both the local and national level (for example, within formal committee structures and within the Central Midwives Board) (16).

Such issues can best be explored by the application of oral history techniques as the central methodological tool. Though not without its problems, oral testimony allows a fuller account of the past to be explored and, by valuing the experience of the individual, allows an exploration of human relationships (17). In this way, historians can engage more easily with the application of abstract notions of power, knowledge and status. Whilst documentary evidence provides important information about the construction and dissemination of midwifery knowledge historical studies are, without some exploration of its practical application or impact, limited to an understanding of the ideal rather than the reality. This work is therefore based upon detailed interviews with midwives who trained and began their careers in the period before 1952 in Britain. All the interviewees trained in the North of England and all went on to practise in the same city (Kingston upon Hull in Yorkshire). Their testimony shows a similarity of experience which, I would argue, reflects the nature of midwifery training. However, whilst I acknowledge the limitations of such a local study (and hope to complete a more geographically diverse study in the future), such an approach does provide a detailed understanding of the dynamics of knowledge which larger studies may obscure.

## 2. *THE OCCUPATIONAL STRUCTURE*

Before exploring in depth the nature, structure and impact of midwifery knowledge, it is important to have some understanding of the

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(16) The Central Midwives Board was the midwives' ruling body. Created by legislation in 1902, it was dominated by medics and had an important role in producing the basis of midwifery knowledge.

(17) PERKS, Robert; THOMSON, Alistair. *The Oral History Reader*, London, Routledge, 1998.

historical development of midwifery in Britain in the first half of the twentieth century and in particular of the way in which this all-female labour force was organised during the period in question. Whilst it is difficult to separate the midwifery labour force from the service it provided, the intention in this section is to provide a short occupational history, focusing on the changing nature of the work and the position of the midwife. This narrative is intended to help the reader locate the discussion of midwifery knowledge within its historical context but does not claim to be exhaustive. Its prime function is to show how legislative change affected midwives and to highlight the importance of the 1936 Midwives Act.

The history of midwifery registration and the development of legislation in Britain has been well documented (18). Midwives had received the attention of legislators from 1902 when the first Midwives Act was passed and the Central Midwives Board (C.M.B.) with its professional register were created. From this time forward, midwives were monitored at the local level through a system of inspection by the Local Supervising Authorities (the L.S.A.s were usually organised through the local Medical Officer of Health's department) and nationally by the C.M.B. Both bodies had wide powers to discipline midwives should they fail to comply with the rules of their profession and in addition, the C.M.B. could remove a name from the register. This system of inspection was not only concerned with standards of practice but also with personal character and behaviour, both of which were considered when assessing competence. The 1902 Act helped to clearly define the role of the midwife as the practitioner with responsibility for normal childbirth by requiring her to call medical assistance only if a patient deviated from the expected pattern of labour (as laid down in training and in the rules) and this definition remained an important part of the professional identity.

Traditionally, midwives were independent practitioners and whilst some worked either for local charities, the Poor Law or the hospitals, the majority worked for themselves in domiciliary practice. Most births took place at home and were midwife-attended, and whilst the 1902 Act

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(18) See DONNISON, note 1, and TOWLER; BRAMALL, note 11.

had altered their relationship with outside agencies such as local government, the majority of midwives appear to have essentially continued to be self-employed into the inter-war years. However, increasing numbers did work for the emerging maternity and infant welfare service which began to be more firmly directed by national and local government in the inter-war years as grants from public money became available and legislation encouraged local attention to the development of services.

As the most usual birth attendant, midwives were a crucial component in the emerging maternity and child welfare service and their role was to be extended in the period after 1902, not only to cover the birth itself but to provide ante-natal, post-natal and neo-natal care. In this way midwives had a range of responsibilities, not only in providing for the needs of mothers and babies but in keeping a watchful eye for any complications and reporting these to a doctor. On the one hand, their influential role was recognised, but on the other, their work was increasingly regarded as being in need of regulation and supervision and their contribution to maternal and infant health was often seen as harmful rather than helpful, especially in the years before 1936 (19).

