

Midwifery Matters: Finding Sources to Shed Light Upon the 1915 Midwives (Scotland) Act

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Before the 1915 Midwives (Scotland) Act, uncertified midwives or howdies commonly attended childbearing women in Scotland. While a similar Act in England and Wales was passed in 1902, Scotland, apparently, did not require such legislation. This paper demonstrates the use of archival sources and of oral history as methodologies to provide answers to questions relating to the Act and after its implementation. The Act officially gave midwives a legal identity and status as autonomous practitioners. However, its provisions affected this autonomy until the later decades of the twentieth century.

This paper examines the establishment and impact of a significant milestone for midwives in Scotland: the 1915 Midwives (Scotland) Act.¹ Passed after years of controversy, the Act, implemented on 1 January 1916, allowed for the statutory regulation, organisation and education of midwives. A Midwives Act had been secured for England and Wales 13 years earlier, in 1902. There are questions regarding the difference between the dates of the two Midwives Acts: what caused this discrepancy? Why was the Scottish Act passed when it was? And, how did midwifery change in the years following the Act?

The Acts were important for public health as a whole. They drew together the focus of late-nineteenth-century campaigning to create a defined profession of midwifery. In so doing, certified midwives had the opportunity, legally, to play their part in improving the health of childbearing women, their babies and, in the longer term, the public health of the people of the United Kingdom.

The history of midwives and their practice in England and Wales, the United States and Europe has attracted attention from historians.² However, until the

¹ *Midwives (Scotland) Act*, 1915 (5 & 6 Geo.5 c.91).

² Examples include: J. Donegan, *Women and Men Midwives* (Connecticut, 1978); J. Donnison, *Midwives and Medical Men* (New Barnet, 1988); E. Fox, 'An Honourable Calling or a Despised Occupation: Licensed Midwifery and its Relationship to District Nursing in England and Wales before 1948', *Social History of Medicine*, 6 (1993), 237–59; E. Fox, 'Powers of Life and Death: Aspects of Maternal Welfare in England and Wales Between the Wars', *Medical History*, 35 (1991), 328–52; J. Lewis, *The Politics of Motherhood: Child and Maternal Welfare in England, 1900–1939* (London, 1980); A. Oakley, *The Captured Womb* (Oxford, 1984); M. Reid, 'Apprenticeship into Midwifery: An American Example', *Midwifery*, 2 (1986), 126–34; J. Relyea, 'The Rebirth of Midwifery in Canada: An Historical Perspective', *Midwifery*, 8

late 1900s, very little was written from, or including, a Scottish perspective.³ It is evident that midwifery history texts purporting to inform about 'Britain' neither included Scotland nor acknowledged the differing legislative dates. To illuminate the Scottish situation, this paper draws upon both written archival sources and oral history interviews to reveal details of what retired midwives remembered about their practice. Oral history proved to be a valuable asset in researching midwifery history. With this in mind, aspects of the methodology of oral history from a personal point of view are included towards the end of the paper. Combining archival and oral history makes it possible to set midwifery, as practised by midwives, alongside the ideals of the *Rules* and mores of the new, post-Act Central Midwives Board.

Before the Act, Scotland's long-ago midwives, or howdies, practised by instinct, using customs, folklore and old habits, and were 'unqualified' as understood today. There was nothing to prevent any woman from practising midwifery; as one old howdie said, 'There wis nae midwife. They ca'ed ye the howdie.'⁴ They learned their craft by observing other howdies or local medical men. Later, in the nineteenth century, some could obtain a hospital certificate, but they were still not state-regulated. Howdies built up a clientele by word of mouth, by taking over from someone, or by recommendation. By the beginning of the twentieth century, approximately 95 per cent of women gave birth at home with a howdie in attendance.

Some were very skilful and kind, but not all were so able. They were accused of being too ignorant to recognise the signs of danger, too late in seeking medical assistance and too impatient. Not all historians agree; Irvine Loudon and Hilary Marland, while acknowledging variations in the ability of uncertified midwives in the late nineteenth century, write favourably about them.⁵

(1992), 159–69; S. Robinson, 'Maintaining the Independence of the Midwifery Profession: A Continuing Struggle', in (ed.) J. Garcia, R. Kilpatrick and M. Richards, *The Politics of Maternity Care* (Oxford, 1990), 61–91; B. K. Rothman, 'Childbirth Management and Medical Monopoly: Midwifery as (almost) a Profession', *Journal of Nurse-Midwifery*, 29, no. 5 (1984), 300–6; M. Tew, *Safer Childbirth? A Critical History of Maternity Care*, 2nd edn (London, 1995); M. Tew and S. Damstra-Wijmenga, 'Safest Birth Attendants: Recent Dutch Evidence', *Midwifery*, 7 (1991), 55–63; J. Towler and J. Bramall, *Midwives in History and Society* (London, 1986); A. S. Williams, *Women and Childbirth in the Twentieth Century* (Stroud, 1997).

