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An Address on the Working of the Midwives Act (England, 1902) delivered before the Obstetrical and Gynæcological Society, of Glasgow.

By SIR FRANCIS HENRY CHAMPNEYS, Bart., M.D., F.R.C.P.,
*Honorary President of the Society; Chairman of the Central
Midwives Board.*

(On Wednesday, April 22, 1914.)

LADIES AND GENTLEMEN,

In accordance with custom I am here to give, as your Honorary President, a discourse of some kind; and, in accordance with a suggestion from a leading member of your body, to talk to you to-night of the working of the Midwives Act in England.

The subject is a large one, and I would not consent to embark upon it did I not feel that I owe you something in return for the distinguished honour which you have done me.

No one except those who have actually done it can imagine the labour of setting in action the machinery expressed in a new Act of Parliament. Doing any new thing is laborious, but this has special difficulties of its own. Some of these will become apparent on consideration of the processes through which a Bill passes on its road to becoming an Act.

It is, in the first place, drafted by a person of more or less skill.

In the first alternative possibilities of misreading and misunderstanding are reduced to a minimum. In this stage careful study will probably enable an intelligent person to realise in his imagination more or less completely the picture which existed in the mind of the draftsman.

In the second alternative possibilities of misreading and misunderstanding are not anticipated, and the result is a picture which is blurred and which is capable of misreading and misunderstanding, to the detriment of the public and to the advantage of lawyers.

I remember an amusing experience of my own in illustration of this:—

Two distinguished gentlemen were dining with me, and, after the departure of the ladies, found themselves on either side of me.

There had been a discussion in the Courts on the meaning of an Act, and one of my guests whom I will call A. remarked on the difficulty which had arisen, and on the obscurity of the Act. I (seeing difficulties ahead) said, "You can ask B. for I believe he drew it."

"Do you draft these Bills?" said A.

"I do," said B.

"Why do you make them so obscure?" said A.

"I make them as intelligible as is desirable," said B.

Well, to resume.

When the Bill is presented to a Committee of its promoters it is "amended"—as it is called. It may be improved, but is most likely to have its unity impaired; and, as this process goes on at every stage during its passage through Parliament, the picture is often so far distorted that those to whom it falls to set the Act in operation have to reconstruct the picture before they can do so; and this process of reconstruction is apt to be very difficult.

I hope therefore that those who eventually obtain a Bill for Scotland will have a kindly thought for those who have done their best to bring the Act into useful operation for England and Wales, and especially for my colleagues on the Central Midwives Board who have framed a code of Rules in accordance with the Act, which has required very little revision since its first appearance, and is now of great value and utility.

Any help which I can give towards a Bill for Scotland will be willingly given.

WHAT GOOD HAS THE MIDWIVES ACT DONE?

The answer to this question in the main lies in the statistics of the Registrar-General.

It will be remembered that the appalling statistics of Matthews Duncan remained very little improved until the last few years.

In order to show the alteration which set in on the passing of the Midwives Act I will quote from a statement by myself reported in the proceedings of the Royal Society of Medicine (vol. iii, No. 9, July 1910, pp. 231-2):—

"From Table A giving the annual death-rates from puerperal sepsis per million of females living, it would be seen that the death-rate in 1902 was 118, and in 1907 it was 81. The census of 1901 showed that in England and Wales there were 16,800,000 women. The saving of life in 1907, as compared with 1902, was 37 per million. In other words, the lives of more than 621 women were saved in 1907 which would have been lost in 1902. Table B calculated in the proportion of 1,000 births, showed the same thing, and these results were graphically set forth in diagrams A and B. Diagram C, showing the death-rates from puerperal

sepsis and accidents of childbirth to 1,000 births, shows that this rate prior to 1903 was never below 4·41; in 1907 it was 3·83. Striking evidence was given before the Departmental Committee to the same effect. As regards infantile mortality, Dr. Robinson, of Rotherham, stated that while the death-rate in cases attended by midwives was 101 per 1,000 in 1907, the death-rate in cases not attended by midwives was 194; in 1908 the mortality in midwives' cases was 92, in non-midwives' cases 195."