The 1902 Act did not replace the untrained handywoman with a trained professional overnight. Although the Act had created the machinery to regulate, certificate and inspect midwives, it did not initially prevent all untrained midwives from practising but instead created a three tier system of hospital-trained, bona-fide (untrained midwives who had practised before the Act and who were considered of good character and allowed to continue their work) and uncertified midwives (the traditional folk midwife or handywoman). Although the uncertified midwife was not permitted by law to promote herself as a trained midwife, she did not disappear—even though little information remains about her work, she does appear to have survived in some localities (20). Whilst midwifery

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(19) Historically, midwives found it difficult to shake off the image of the untrained handywoman and the standard of midwifery in Britain was often seen as a cause of maternal deaths. It was only as the maternal mortality rate began a sustained decline from the mid 1930's that this began to change.

(20) Local studies are useful here. In Kingston upon Hull, there is evidence to show that handywomen were being warned to desist practising and some were prosecuted

was changing, the untrained bona-fide midwife still continued to be an important part of the labour force for some time.

The 1902 Act remained (with some amendments) the basis for the organisation of midwifery until 1936 when another Midwives Act completely altered the whole structure of the midwifery labour force by making all midwives salaried public employees. However, this legislation was the culmination of trends that had begun much earlier (21) and were already affecting independent practice. The introduction of municipal midwifery schemes for example (where local government employed midwives and arranged the collection of subsidised fees from mothers) resulted in some conflict between the L.S.A.s and independent midwives. At the same time, the C.M.B was further refining the role and responsibilities of the midwife—for example, by requiring her to carry out ante-natal inspections from 1926 and by extending her post-natal responsibilities from 10 to 14 days from 1937.

However, the most significant piece of legislation for midwives had come in 1936 when the Midwives Act completely restructured midwifery. Arguably more important to midwives, in professional terms, than the introduction of the National Health Service in 1948 (22), this legislation was to form the basis of the structure of midwifery throughout the period under consideration. The Act completely altered the organisation of the midwifery service in England and Wales by legislating for «the organisation throughout the country of a domiciliary service of salaried midwives under the control of the local supervising authorities» (23). It

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following the legislation of 1910 (which prevented them acting as midwives «habitually and for gain»). *Annual Report of the Medical Officer of Health*, London, HMSO, 1911, p. 43. However, whilst official sources would suggest that the handywoman had disappeared, oral history accounts provide evidence of her continued existence. In Hull, for example at least one such woman was working into the 1940's. RHODES, Maxine. Unpublished interview with Hull Midwife.

- (21) For a detailed account of the pressure for reform see: WILLIAMS, A. Susan. *Women and Childbirth in the Twentieth Century*, Stroud, Sutton Publishing, 1997.
- (22) However, there is room for more research into the impact of the NHS, midwives' reaction to it and place within it.
- (23) MINISTRY OF HEALTH. *Circular 1569: Midwives Act 1936*, London, H.M.S.O., 1936.





The Nurses' Home, Albion Street, Hull. Pupil midwives lived here whilst completing their district training.

was generally hoped that, as a result not only would maternal mortality be reduced but midwives would also benefit as the «whole status of the midwifery profession will be raised by providing adequate salaries and secure prospects of those midwives who enter the service» (24).

For midwives, the legislation was significant in two respects: firstly, it stimulated the reorganisation of training programmes and secondly, it created a state-salaried midwifery service, making all midwives public servants. Courses of training had been lengthened and their content widened before 1936, offering women without nurse training (the direct-entry midwife) longer periods of instruction than their nurse-trained counterparts. Further changes came in 1938 as a consequence of the Act when training was split into two parts and its length doubled. Part One was based in the maternity hospital and included a mixture of theoretical, lecture-based sessions and practical experience. This initial training was of six months' duration for nurses but was extended to eighteen months for those without state registration. Part Two lasted six months for all entrants and was mostly practical—students could experience the entire six months in the community or could divide their time between the hospital and the community (25). Such changes were designed to improve the standard and scope of education and to contribute to what had been described as the «legitimate aspirations of the midwife for a higher professional education» (26).