³ H. L. Diack, 'Women, Health and Charity: Women in the Poor Relief Systems in Eighteenth-Century Scotland and France' (unpublished PhD thesis, University of Aberdeen, 1999); D. A. Dow, *The Rottenrow: The History of the Glasgow Royal Maternity Hospital 1834–1984* (Carnforth, 1984); V. Fleming, 'Autonomous or Automaton? An Exploration Through History of the Concept of Autonomy in Midwifery in Scotland and New Zealand', *Nursing Ethics*, 5, no. 1 (1998), 43–51.

⁴ L. Reid (hereafter cited as LR), 101, from oral testimonies collected between 1997 and 2002. This archive is held at North Lethans, Fife.

⁵ I. Loudon, *Death in Childbirth* (Oxford, 1992); (ed.) H. Marland and A. M. Rafferty, *Midwives, Society and Childbirth* (London, 1997).

Up until the passing of the Act, any woman in Scotland could call herself, and practise as, a midwife. From 1 January 1917 no woman, unless certified under the Act, could either call herself a midwife or imply that she was certified. From 1 January 1922, a five-year period of grace, no uncertified woman could practise midwifery ‘habitually and for gain’ unless under the direction of a registered medical practitioner. Yet howdies, an important part of the birthing scene up to this time, remained in pockets in Scotland until long after the Act.

Before legislation anywhere in the UK, the status of howdies suffered. No real training or regulation meant no solidarity. They lacked clout: they were women with little hope alongside up-and-coming medical men. In Scotland, medical students, as well as being taught medicine and surgery, took a midwifery course.⁶ Medical men frequently attended normal births from the mid-eighteenth century, further eroding howdies’ practice. The howdies were blamed for so-called ‘obstetrical disasters’; they needed training, their activities controlled.⁷

In 1726, Edinburgh Town Council appointed Joseph Gibson as Professor of Midwifery. He was the first to hold this appointment in the UK and also the first to establish formal lectures for midwives. He was well known for his efforts to promote midwifery and had in 1723 advertised ‘An Account of what Mr Gibson proposes to do in a Course of MIDWIFERY’, adding that he ‘may be spoke with [*sic*] at his house in Leith’.⁸ Other courses followed in Glasgow, Aberdeen and Dundee. But, still, any woman could practise midwifery.⁹

At the end of the nineteenth century, UK mortality rates remained high. Maternal and child health was poor, the birth rate was falling, and there was fear of population decline. In addition, much of the population was ill-nourished, with many young men considered unfit to fight in the Boer War. These issues combined to take this public health problem into the political arena. A key factor was pregnant women and their babies: they were the future. Also considered key were midwives, who had a significant impact upon birthing and postnatal practices, and influence on mothers.

Various Midwives Bills emerged, promising restrictions on midwifery practice. Objections to these came from the women’s movement, from some midwives and from the nursing sisterhood, who were also striving to achieve professional regulation and who invited midwives to join them. The midwives declined, and the nursing press called midwives ‘obsolete’.¹⁰ After twenty years of effort, the 1902 Midwives Act was passed for midwives in England and Wales – a major landmark. It restricted midwives’ practice: the new Central

⁶ M. Dupree and A. Crowther, ‘A Profile of the Medical Profession in Scotland in the Early Twentieth Century: The Medical Directory as a Historical Source’, *Bulletin of the History of Medicine*, 65, no. 2 (1991), 209–33, at 220.

⁷ L. Reid, *Midwifery in Scotland: A History* (Erskine, 2011), 10.

⁸ Blairadam Archives, *Colville Papers*, CC, 9/26 (1723).

⁹ Reid, *Midwifery in Scotland*, 13.

¹⁰ *Ibid.*, 16.