I have been favoured by Dr. Stevenson, of the General Register Office, Somerset House, with a continuation of the figures up to and including 1911, and now give the calculation up to that date which is arrived at by substituting the results of 1911 for those of 1907:—

"From Table A giving the annual death-rates from puerperal sepsis per million of females living, it would be seen that the death-rate in 1902 was 118, and in 1911 it was 72. The census of 1911 showed that in England and Wales there were 18,672,986 women. The saving of life in 1911, as compared with 1902, was 46 per million. In other words, the lives of 859 women were saved in 1911 which would have been lost in 1902. Table C, showing the death-rate from puerperal sepsis and accidents of childbirth to 1,000 births, shows that this rate prior to 1903 was never below 4·41; in 1911 it was 3·67."

These figures show that the passing of the Midwives Act was followed by a sudden and considerable fall, and that the improvement since this has been gradual and comparatively slight.

It would seem that the great initial improvement in the puerperal mortality must have been due to improvement in the midwives; we may hope for still further improvement not only in cases attended by midwives but by medical practitioners, but can hardly expect so striking a change in the future.

COMMENTS UPON THE MIDWIVES ACT (ENGLAND AND WALES), 1902, WITH REFERENCE TO THE AMENDING BILL OF 1910, AND THE BILL FOR SCOTLAND, 1912.

I shall not go through the whole Act, but shall only comment upon points of importance.

1. (2) England. Almost at the very outset a serious defect meets us in the qualifying words "*habitually and for gain*." "Habitually and for Gain."

By this clause a woman without education, training or skill commits no offence in attending women in their confinements unless it can be proved that she does so—

(a) habitually, *and* (not "or");

(b) for gain.

Both (a) and (b) have proved ambiguous, both have to be

defined in any given case, and there is no authoritative definition of either.

(a) "Habitually" may mean anything, and magistrates have declined to convict.

(b) "For gain" is also indefinable.

If payment is not demanded, and a money reward is given as a thank-offering, is that gain?

Moreover, as above said, both (a) and (b) have to be proved before an offence is constituted.

I am glad to see that in the Bill for Scotland 3 (2) these words are omitted. They are quite unnecessary, as the words at the end of the clause exempting "anyone rendering assistance in a case of emergency" completely cover all that is desirable.

Employment
of uncertified
substitute

1. (4) England. This section has occasionally been invoked in order to interfere with *bonâ fide* training.

The Board has always declined to endorse such a reading, which is manifestly absurd. On the other hand, the trainer is held fully responsible for the acts of her pupils.

Constitution
of Board

3. The constitution of the Board (3. England, 5. Scotland).

I have little to say about this. It is obvious that midwives and doctors should be represented; it is desirable that there should be a proportion of women; it is desirable that the great Government Departments concerned should be represented including the Privy Council, which is the head of the whole machinery, and the Local Government Board, which is concerned in the administration of the Poor Law, and is in touch with the Medical Officers of Health; such representation is apt to prevent mutual misunderstanding, and to further the smooth working of the Act.

But it is of the first importance that all who occupy seats on the Board should remember that the great aim of everyone concerned with the working of the Act should be, not the furtherance of the claims of constituents, but the guardianship of the lives and health of the poor mothers of our country. I am happy to say that I cannot remember an occasion when my Board has forgotten this primary duty.

I see that in the Bill for Scotland, as in the amending Bill for England 1910, a clause is inserted providing for the future revision of the constitution of the Board by a simple procedure not requiring the protracted machinery of an Act of Parliament. This should be helpful. (Scotland 6, amending Bill England 2.)

Suspension
of Midwives

3. 1. (f) England, prescribes among the duties of the Board that of deciding the conditions under which midwives may be suspended from practice.

8. (3) England, prescribes among the duties of the Local Supervising Authority that of "suspending any midwife from

practice, in accordance with the rules under this Act, if such suspension appears necessary to prevent the spread of infection."

Some difficulty is apt to arise under this head with the Local Supervising Authority. Cases have occurred in which a midwife has been suspended indefinitely, which is not the intention of the Act, nor in the best interests of the community.

A midwife who is infectious should be disinfected, and should then be allowed to resume her work.

A midwife who has broken any rule of the Board regarding infection should be referred to the Board for penal proceedings.

In consequence of this the Central Midwives Board at the last revision of the Rules framed an important Section F, which provides that all suspensions should be at once reported (with the grounds thereof) to the Board; and also that the period of suspension should not be longer than is required for adequate disinfection; and that all suspensions longer than 24 hours should be at once reported, with reasons, to the Board, and should be subject to revision by the Board.