The Act also altered conditions of employment. Initial analysis shows that there were advantages for midwives in terms of security, salaries, paid holiday and the regulation of the working day. At the local level, individual midwives received an annual salary, were included in pension schemes and had three weeks' annual leave; their pay depended upon qualifications and experience but they generally received between £180 and £235 per annum in 1936 (27); they were provided with a uniform, equipment and a laundry allowance and were issued with bicycles. However, the long-term impact on status is less clear. Independent practice was now less viable and, as the shortage of midwives worsened

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(25) For details of the changes see: MINISTRY OF HEALTH. *Report on the Work of the Central Midwives Board for the year ended 31<sup>st</sup> March 1937*, London, H.M.S.O., 1938, pp. 13-14.

(26) FAIRBAIRN, John, S. *A Text-Book for Midwives*, Oxford, University Press, 1930, p. vii. Fairbairn was Chairman of the C.M.B. 1930-1936.

(27) KINGSTON upon Hull Health and Public Assistance Committee, Maternity and Children Sub-Committee. *Minutes of Proceedings*, Hull, December 1936.

into the 1940s, workloads increased (28). This loss of independent practice did nothing for midwives' professional status within the hierarchy of medical health care workers. In fact it worsened their position, ensuring that distinctions were maintained between them and those professions which had retained a large degree of self-determination. In reality however, other factors were at work which ensured that midwives utilised their knowledge in practice to ensure professional status and independence.

### 3. *THE NATURE AND PRACTICE OF MIDWIFERY KNOWLEDGE*

Like all other knowledge systems, midwifery knowledge is culturally constructed and historically specific, and this can be seen even from a simple occupational history which shows the manifest opportunities for the reorganisation of knowledge. Within midwifery, new roles and responsibilities altered the boundaries of the work but knowledge was also affected by wider influences such as the changing form of the maternity services, the role of the state in developing a national maternity policy and the shifting nature of the medical gaze through the development of obstetrics. Whilst it is important to understand the way such external factors affected the nature of midwifery knowledge in this period, this work is essentially concerned with the intra-professional dimensions of knowledge. It seeks to explore how midwives interacted with this knowledge and to show the consequences of this for their professional status. By exploring the relationship between midwifery knowledge, independence and status in the workplace, the consequences for midwives' power as a professional grouping can be seen. As will be shown, the relationship between knowledge and power was not straightforward and did not have a uniform effect.

Entry into the midwifery profession required a period of specialist training and the education pupils received was vital to the process of becoming a midwife. The body of knowledge pupils came into contact

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(28) MINISTRY OF HEALTH. *Report of the Working Party on Midwives*, London, H.M.S.O., 1949.



A group of trainees outside the Nurses' Home. The woman at the back is the Supervisor of Midwives.

with not only contained the technical skills, rules and basic information which would form the foundation of practice but also reflected values and attitudes concerning the status and role of the midwife within the maternity services. Training made enormous demands of pupils personally; it required them to live on hospital premises, to conform to the regulation of hospital life, to work in the hospital and to study. By immersing

pupils in midwifery knowledge in this way, a professional code of conduct could be enforced (important when recruits were not solely selected from nursing) which tended to reinforce hospital hierarchies and therefore the lower status of the midwife vis-à-vis others in the medical team. By focusing on the C.M.B. rules and by reinforcing the definition of the midwife as the practitioner with responsibility for normal childbirth, clear distinctions could be maintained between her work and that of the doctors. At the same time, the contradictory nature of midwifery knowledge was also expressed in the training programmes. Whilst on the one hand midwives were taught to know their place in the medical hierarchy, at the same time they were taught to be independent practitioners and to be proud of this position. As a result, this period of training was crucial in developing the professional persona and provides insight into the pupils' first interaction with midwifery knowledge.