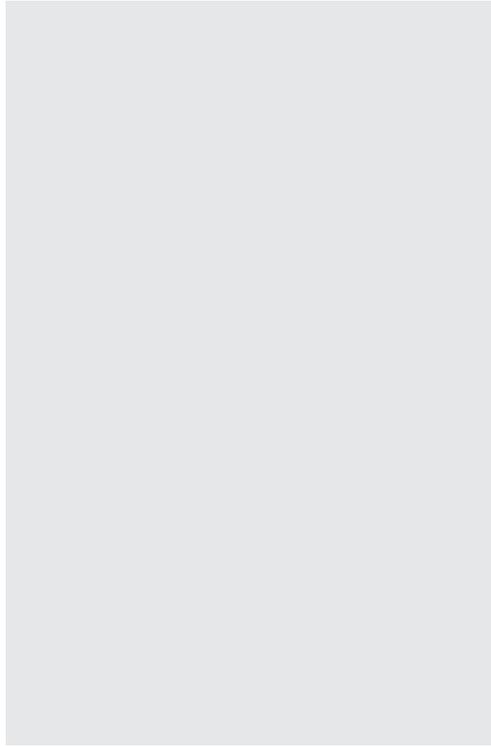


Plate 1 Howdie Elizabeth Sanderson (d.1907).

Midwives Board for England and Wales was medically dominated with punitive *Rules* and practice-limiting policies.

In Scotland, whatever was happening south of the border, howdies remained at nearly all births. Some, such as the Shetlander, Betty Balfour, known as ‘Aald Mam o Houbanster’, practised in very difficult circumstances. It is said that one day she was attending a labouring woman on the isle of Muckle Rôe. Jeemie, her blacksmith fisherman husband, had rowed her there from the mainland. Prolonged labour endangered the lives of mother and baby. Betty consulted Jeemie, and demonstrated what she required: forceps. Armed with a pair of these fashioned by her husband, she saved both mother and baby and was apparently the first in the area to use forceps. She died at Houbanster, aged 86, in 1918.¹¹

Howdies also included Elizabeth Sanderson (Plate 1), who was widowed in 1891, dependent on poor relief, and lived with her six young children in

¹¹ Ibid., 9.

damp, inadequate housing. With no formal training, she probably turned to midwifery to earn a living. Her daughter, Elizabeth Hutchison, recalled that:

From the confinements, she would bring home sheets for the laundering which she did at night. [I remember] as a child often joining [my] mother ... in the wash-house to keep her company while she worked ... It was always cold there ... she was asthmatic and [I believe that] it was these cold, damp conditions that contributed to her death at a relatively early age.

Elizabeth Sanderson died aged 52, on 2 March 1907, of acute bronchopneumonia after five days' illness.¹² She was not the only howdie who took home the washing.

The early legislative proposals for a Midwives Bill did not extend to Scotland due to resistance in the House of Commons. This reflected similar feelings among obstetricians and general practitioners (GPs) in Scotland, one of whom said at a meeting of the Edinburgh Obstetrical Society: 'Registration of midwives in Scotland was *not* needed: midwives could die a natural death.'¹³ Members of Parliament agreed that applying the English and Welsh legislation to Scotland would require too many amendments; it would be too difficult because of the countries' differing legal systems; and, one MP said, 'these things are managed better in Scotland'.¹⁴

With such opposition, it is surprising that midwifery legislation in Scotland was implemented at all. However, a challenge came from the Scottish Medical Officers of Health (MOHs), who argued that these things were *not* done better in Scotland, and campaigned for midwifery legislation. Central to their argument was Scotland's high mortality rate, caused largely by acute poverty. Dr A. K. Chalmers (1898–1925), MOH for Glasgow, also appeared to blame poor midwifery practice. However, he was possibly exaggerating this to press his case, as other cross-UK contemporary and recent studies are contrary to Chalmers' data and views. Another reason for the MOHs' challenge was that an administrative basis for midwifery legislation, which had supposedly been lacking in Scotland, was now in place. New Schemes of Maternity and Child Welfare emerged in Scotland in the early 1900s, resulting in other related Acts: the 1907 Notification of Births Act; the 1908 Children Act; the 1908 Education (Scotland) Act; and the 1915 Notification of Births (Extension) Act. These Schemes cemented the power of the Scottish local authorities. Any objection to a Midwives Act for Scotland was now invalid, and thus, the Midwives (Scotland) Act became part of the Schemes. Finally, the outbreak of the First World War in 1914 signalled the departure of many doctors for the

¹² Ibid., 18 (acknowledgements to Dr Iain Hutchison).

¹³ 'Should Midwives be Registered in Scotland?', *Transactions of the Edinburgh Obstetrical Society*, 20 (1894–95), 167.