Both the Scottish Bill 8 (1) (a), and the English Amending Bill 8. (1) (a) provide powers for the Board to suspend a midwife in lieu of striking her name off the Roll, and also to suspend her pending the decision of a penal case; also (b) for the local supervising authority which takes proceedings against a midwife, either before a Court of Justice or the Board, to suspend her from practice until the case has been decided.

These rules should be very carefully considered in the light of our experience as above related.

The proposal to compensate her for loss of practice (8. (2) in both) in suitable cases seems just.

Clause 9 (Scotland) and 9 Amending Bill (England) provide power for the Board, if they think fit, to pay the expenses of any midwife summoned to appear before them.

Payment of expenses where midwife summoned by Board

Such discretion would certainly be sometimes exercised in cases in which charges are proved to be frivolous or ill-founded.

Clause 10 (Scotland) and 10 (1) (England) enable the Board to prohibit any midwife removed from the Roll from attending women in childbirth in any capacity (even as a monthly nurse). I highly approve of this power. No doubt the injunction would be used with discretion.

Prohibition from attending women in childbirth where midwife removed from Roll

Clause 11 (Scotland) and 10 (2) Amending Bill (England) authorise a penalty of £5 for failing to surrender a certificate when called upon to do so.

Penalty for failure to surrender certificate on demand

A very good and necessary regulation.

Clause 12 (Scotland) and 16 (England) provide for notification to local supervising authorities of the removal of names from the Roll.

Notification to L.S.A. of name removed from Roll

**Reciprocity
of
certification**

Clause 13 (Scotland) and 12 Amending Bill (England) provide for reciprocal treatment (a sort of *ad eundem* certification) of midwives certified in other parts of His Majesty's dominions, provided that the standard of training and examination is sufficient. This proviso is of great importance.

**Payment of
expenses
where mid-
wife
summoned
by Board**

Clause 14 (Scotland) practically repeats Clause 9 (1) (Scotland) and 9 (1) Amending Bill (England) (see above) authorising the payment of the expenses of midwives summoned before the Board, at the discretion of the Board, possibly an oversight.

**Appeal to
High Court**

Clause 15 (Scotland) corresponds with Section 4 (England 1902) providing for appeal from the Board to the High Court.

**Finance of
the Board**

This is provided for in Section 5 of the English Act, which calculates the amount to be paid by each district in proportion to *the number of midwives who have given notice of their intention to practise.*

In the Scottish Bill, Clause 16, the amount is in proportion to *the populations of the districts.*

This is also the provision in the Amending Bill for England 1910, Clause 3.

It is a great improvement.

I do not know whether the Scottish Board will find a difficulty in getting in their money in the first instance. A new payment is always a grievance. If they do, they will find that quiet persistence will succeed, and that, after the first year or two, they will have no trouble.

The consequent sections (English 6—9 inclusive) (Scottish Clauses 17—19 inclusive) are practically identical and require no comment.

**Powers of
entry**

(Not in Midwives Act 1902; present in Scottish Bill, Clause 20; and in Amending Bill (England), Clause 15.)

The object of this clause is to exercise supervision over lying-in homes in the interest of mothers and children. It is very difficult to do good without doing harm, and the Central Midwives Board feared that this clause would tend to penalise the employment of a certified midwife in a lying-in home.

**Notification
of Practice**

Clause 21 (1) (Scotland) corresponds with Clause 10 (England) except that the Scottish Bill contains two additional Clauses (2 and 3) obliging a midwife who has not notified, and attends any woman in childbirth "in any capacity" (probably this means as a monthly nurse) in the absence of a doctor to notify the local supervising authority within 48 hours. And similarly obliging a midwife to notify a change of address within three days (Scotland) or seven days (England).

These new clauses appear in the English Amending Bill as 11 (1) and (2).

I am afraid that trouble might arise out of this regulation.

These offences are dealt with in identical clauses in the two Bills (11 and 12 England, and 22 and 23 Scotland).

Clause 24 (Scotland) and Amending Bill of 1910 (England) Clause 13 authorises local supervising authorities to contribute towards the training of midwives.

The training of midwives is becoming an increasingly difficult problem, and it may prove necessary in England to subsidise them in some such manner if they are to obtain the standard of excellence desired by all in the interests of the poorer mothers and babies.

The Act of 1902 contains no clause with this object.

The Scottish Bill (25) authorises such payment by the Local Government Board subject to a power to recover the same from the husband or guardian when either is able to repay it.