However, to fully understand the nature and impact of midwifery knowledge we need to look beyond initial training (with its technical, moral and professional dimensions) to the final aspect of midwifery knowledge—its experiential element. In practising midwifery, midwives interacted with their knowledge system and this was not without effect. Midwifery knowledge was, of course not static but was altered by external influences: the introduction of new rules, work practices and changing attitudes to the place of birth, for example. It was also malleable internally; being moulded by an individual's experiences as information was added and subtracted as a result of interactions in the workplace. It is this dimension that was particularly important for the midwife, as experiential knowledge could help her to reinforce her position (as independent professional practitioner) within the hierarchy of medical health care workers and it was in the workplace that midwives expressed their professional identity most clearly. By being able to utilise their experiences to add to their knowledge, midwives were able to exert some power in the workplace and thereby maintain a degree of autonomy. Whilst in general terms, these processes may not have resulted in the midwife being seen by medics as their equal, she was a professional in her own mind (and to some extent in the mind of those she attended) (29). It

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(29) Researchers have tended to view the professionalisation of midwifery in light of

was therefore her interaction with midwifery knowledge in practice that resulted in her having a sense of status, independence and power. The practical application of what had been taught and the way this informed the professional persona lies at the heart of understanding the relationship between midwifery knowledge and professional development.

Midwives were defined by the C.M.B. rules (and saw themselves) as the practitioners with responsibility for normal childbirth and were obliged to call the doctor only if there was any deviation from the expected pattern of birth. Many of the midwives in this sample talked about the midwifery rules as the foundation of good practice:

«The art isn't delivering the baby. Anybody can catch a baby ... The art is knowing when things are going wrong. If you can foresee the problems you get the woman in hospital in good time you see, before anything happens. That's the art of midwifery» (30).

The importance of being prepared to call in medical aid was also discussed and midwives had no hesitation in calling for assistance: «The midwife is the professional of normality. When abnormality steps in then call for medical aid» (31). She then added, as if to reassert her professional status: «But there is nothing to stop you, as a midwife, doing without a doctor completely» (32). This comment reflects the attitudes of the majority of the sample who were keen to assert their status as independent professionals in their own right, who were capable of operating without supervision and were not simply defined in terms of their relationship to the work of the doctor.

Whilst the interviews indicate that midwives had a clear understanding of the boundaries of their role, many were keen to talk of their experience in helping deliver (without the doctor's presence) complicated births

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their relationship with medics, particularly obstetricians. Whilst there were, of course, important implications for midwives in the development of obstetrics as a specialism, midwives cannot simply be excluded from professional status because of the disdain of the medical profession.

(30) Mrs S, Tape 4.

(31) Miss S, Tape 1 and 2.

(32) Miss S, Tape 1 and 2.

in domiciliary care. Most commented that they had been prepared for these eventualities in training and that such events were often the result of a doctor's misdiagnosis. One midwife, recalling a breech delivery, stated: «The doctor insisted it was the right way up and I said it wasn't and when it came to the delivery, the doctor wasn't there when I wanted him so I had to deliver it» (33). This was by no means an isolated case and all commented on their experience of twin and breech deliveries at home. Midwifery knowledge in this period treated simple breech birth (in women having subsequent rather than first babies) and twins as routine (34) and most seemed to take this in their stride—although one midwife recalled the nervousness of the newly-qualified recruit: «All the time you are with someone ... at any time, something could go wrong and you hope it'll come back to you» (35). Despite being part of their work, these experiences helped reinforce, in their own minds, their ability to deal with a variety of outcomes successfully:

«Childbirth is a natural thing. Providing you know the pelvic measurements are normal, the blood pressure's normal and everything's alright, there is no reason why anything should go wrong ... you know' and later 'I mean, I was out all that time and I had very, very little trouble» (36).

Such testimony however hides important power divisions between doctors and midwives and these became more apparent if things went wrong. Midwives were more closely regulated and could be called in to the Supervisor's office to explain their actions. Local Supervising Agencies had the power to withdraw a midwife from the Register but did not have the same control over doctors. One midwife recalled summoning a doctor to a patient who showed signs of internal bleeding. He did not admit her to hospital, but the midwife did not feel able to overrule him

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(33) Mrs S, Tape 4.