¹⁴ Dow, *Rottenrow*, 151; Reid, *Midwifery in Scotland*, 30; 'Should Midwives be Registered in Scotland?', 167.

front, leaving pregnant and labouring women in Scotland to be attended by howdies.¹⁵

Initial reading on the Act in Jacqueline Jenkinson's *Scottish Medical Societies 1731–1939*¹⁶ set me on a course towards even more revealing commentary in Hansard, straight from the mouths of the MPs. The first Midwives (Scotland) Bills were proposed before the First World War, in 1912, but failed to pass into law. By February 1914, opinion in Scotland was all for legislation, but parliamentary attention was diverted later that year by the onset of war. A Commons skirmish concerning a Scottish Bill taking precedence over English measures, especially in wartime, raised hackles. This situation was smoothed over by the Marquess of Crewe, who intervened and highlighted the relevance of the Bill to the circumstances pertaining during war. On 19 August 1915, an influential medical and educational group lobbied the Secretary for Scotland and the Lord President of the Privy Council with a *Memorial Anent a Midwives Bill for Scotland*, making an urgent case for a Midwives Act for Scotland, particularly in wartime.¹⁷

The Midwives (Scotland) Bill received the Royal Assent on 23 December 1915 and was implemented on 1 January 1916. However, this speedy enactment of the Bill was due primarily to the wartime shortage of doctors in Scotland and not because of the need for recognition of midwifery as a profession in Scotland.

The implementation of the 1915 Midwives (Scotland) Act enabled the formation of a Central Midwives Board for Scotland (CMB), which existed until 1983. Midwives in Scotland were now recognised as a group with a legal identity. They could practise lawfully and, in theory, autonomously.

The key component of the written archival source material for this research was the collection of documents of the CMB. Examination of the minutes and some reports of the CMB over the period of its existence from 1916 to 1983 in the National Records of Scotland made it possible for me to note the changes in the formal framework within which midwives trained and practised. Other annual reports are held in the National Library of Scotland, while other CMB documents are currently housed at the Royal College of Midwives (RCM) Scotland.¹⁸

¹⁵ Reid, *Midwifery in Scotland*, 35.

¹⁶ J. Jenkinson, *Scottish Medical Societies, 1731–1939* (Edinburgh, 1993).

¹⁷ National Records of Scotland (hereafter NRS) CMB 4/2/6 *Memorial of the Medical Faculties of the Universities, The Royal Medical Corporations, and the Medical Officers of the Maternity Hospitals in Scotland to The Right Honourable H. M. Secretary for Scotland and the Right Honourable The Lord President of H. M. Privy Council Anent a Midwives Bill for Scotland*, 19 August 1915.

¹⁸ NRS, CMB 1/1–9 Central Midwives Board (hereafter CMB) Minutes of Meetings 16 February 1916 – 30 June 1983. CMB Annual Reports: NRS, CMB 2/1–3, 1917–1923; NRS, CMB 2/10–14, 1925–1930; National Library of Scotland, GH6, 1931–1935; Royal College of Midwives (hereafter RCM) Scotland, 1967–1983.

I supplemented these by consulting official parliamentary reports (Hansard), in the University of Glasgow Library. Also, from the ‘stacks’ of that library, I found Dr W. L. MacKenzie’s *Report on the Physical Welfare of Mothers and Children* to be relevant. Although published after the Midwives (Scotland) Act, this report was discussed in 1916 and contains much pertinent information on the issues regarding the health of the women and children of Scotland in the early twentieth century. In his Introductory Letter, MacKenzie demonstrates his vision to see medicine as an instrument for social change when he writes, ‘they [the Carnegie United Kingdom Trustees] have induced me to break the limits of official convention and to show, however imperfectly, the intricate play of the social forces that determine whether an individual child shall live or die’.¹⁹

I was led to MacKenzie’s work through reading Thomas Ferguson’s classic text, *Scottish Social Welfare*, which contains other material relevant to the background to the Midwives (Scotland) Act.²⁰ For example, Ferguson quotes one old woman in Shetland who had eleven children:

I never had a doctor. The wife who came to me from Unst used to bring a testament and a razor with her. The razor she placed under my pillow for luck, and she used to read a chapter out of the testament now and then to keep up my spirits.²¹

I consulted many more texts from varied sources; one book or reference led to another. Extensive reading, even if initially irrelevant, added to the depth of the picture surrounding the contemporary midwifery and public-health scene. One particular text which shouts its usage by the number of markers remaining within the pages of my personal copy is Irvine Loudon’s *Death in Childbirth*.²² Loudon gives an international perspective, compares maternal death rates, examines possible reasons why, acknowledges strain between doctors and midwives, and highlights at times problems in practice. From the international to the Scottish, McLachlan’s *Improving the Common Weal*, was also particularly useful.²³ Different writers giving a broad contemporary picture of the health of the people of Scotland sent me on a trail to find further sources.