The Amending Bill (England) (17) enables the medical practitioner to recover his fee from the Guardians of the Poor, who may recover it in their turn "from the patient or person liable to provide the patient with medical aid."

The payment of medical practitioners has been a great difficulty in working the Act; ghastly cases have occurred in which women have been allowed to die on account of the refusal of one medical practitioner after another to go to the help of a midwife. The promoters and administrators of the Act have been freely abused for the absence of any provision for the payment of doctors. The memory of the average person is notoriously short, but some are able to remember that, when the Bill was in the making, the practitioners and their representatives devoted their energies to attempting to prevent legislation rather than to the provision of payment of the doctor.

The Insurance Act has considerably changed the situation, and should relieve the tension; it is too early at present to say to what extent.

The Act (3. 1) says that the duties and powers of the Board shall be "To frame rules" which have to be approved by the Privy Council.

This set of Rules, inaugurated in 1903, and revised in 1907 and 1911, forms the code under which the Act is administered. They were the outcome of much hard and anxious work originally, and very little alteration became necessary at their subsequent revisions.

I strongly advise those who are interested in framing a Bill for Scotland to consider them carefully. I think that they will find them useful, and indeed a great part of them might be studied with advantage by all practitioners of midwifery.

It will only be necessary to refer to certain points in the Rules.

Section C, "Regulating the course of training and the conduct

Obtaining a certificate by false representation and wilful falsification of the Roll Contribution towards the training of midwives

Payment of fees of Medical Practitioners called in on advice of midwives

Rules

Training

of Examinations, and the remuneration of the Examiners " is the first Section that we need consider to-day.

1. (1) prescribes attendance on not fewer than 20 labours, "making abdominal and vaginal examinations during the course of labour and personally delivering the patient."

Twenty labours is none too many. The words which describe how they are to be attended have been very carefully selected, in order to prevent (a) mere looking on; (b) scamping of the experience by allowing several to count the same case.

Difficulty has been experienced at times in the matter of internal examinations. The Board insists on the exact fulfilment of its rule, on which the education of the touch of the midwife depends.

Some training schools have found it difficult to provide sufficient cases for the pupils whom they accept; but the primary duty of the Board is to secure the proper training of the midwife.

The granting of certificates by bodies or individuals other than the Board requires the careful supervision of the Board, and it is a common experience that signing of certificates is apt to become perfunctory.

The training must occupy not less than three months. This time is confessedly very short, and is generally prolonged beyond the minimum. The question of increasing the duration of training is largely one of pecuniary means.

As a matter of fact a large proportion of successful candidates (about 58 per cent.) never intend to practise as midwives, but desire the certificate of the Board as a qualification for appointments or as a superior nursing diploma. Some 42 per cent. intend to practise as midwives. It also appears that the candidates who intend to practise as monthly nurses come for the most part from different institutions.

It is evident that the Act was not passed—with toil and strife—to add a gilt edge to monthly nurses, but to provide well-trained midwives for the poor.

It is probable that the Board may reconsider the duration of the training required, and that, in so doing, the convenience and the pecuniary means of the real midwife-candidate may principally be considered.

Examination Rule C. 4, specifies the subjects on which candidates are liable to be examined.

At the next revision the Board may probably add a clause referring to "serious skin eruptions" which are mentioned in the Rule (E. 19 (5)) relating to the "conditions in which medical help must be sent for."

**Penal
procedure**

Rule D. concerns the "Rules of Procedure on the removal of a name from the Roll, and on the restoration to the Roll of a name removed." This Rule is very precise, and the procedure is

minutely described. Yet it has not infrequently happened that a local supervising authority has failed to understand it. At the last revision of the Rules therefore a note was prefixed to the Rule in order to guard against possible misapprehension. This appears to have been of service in the way of preventing misunderstanding.

The procedure is briefly as follows :—The Board receives a complaint of some misconduct on the part of a midwife. The local supervising authority of her district finds (or does not find) a *prima facie* case. The solicitor of the Board formulates the charges. The Penal Cases Committee of the Board decides whether to cite the accused to appear before it.

In a very few cases, where the charges do not seem to warrant citation, a caution may be administered, but a censure is never administered unless an offence is either proved before the Board or admitted by the accused.