(34) BROWN, R. Christie; GILBERT, B.; DOBBS, Richard H. *Midwifery: Principles and practice for pupil midwives, teacher midwives and obstetric dressers*, London, Edward Arnold, 1950, p. 563 and chapter 59, pp. 587-588. This was the teaching and reference text for some of the midwives in the sample.

(35) Mrs B, Tape 7.

(36) Mrs F, Tape 3.

and the mother died. Following the death, she had to go in to the Supervisor's office and explain the case to a female doctor:

«I was very sorry about Mrs X. I couldn't work. The next day I couldn't go to work. I had to go to the office and explain the case. She said, "You didn't fiddle with the fundus". (*Manually interfere with the womb*). She gave me quite a wiggling (*telling off*) and I said: "I don't think I warrant this treatment". I didn't feel at all guilty ... just intensely sorry. To see that woman gasping, you know it's internal haemorrhaging» (37).

Midwives had less power than doctors but it was only when disaster struck that they would be questioned; in reality, they had to deal with events as they occurred. When interviewed, midwives recalled dealing with haemorrhages and incomplete delivery of the placenta and talked of independently administering drugs (38). One midwife, remembering the limited treatments available to them, recalled:

«We didn't have an injection for stopping the bleeding. You gave them so many drops of ergometrine. It took twenty minutes to act. We managed to get Pituitrin. We used to give them hot vaginal douches to stop them bleeding» (39).

In reality therefore, midwives regularly stepped into the preserve of doctors and such experiences had important consequences for the midwives' professional persona. The fact that they could and did attend such births further reinforced midwives' belief in their competence and status as professionals, equal but different to doctors.

Although all the interviewees discussed attending abnormal presentations, the doctor always attended those births that required instrumental intervention (such as a forceps delivery) and there is no evidence to suggest that the midwife would perform any other role than that of maternity nurse at such events. Such evidence, taken in conjunction with the testimony on abnormal presentations, not only suggests that

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(37) Mrs Sy, Tape 8.

(38) Usually an activity associated with the role of the doctor (or at least supervised by him), midwives were allowed to administer some medication.

(39) Miss S, Tape 1 and 2.



normal and abnormal birth was less well defined than today but that in practice there was some blurring of divisions between the work of doctors and midwives. The distinctions made between the role of the doctor and the midwife were clear in the textbooks and in the C.M.B. rules but in reality, it was the use of certain birth technologies that separated expertise. Doctors were brought in for forceps deliveries and suturing, practices which it was believed, needed medical training, whilst midwives' work though technical was regarded as less specialised.

Practical experience was clearly important to professional development, but the correlation was neither simple nor direct. Training in community midwifery and early practice tended to help form attitudes to the work and interviewees spoke of being altered by their experiences. One, for example, spoke about how her early experiences of hospital work ensured her career moved onto the District (community midwifery). In this case, the midwife when newly qualified had had two traumatic experiences close together, both involving maternal deaths:

«We knew she wasn't going to recover. She was unconscious and Sister had gone to dinner and I was left with this fisherman (*the husband of the unconscious woman*) ... and he said: "But she's going to be alright isn't she?" And you're left there, very young and what do you ...? It's the only death I'd had anything to do with and I thought: "Oh, I don't want to work here anymore"» (40).

Such experiences however provided these midwives with additional knowledge and informed their sense of what women required in childbirth and of their own responsibilities within this. Another, for example, maintained that hospitals were the best places for all births although it later transpired that her faith in domiciliary delivery had been shattered by her experiences. Asked to attend a woman who had delivered herself, she had arrived at the scene and was eventually let into the house by a young child: «and when we got in, she'd had a baby ... The baby was there. It was a fresh stillbirth with the placenta sitting on its head, on its face, and it was a coroner's case» (41). This midwife expressed a

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(40) Mrs B, Tape 7.