Under the Act, the CMB in Scotland was established to oversee a new professional group: legal practitioners of normal midwifery. This was a necessary step forward, yet the CMB, like its counterpart in England and Wales, introduced restrictive and punitive *Rules*. Thus, in practice, the provisions of the Act impeded midwives’ autonomy. As a researcher, it was important for me to find and read the *Rules* of the CMB to see how they chimed with the

¹⁹ W. L. MacKenzie, *Report on the Physical Welfare of Mothers and Children*, III (Dunfermline, 1917), Introductory Letter, xii.

²⁰ T. Ferguson, *Scottish Social Welfare, 1864–1914* (Edinburgh, 1958).

²¹ Ferguson, *Scottish Social Welfare*, 511.

²² Loudon, *Death in Childbirth*.

²³ (ed.) G. McLachlan, *Improving the Common Weal, Aspects of Scottish Health Services, 1900–1984* (Edinburgh, 1987).

minutes of CMB discussions, how they were translated into what midwives were allowed to do, and how they progressed or changed through the years. Every certified midwife had a copy of the *Rules* and was expected to adhere to them.²⁴ In the eyes of Board members, the *Rules* were created for good reason: many women who became certified midwives from 1916 onwards were howdies, often possessing little or no formal education, and this made the Board nervous. A. K. Chalmers, MOH for Glasgow, wrote:

Many of those [midwives and handywomen] who were interviewed, [in Cowcaddens in 1906] carried whatever equipment they might require, such as syringes and catheters and ... disinfectants as ... necessary, in the pocket of their dress, and many who had a bag, misused some of the material they carried in them ... 59 carried a Higginson's syringe, but 22 admitted using it impartially for douching or for administering enemeta, frequently for the same patient and always without any effort to disinfect the nozzle save by external rubbing. Twenty two also carried no thermometer ... one had a thermometer with whose use she was unacquainted, and some did not recognise a thermometer when shown it.²⁵

So, the Board was right to be anxious. Part D of the *Rules* pertained to enrolling women in practice when the Act was passed.²⁶ A few possessed training certificates from CMB-approved UK institutions;²⁷ registration, now the law, was for them a formality. Howdies who had been in bona fide but uncertificated practice for at least a year could similarly be registered, provided they were 'trustworthy, sober and of good moral character'. They could also, if they wished, sit the CMB examination.²⁸ The Board justified enrolling howdies as 'it would have been very unfair to have suddenly deprived of their livelihood a body of women who have been rendering useful service to the community'.²⁹ However, at the time, the *Rules* hindered the professional development of midwives. The medically dominated CMB, along with the Schemes of Maternity and Child Welfare, local authorities and MOHs, held power when organising maternity care in Scotland.

Throughout the period from 1915 to 1983, the identity and autonomy of midwives remained subject to negotiation and change, both in terms of management and practice. Reading the CMB minutes revealed that much of the reasoning for this lies with the Act, its Constitution, the newly formed

²⁴ NRS, CMB 4/1-5, Central Midwives Board for Scotland, Schedule, *Rules framed under Section 5 (1) of the Midwives (Scotland) Act, 1915* (5 and 6 Geo. V. c.91), 17 April 1916 and 26 August 1916; CMB *Rules* from 1918 to 1980 are currently held at RCM Scotland.

²⁵ A. K. Chalmers, *The Health of Glasgow 1818-1925* (Glasgow, 1930), 262.

²⁶ NRS, CMB 4/2/10, CMB *Rules*, 6.

²⁷ *Ibid.*, 7.

²⁸ NRS, CMB 4/2/10, CMB *Rules*, 7; NRS, CMB 4/2/17, J. Halliday Croom, *The Midwives (Scotland) Act: Its Object and Method*. Read before the Maternity and Child Welfare Conference, Glasgow (March 1917), 2, 3.

²⁹ NRS, CMB 1/2, CMB *Minutes*, 1 (28 September 1916).