The midwives who are cited are furnished with a copy of their indictments in separate counts, to which alone they have to answer, each count bearing a reference to the Rule or Section in the Act concerned, where possible; this last proviso meaning (in reality) such offences as are included in the phrases “ malpractice, negligence or misconduct ” (Act, Section 8), where these cannot be more specifically mentioned. The commonest instance of this class is drunkenness, which naturally requires no special rule to forbid it. Yet, on the principle that “ what is sauce for the gander is sauce for the goose,” the Board’s practice is to require evidence of (a) drunkenness on duty, or (b) repeated drunkenness, before it considers itself justified in cancelling a certificate.

Here difficulty has sometimes occurred with the local supervising authority. The Board, however, requires very definite evidence of intoxication, which is sometimes hard to get. In any case it is better to fail to convict a guilty person than to convict an innocent person; and, as a matter of experience, the lucky drunkard of to-day generally appears as the undoubted drunkard of to-morrow.

At the “Penal Board” the proceedings generally follow those of a Court of Law, except that no oath is administered, and witnesses cannot be compelled to attend. The accused may be defended by counsel or solicitor. Where no counsel is retained the Board (and especially the chairman) feels it to be its duty to see that the accused suffers no disadvantage thereby.

In a large number, or even in the majority of cases, the accused does not appear in person, but sends in a defence, and statutory declarations of witnesses are accepted. The court is rather one of equity than of criminal law; but such an enquiry as is held has many advantages, and is as a matter of experience eminently fair.

In the only instance in which its decision has been appealed

against to the High Court of Justice (Act, Section 4) it was strongly upheld, and its procedure favourably commented on by the judges concerned. In the course of the investigation counts in the indictment are frequently expunged.

At the end of the enquiry the Board deliberates in *camerâ*, and decides which counts it considers proved and which not proved, and strikes out the latter. Having settled its findings, it asks the Inspector of Midwives, or other similar official if present, concerning any previous convictions. This is never done until the proof of the indictment is settled.

As regards sentence, the following are the sentences in use :

Removal from the Roll.

Severe censure.

Censure.

Caution.

The latter (Caution to obey the Rules) is the only pronouncement ever made without proof of the truth of the accusation. There is another pronouncement not very long in force, which is found very convenient.

In some cases, especially those in which no grave offence has been proved, and yet the Board is of opinion that the accused is a woman who may be very undesirable as a midwife, it decides that the counts of the indictment (as many as are proved) are proved, but suspends sentence and asks for a report from the local supervising authority in 3 and 6 (or 3 or 6) months. If favourable no further action is taken; if unfavourable, the name is erased from the Roll.

This procedure answers well in the case of women who habitually break rules as to notifying the local supervising authority, etc., and in whose case the gravity of the offence becomes cumulative by persistent repetition.

COPY OF THE WORDING USED BY THE BOARD WHEN JUDGMENT IS POSTPONED AT THE HEARING OF A PENAL CASE.

“The Board finds the charges proved, but postpones sentence until the next Penal Board after the expiration of six months from this date, and requests the Local Supervising Authority to furnish the Board with a report on your conduct and methods of practice at the end of three months and again at the end of six months.”

A report in three and six months is often asked from the Local Supervising Authority also in cases where a censure is administered.

But a censure is a sentence, and the midwife cannot be punished twice for the same offence; whereas postponement of sentence keeps the offence alive and suspends a Sword of Damocles over the midwife's head.

This procedure, together with the reports, acts most beneficially, and works a real reform in many cases.

Rule E deals with the subjects of Regulating, Supervising, and Restricting within due limits the practice of midwives. **Regulations governing practice**

The first point to be noted is the word "washable" as applied to the material of the midwife's dress.

The word means exactly what it says. The sort of material "Washable" is suggested in the phrase "such as linen, cotton, etc.," but otherwise the responsibility for the material being "washable material that can be boiled" is left to the midwife.

Rule 5 is one of special importance. It has been greatly improved at the last revision by bringing the woman, "whether acting as a midwife or as a nurse" or being "herself liable to be a source of infection," under the disability of being unable to practise until disinfected to the satisfaction of the Local Supervising Authority. **Disinfection**

The meshes of the net have been made smaller, and now catch the woman (1) who might have pleaded that she was not acting as a midwife; (2) who, not having been in contact with an infected person, is herself infectious (as, for instance, from a foul ulcer of the leg);

(3) and it is to be noted that it is not necessary to prove that a midwife has been *told* that a patient is septic; she is bound to suspect the condition herself and to get disinfected.