(41) Miss P, Tape 5.

belief that women were best protected by the hospital system, especially if they could not arrange adequate care for themselves. In other cases, the unpleasant experiences provoked sympathy. One midwife recalled cases of puerperal insanity which «frightened the daylight out of me» (42) but encouraged a compassionate approach and a desire to engage other health professionals in its cure. Experiential knowledge did not always arise from pleasant experiences and many of the midwives in this sample appeared deeply affected personally and professionally by practice and these helped form her own attitude and her approaches to pregnant and childbearing women.

Midwives appear to have engaged with midwifery knowledge in different ways, depending on whether they worked in the mothers' own homes or in the maternity hospital. In hospital there was a more rigid hierarchy and, by design, a more formal system of monitoring both staff and patients. Few examples of independent working or rule breaking were recalled by those based in maternity hospitals, although one midwife did comment on her ability to assert herself. Recalling her work with junior doctors in the hospital, she had a system for protecting midwifery cases: «I would just say to the doctor: "No, she's not yours, mine. No, normal. Oh, I'd like you to see her (*and so on*)" and they no more dare touch my patients!» (43). However, since this example came from later in her career this suggests that such confidence did not accompany initial qualification.

It was in domiciliary practice that midwives found more opportunities for independent working and it was here, in the community, that they believed they had standing: «I felt I was somebody» (44). Midwives talked about their practice and linked their independence at work with their ability to have (almost) complete control over the birth: «I did most of my own deliveries without a doctor present at all because I used to manage it ... When I was training I was glad to have someone at the side of me» (45). Midwives talked of the need for patience, of the

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(42) Mrs B, Tape 7.

(43) Miss S, Tape 1 and 2

(44) Mrs Sy, tape 8.

(45) Miss S, Tape 1 and 2.

necessity for taking time with births and letting nature take its course. One repeatedly stressed this: «You just used to wait the time» and later «Let nature take its course. It's a normal thing is childbirth and always will be and, I mean, you can't rush it» (46)—such practice was reinforced by the midwifery rules which encouraged midwives to wait (for example, for two hours for the second stage to progress in women having first babies). Domiciliary work therefore allowed plenty of opportunities to refine what had been taught. Initially nervous of the increased responsibility («I was left there on my own, just new on the District») (47), midwives soon found their professional persona. Many recalled trying to order the domestic environment in line with training, demanding bed linen be changed (often when there was not a clean alternative) but in practice having to make do with what was available. One remembered trying to keep new born twins warm with limited facilities: «All I could do was fill up an ordinary glass bottle with as hot a water as I could manage ... and put it near them in the clothes basket» (48). Another, remembering some of the conditions, talked about the problems of preparing for delivery and disposing of the afterbirth: «After you'd had the delivery you'd ... to dispose of the afterbirth at home so it used to be put on the fire. It was only a little fire. It was a problem but it was the rules and we must burn it before we left the house» (49). The midwives in this sample worked with some of the poorest women in the city and midwives were proud of their ability to cope under difficult circumstances—«I have drunk tea with the dirtiest» (50). They spoke of giving practical help: «She had no blankets for the cot. Only a dozen nappies. Well I hadn't been on the District long ... I took her a lovely thick grey blanket ... half a dozen nappies ... oh, she was delighted with them» (51). This ability to work with women and adapt to the surroundings offered midwives greater autonomy than hospital working.

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(46) Mrs F, Tape 3.

(47) Mrs S, Tape 4.

(48) Mrs Sy, Tape 8.

(49) Mrs S, Tape 4.

(50) Mrs Sw, Tape 9.

(51) Mrs Sy, Tape 8.