CMB, the *Rules* and the attitude of some of its members towards midwives. For instance, the Act decreed that the CMB should have two midwives on the Board. That is, two midwives out of twelve members. Even as late as 1951, when midwife CMB member numbers were approaching the halfway point, the Chairman, Professor R. W. Johnstone, felt that: 'It seemed unnecessary, and indeed, inadvisable to give them [midwives] 50 per cent of the total seats.' This would have removed the medical majority vote which had been enjoyed thus far. Also, Professor Johnstone's remark, using 'them' to mean midwives, seems to demonstrate his lack of regard for his midwife colleagues. Progress of professional recognition and ability was slow; only in 1977 was a midwife installed as the first midwife Chairman in her own Board.³⁰

An important remit of the CMB was the training and education of midwives. This included approving training institutions, deciding on the curriculum, setting examinations, and deciding on who should teach, examine and agree competence. Those who taught pupil midwives were, initially, lecturers and teachers: lecturers were medical practitioners with sufficient experience and expertise to be approved by the Board; teachers were experienced midwives approved by the Board. There was no formal training course for midwives who wanted to teach until the late 1930s, when the CMB started to establish a course leading to the Midwife Teachers' Diploma.³¹

Gradually, the curriculum expanded. Antenatal care, included eventually along with intra- and post-partum care, brought its own archival sources. One in particular was personal to each pupil midwife and revealed interesting data regarding antenatal care. From 1928, the CMB required pupils to present a case book, the 'Blue Book', at their final examination. Each contained a record of the maternity history of twenty women for whom a pupil had cared during labour, birth and postnatally.³² Most Blue Books showed records of ten home and ten hospital births.

Examination of six pupil midwives' Blue Books illuminated their care of 124 women from 1939 to 1947. The information contained in this small, random, urban sample supports that of oral testimonies and other sources. These suggest that antenatal care across Scotland in the early days was sporadic and irregular as midwives in some areas had little input, while some mothers were poor attenders and did not see the importance of clinics. One midwife acknowledged that 'There was very little antenatal care ... [Most] mothers didn't go to the clinics.'³³ The same midwife recalled that maternal records were not shared, even between professionals – she learned from the mother how she had fared at the municipal clinic. When in labour, the attending

³⁰ Reid, *Midwifery in Scotland*, 47.

³¹ CMB *Rules*, 1940, 20.

³² CMB *Rules*, 1928, 10. I am indebted to the individual midwives who allowed their Blue Books to be used for this research. There is no formal archive.

³³ LR 44.

midwife often had no knowledge of the mother's previous history, and lack of professional history-sharing added to the level of risk to birth outcome.

Oral testimony has considerable potential for investigating the history of midwives. Now an accepted form of historical research, oral history is used to obtain information where little documented evidence exists or where the documented evidence is one-sided or suspect. It also revises history by challenging an accepted, usually written, view of an issue. The written archival sources that I consulted omitted details of midwifery practice and the careers of midwives. From its inception, the CMB was very involved in educating, improving and supervising practice, and this is reflected in its minute books. What these cannot show, and what added significantly to my research, are the personal views of midwives long past their practising days, but full of memories. It seemed appropriate for me to use oral history interviews to examine the work and career histories of midwives in Scotland in the comparatively recent past. Exploration of the background to, and methodology of, oral history was the recommended way to begin. This involved further research and reading, relevant research courses, study days, seminars and discussions.³⁴

Between 1997 and 2002, I conducted a series of 45 semi-structured interviews with midwives who practised in Scotland during the period of the CMB. They provided me with information about continuities and changes in practice, the extent to which they followed the formal *Rules* of the CMB, and their relationships with other professionals, fellow midwives and women in their care. These vibrant testimonies highlighted from *their* point of view what it was like to be a midwife in Scotland in the early and middle decades of the twentieth century. They described something that the minutes did not: what midwifery was like on the ground. A wide selection of interviewees from Shetland to the Borders revealed how midwives practised, including the swift decisions they were obliged to make; the miles they walked; the transport they used, ranging from bicycles and boats, buses and trams to municipal limousines and hanging on to the end of a scaffie-lorry; the births they attended, from those in grand houses to tinkers' tents and makeshift squats; the 'dunnies' below ground and the tenement stairs they climbed with quantities of bags and equipment, just in time to attend the birth of a baby in a hurry.³⁵ The research

³⁴ Examples include: P. Thompson, *The Voice of the Past*, 2nd edn (Oxford, 1988); (ed.) R. Perks and A. Thomson, *The Oral History Reader* (London, 1998); W. Storrar, *Scottish Identity: A Christian Vision* (Edinburgh, 1990); N. Leap and B. Hunter, *The Midwife's Tale: An Oral History from Handwoman to Professional Midwife* (London, 1993); P. Summerfield, *Reconstructing Women's Wartime Lives* (Manchester, 1998); (ed.) E. Breitenbach and E. Gordon, *Out of Bounds: Women in Scottish Society 1800–1945* (Edinburgh, 1992); Oral History Course held by the Wellcome Trust, Oxford, 18–22 October 1999; Oral History Day held in Glasgow, 22 January 1999; workshop on 'Narrative and Memory in the History of Health, Medicine and Illness' held in Glasgow, 28 April 2001; Scottish Oral History Group conferences and workshops.

³⁵ L. Reid, *Scottish Midwives: Twentieth Century Voices* (Dunfermline, 2008).

necessarily focuses on female midwives. Until the 1975 Sex Discrimination Act, midwifery was one of the professions where discrimination on the grounds of gender was permitted. However, one of my interviewees was the first male Scot to undertake midwifery training in Scotland and he provided a sensitive insight into present-day male midwifery.³⁶

It turned out that three of the midwives whom I interviewed had been members of the CMB, and were therefore able to give a personal and particularly useful insight into working with the Board. Being a midwife on the CMB, which was dominated by non-midwives, was not easy. For instance, Margaret Kitson commented:

When I joined the CMB I was considered to be very young and inexperienced – there were a lot of rather patronising attitudes amongst the people who had been on the Board for a long time. It was necessary to begin with, just to sit down and be quiet and listen. It was very medically dominated. I was elected by the midwives [in 1973] ... I felt then I had a great responsibility to speak for the midwives but it was really very difficult ... There was a very definite, ‘we know best’. There wasn’t encouragement to speak up and only gradually did that atmosphere change ... and it became more possible for people to express their views.³⁷

The Act stated that a howdie would be practising illegally should she act as a certified midwife in Scotland outwith the five years of grace granted in the terms of the Act (see above). However, oral evidence shows that howdies were in practice, frequently without active GP supervision, in parts of Scotland until the 1950s. Many GPs connived with them and were said to be supervising, but it was amazing how many babies were born with only the howdie in attendance, even after legislation.³⁸

Some howdies not only avoided being enrolled, but started practice decades after the Act. This was controversial; it was illegal and in competition with the certified midwives. One midwife said:

In an area in Central Scotland [in the 1940s], there was [a howdie]. ... she was very loath to give up ... she was in the outskirts of town ... and she was the one who would deliver the babies. Some of [the certified midwives] had battles with her. She would say [to the mother], ‘Oh you’ve time enough to send for the midwife,’ and then she would be able to get the baby.³⁹

Pupil midwives recalled attending home births on their own because the midwife supposed to accompany them was late – this was certainly not in the CMB *Rule* book policy. Alice Porter, a pupil midwife in Aberdeen during the Second World War, told me of attending a mother in a deserted, bombed-out house in George Street with no one else there but an old woman who sat at the

³⁶ LR 17; Reid, *Scottish Midwives*, 137–45.

³⁷ LR 41.

³⁸ Reid, *Midwifery in Scotland*, 24.

³⁹ *Ibid.*, 22.

empty fireside, smoking a clay cuttie and spitting into the grate. There was no water. Alice said:

I couldn't leave the lassie. A policeman knew I was there and I asked him to return soon. I disinfected my hands with Dettol before I examined the woman. My chair had a rim but no seat ... Just before the baby was born the sirens sounded. The blast blew out the sacking covering the windows, soot blew into the room from the roofs. There I delivered the baby. The policeman arrived with an ambulance, I carried the new baby down the broken stairway and mother and child were transported to hospital.⁴⁰

Along with learning about oral history and how to interview, I had to recruit interviewees. Contact letters to Scottish newspapers and journals appealing for information elicited a huge response, by letter and telephone, mostly from midwives and relatives of deceased midwives in Scotland. There was the practice of 'snowballing' – one retired midwife would introduce another. This could result in a lively double act. A direct invitation to be interviewed by telephone or letter, through a contact or at conferences, seminars and workshops, also brought favourable responses.

Given that the Act was passed in 1915 and I began my research in 1997, the chance of interviewing a midwife contemporary with the Act was unlikely. The oldest certified midwife was 96 when I visited her, and had qualified as a midwife in Edinburgh in 1928.⁴¹ The gap of twelve years between 1916 and 1928 is partly closed by information from the relatives of deceased midwives. Two of the midwives were uncertified, or howdies, and because of their scarcity at the date of interview, their testimonies are of particular interest. The interviewees with one exception were women, chosen to cover as wide a range as possible chronologically, in different types of practice, and geographically within Scotland.