Whilst training remained the basis of practice, it was not fixed and rules were not always adhered to. In this way, midwives acted autonomously, and some of the midwives talked of bending or breaking of the rules quite freely. One for example, talked of putting in stitches, which was a complete violation of the C.M.B. rules as suturing was considered the preserve of doctors. However this midwife knew exactly what she was doing and commented: «To put in a couple of stitches, there was nothing in that» (52). Moreover her testimony is particularly interesting as it not only illustrates her belief in herself as a competent professional but also highlights her deference to the doctors: «Put one or two stitches in to save a doctor at two o'clock in the morning—maybe up all night before—from getting up» (53). Other instances of deliberate flouting of the rules could also be found amongst those who worked in domiciliary practice. One midwife in particular talked frankly about her thoughts on some of the midwifery rules and admitted to deliberately refusing to attend the disinfecting station in cases of puerperal fever and to wear gloves when asked to do so (54). Whilst much of this independence in practice can be explained by the continued dominance of midwives at the side of childbearing women (most births at this time, whether hospital or domiciliary, were without complication), the structural organisation of the working environment was also important. The predominance of domiciliary work, the tendency to work alone rather than in teams and the lack of direct supervision helped midwives maintain a degree of autonomy.

Their independence and status were further reinforced through their dealings with the women they attended. Midwives felt part of a community and some recalled that women would often have the same midwife for successive births. Others felt they were respected:

«In those days the midwife was “The Midwife” and there was always someone that literally ran after you ... We had a higher status in the community. Once you are the same as them (the patients), they're not going to take your advice quite the same» (55).

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(52) Miss S, Tape 1 and 2.

(53) Miss S, Tape 1 and 2.

(54) Mrs Sy, Tape 8.

(55) Mrs B, Tape 7.

This power relationship was apparent with all the midwives. Only one commented on this: «Some patients used to be scared of the midwives. Some midwives were, I don't know, so strict, so sergeant major type» (56). At the same time, however, her testimony illustrates the rather patronising way she treated women whom she referred to as being «very, very good» (57). It was also in their relationships with the women they attended that the midwives were able to assert their power and independence in the workplace. One particular episode illustrates the typical approach to women in childbirth: «We had one lady who had to have a stitch in and we asked the husband to come in because she was being a bit naughty and he told her off (*laughs*) and she was as good as gold!» (58). Others recalled how women apparently did not understand the necessity for cleanliness: «They never had good mothers themselves you see. So of course, they didn't know how to cope» (59). Another recalled her general approach as a relationship but it was clear this was not an equal one: «You've got to have plenty of patience. You've got to know your patients and your patients have got to know you and rely on you and ... do as you ask them» (60). Clearly, it was therefore in dealing with mothers that midwives could reinforce their status. Midwives were often regarded with awe, sometimes feared and although midwives reported good relationships with mothers, there were sharp power divisions between them.

Midwives were proud of their role as the practitioner with responsibility for normal childbirth; from this they gained their self-image. They were defensive of their position as independent practitioners and resentful of what they saw as unnecessary interference by doctors. They protected their place at the side of women and often gained great satisfaction from the misdiagnosis of doctors. One remembered a woman she suspected was having twins and how the doctor failed to notice this until the birth:

«Came the day, she went into labour and one little baby came. I said "The other one won't be quite so big then Doctor, will it?" He was

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(56) Mrs F, Tape 3.

(57) Mrs F, Tape 3.

(58) Miss P, Tape 5.

(59) Mrs Sy, Tape 8.

(60) Mrs F, Tape 3.

really livid with me ... I never liked that doctor. She had twins...He went beetroot red and I never regretted it (*laughs*). Well, I mean, I had suggested to him there might be more than one» (61).

Although this would suggest antagonism between the midwife and the local G.P., midwife's interactions with doctors were more complex than this and much of her professional status was in fact shaped by her dealings with doctors. Some had good relationships with doctors and believed that this was vital for sound practice: «As long as you got a good doctor at the back of you, you're alright» (62). But relationships varied and midwives had better relationships with some doctors than others:

«I used to have Doctor M a lot because he was very good. We had another doctor, Doctor C ... but he was a terror. He would come out and say: "It'll be born. Next time I come it'll be in its cot". Well I'm afraid in another hour, another hour and a half, I had to call him again and we invariably got a stillbirth ... He was stubborn» (63).