A notable feature about most of the interviewees was their pleasure and satisfaction in their work. Nevertheless, there were a few who demonstrated the opposite. One South African who trained as a midwife in Glasgow in 1934 acknowledged that her training was 'very interesting' but refused a post in midwifery as she 'hadn't enjoyed doing midwifery and ... didn't really want to carry on'.⁴² One midwife volunteered to be interviewed because of her disquiet with her midwifery training in the mid-1970s, her distress at what routine medicalised maternity care was doing to women in that particular maternity hospital at the time, and her desire to enlighten others of the situation.⁴³ She also found it helpful to read and reread the edited transcript of her testimony. This therapeutic use of transcripts appears to be unusual, although scholars

⁴⁰ Ibid., 101; a clay cuttie is a short white clay tobacco pipe.

⁴¹ LR 19.

⁴² LR 22.

⁴³ LR 20; Reid, *Scottish Midwives*, 126.

have acknowledged the psychological aspects of the interview itself.⁴⁴ Thus, interviewees can use the interview situation as a means of making a point. However, I found that most respondents just wanted to help. As the history of midwifery in Scotland had not previously been recorded to any great extent, some saw their participation as worthwhile and used phrases such as ‘Anything to help the cause.’

There were many other aspects of using oral history which I had to take into account. One was the type of interview carried out. Was this a life history, a ‘single issue’ interview, or a specific history which might include a career history? The ideal of conducting more than one interview with each participant was not usually feasible for this project, because of time constraints involving distances and travelling, transcribing, and analysis of transcripts. Yet I occasionally asked for more than one interview. I spoke to one midwife without recording her and returned to her two years later with the tape recorder. This worked well, highlighting the benefit of a ‘warm-up’ session. On two occasions the recording equipment failed; in each case a second interview went well. Another elderly interviewee on the Isle of Harris had an initial, informal visit before two recording sessions, the second of which was noticeably more relaxed than the first, confirming the benefit of multiple visits. However, I obtained a considerable amount of information from the single interviews. Many people enjoyed telling their story; also, they and their story were the centre of attention. One retired midwife in her 80s said, ‘you know, this is a very exciting day for me’.⁴⁵ This was a reminder for me. While the interviewee was giving something to the interviewer, she was also gaining: company; possibly a feeling of importance; and the chance to talk to someone who understands what she has done and to discuss the ‘old days’.

I attempted to carry out the interviews in the place where the interviewee, often quite elderly, would feel most at ease. This was usually her own home, or in the case of someone being cared for, where she usually spent her time, whether it was her bedroom or sitting room.⁴⁶ Here, she had the safety of being in her own surroundings. Also, in these circumstances, the interviewee is the hostess, feels in charge and usually derives pleasure from being in this situation and dispensing hospitality. Some practising midwives chose their office for the interview, and one interview was held in a conference centre after the meeting had dispersed.

In most instances, it is best to be alone with the respondent; complete privacy encourages an atmosphere of trust which engenders openness. However, occasionally the interviewee arranged for another midwife to be present. Interviewees prompted each other as they talked of past midwifery memories which, for this purpose, enhanced rather than detracted from the

⁴⁴ Thompson, ‘Memory and the Self’, in *Voice of the Past*, 152–65.

⁴⁵ LR 27.

⁴⁶ Thompson, *Voice of the Past*, 205.

value of the interview. Another time, the ‘main’ interviewee was very articulate while the other was quieter, but as the latter adjusted to the situation she had a very interesting tale to tell. On another occasion, the interviewee’s elderly sister remained present throughout, which was helpful for checking facts, and did not appear to intimidate the interviewee. Finally, the recording of a discussion of a group of retired midwives around a kitchen table, although difficult for me to transcribe, proved to be a highly useful way to gather a large amount of information.⁴⁷

This paper has demonstrated how written archival sources and oral testimonies may be used in combination to reveal some aspects of the history of midwifery in Scotland. The research conducted through these two methods has shown how the 1915 Midwives (Scotland) Act acted as a catalyst to further the professionalisation of midwives. Simultaneously, implementation of the Act attempted, with varying results, to advance and improve midwives’ *raison d’être* while enhancing the level of midwifery care offered to childbearing women. Through time, midwifery in Scotland changed from being alegal,⁴⁸ unlicensed and unregulated to a legal, respected profession with women at the heart.

⁴⁷ Ibid., 205–6.

⁴⁸ ‘Alegal’ is a term used to describe unregulated midwifery in New Brunswick before 1985, and means ‘without regulation’: see Relyea, ‘The Rebirth of Midwifery in Canada’.