Clearly the interaction with doctors was not always easy but it did encourage self-reliance and some assertiveness. This could be very useful for doctors as to work with a competent midwife would mean fewer calls for assistance, particularly at night: «With doctors of my own generation, if we had to send for them in an emergency, it was said well they took their time because they knew the midwife would have dealt with it by the time they got there» (64); «If you worked in an area for a long time ... you could phone them up if you were having a problem and they'd arrange admission to hospital without coming out, on your say so» (65).

Difficulties arose when doctors overruled midwives or would not attend when called out: «He said: "It's my half day. I'm not coming out to anybody"» (66). This evidence suggests that the relationship was not

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(61) Mrs Sy, Tape 8.

(62) Mrs F, Tape 3.

(63) Mrs F, Tape 3.

(64) Mrs S, Tape 4.

(65) Mrs B, Tape 7.

(66) Mrs Sw, Tape 9.

straightforward; doctors were not simply observing midwives or supervising them. The fact that midwives were duty bound to call for medical assistance in some circumstances did not mean that she could be regarded automatically as the doctor's inferior. The relationship between the two professionals was clearly more complex than that, with some level of interdependence. Whilst some report excellent working relationships with local G.P.s, it appears that these relationships were extremely fragile and it might only take one incident for a midwife to lose faith in the ability of all local doctors. Such experiences of practice reinforced in the midwife's mind the need for her to assert herself, both to protect her professional space and, as she saw it, to protect women in childbirth.

#### 4. CONCLUSION

Whilst the midwifery rules tended to reinforce the status of midwifery as inferior to that of doctors, midwives were at the same time, encouraged to work independently, trust their own judgement and develop a sense of professional pride. In reality, the division of professional space between the doctor and the midwife reflected what midwives had been told about the limitations of their role, but at the same time, midwifery knowledge with its experiential element encouraged a sense of professional independence, an awareness of their sphere of influence and consequently a degree of power in the workplace. Midwifery knowledge cannot simply be defined by the information given in training. Whether it be technical, moral or professional, midwives seem to have refined what they had been taught and thereby retained some power in practice. It is this experiential element of midwifery knowledge that further complicates issues of power and status in the workplace.

On the one hand, midwives had a clear vision of the medical structure of the maternity service and their place within it but at the same time, they did not always accept the confines of this structure. They fiercely guarded their position within the service and evidence suggests that both domiciliary and hospital midwives retained a degree of control over their position in the workplace and that they often redefined the formal knowledge taught in training to fit practical experience. In this way, they were able to retain some power at work

whilst formal manifestations of midwifery knowledge (professional regulations, for example) reinforced their inferior status.

Midwifery knowledge has to be seen as a complex entity—comprising of training and experiential elements—not fixed but mutable, both informed and altered by practice. By exploring how midwives viewed themselves and how they interacted with midwifery knowledge, a greater understanding can be obtained of their power and independence in the workplace and, as a result, of their professional status. Midwifery knowledge cannot simply be defined as the technical skills which pupils were taught in training; it was also shaped by a number of other factors. The environment in which practice took place and the midwife's relationships with both the women (and the families) she served and with the doctors, all contributed to her standing as a professional. Practical engagement with midwifery knowledge encouraged professional independence (a theme introduced in a small way during training) especially in the domestic setting but even in the restricted and more rigidly hierarchical environment of the hospital, midwives found ways to assert themselves and maintain their professional independence. It is only by exploring these contradictions at the local and individual level that we can see how crucial midwifery knowledge was to developing a sense of the professional self, whilst providing simultaneously structures which made any improvement in status within the medical profession virtually impossible. Whilst midwifery knowledge was crucial in developing a professional identity through its experiential element, at the same time it reflected and supported existing power structures within medicine; in this way, midwifery knowledge expressed its contradictory nature. As a result, midwifery knowledge enabled intra-professional development by encouraging autonomy in the workplace, whilst at the same time it also helped to maintain important inter-professional distinctions (in particular the difference between the work of the doctor and that of the midwife) which contributed to maintaining the low status of midwives. By examining more closely the individual's experience of their occupational knowledge, historians can better explore the complex dimensions to professionalisation, especially in those professions which are gendered.