Rule 6 obliges a midwife "in cases where a doctor has been sent for" to await his arrival and faithfully carry out his instructions." **Duty of midwife where doctor sent for**

Offences against this Rule are not uncommon.

Rule 8 limits internal examinations to those absolutely necessary, but as this Rule was quoted in some quarters in opposition to Rule C.1.(1), obliging the pupil to watch the progress of the twenty labours by vaginal as well as by abdominal examinations, a footnote was appended to the effect that Rule E. 8. was not to be taken as relieving a pupil from any of the obligations of Rule C. 1. (1). **Internal examinations**

Rule 11 lays down the duration of responsibility of the midwife "in a normal case," and prescribes that duration as 10 days; and also obliges her, if she attends longer, to note the fact and its explanation in her Register. It does not prescribe the number of visits, but leaves her the responsibility of paying as many as necessary. This Rule is often important in penal proceedings. **Puerperium**

Rule 13 obliges a midwife to take and record the pulse and temperature at each visit. **Pulse and temperature**

It was inserted at the last revision.

To have imposed it in 1903 would have meant that a very large number of *bonâ-fide* midwives (*i.e.*, the untrained women in practice at the passing of the Act) might have been struck off as soon as

they were on, which would have been contrary to the spirit of the Act.

But it was felt in 1911 that the time had come to raise the standard, especially as it appeared from the penal experiences of the Board that a good many women either would not or could not learn to take the pulse and temperature so important for the safety of their patients.

Breaches of this Rule have never, I think, been the *only* cause for removing a midwife from the Roll.

I may say that many Local Supervising Authorities, by the help of their Inspectors of Midwives, have taken great pains to teach their old *bonâ-fide* midwives these methods.

Care of the
child's eyes

Rule 15 concerns the care of the child's eyes immediately the head is born, and gives a reference to page 42, where is to be found a leaflet on Ophthalmia Neonatorum drawn up by the Chairman at the request of the Board.

Laying out
the dead

Rule 17 deals with the difficult subject of laying out the dead. To forbid a woman to do this for a still-born child which she had delivered, or for a woman on whom she had attended, would be absurd; any infection would already be incurred, and one disinfection would do.

Again, no harm is done by her laying out a body in a case of non-infectious illness, if she is not attending a confinement at the time and is disinfected afterwards.

In the case, however, of her laying out a strange body she is subject to the prohibition of the Local Supervising Authority.

This Rule was framed to meet the case of villages where there is only one woman to do nursing and midwifery. It sounds complicated, but represents real facts, and has not been complained against.

Drugs to be
recorded

Rule 18 obliges the midwife to record any drug other than a simple aperient in her Register.

The Board deliberately refrained from scheduling approved drugs, or forbidden drugs, and placed the whole responsibility on the midwife.

Medical help

Rule 19 prescribes the conditions in which medical help must be sent for.

It is probably the most frequently broken of all the Rules.

The Board, in framing it, carefully avoided ordering the midwife to send for medical help, but obliged her to explain that the case is one in which a doctor is required, and to fill up the proper form and hand it to the husband or the nearest relative or friend present.

This is intended to prevent the doctor from saying that the midwife has sent for him and is responsible for his fee; but I am bound to say that it has not prevented this assertion in all cases,

though unfounded. The choice of a medical practitioner rests with the patient or her representative.

The Rule then proceeds to give instances of cases in which medical help is required in cases of Pregnancy, Labour, Lying-in, or where the child requires it.

Finally, various forms of notification are appended.

Rule 27 forbids a midwife to append letters to her name.

Letters
C.M.B.

This became necessary on account of such appended letters as C.M.B., which gives a sort of impression that it is something more than merely "M.B.," and is probably as good as "C.M.G."

This use of unauthorised capital letters after a name is not confined to midwives, nor even to women, and seems to be a relic of original sin.

Rule F, concerning suspension from practice, has already been commented on in connection with Section 8 (3) of the Midwives Act.

Suspension

Appended to the Rules are various certificates, also a leaflet on Ophthalmia Neonatorum, and one on Cancer of the Uterus, drawn up by the Chairman at the request of the Board.

Forms of
certificates
and leaflets

The latter is an attempt to save lives which may sometimes be saved by prompt treatment by making use of midwives as missionaries.

They are given to all midwives on their certification, and are widely distributed by many Local Supervising Authorities.

Finally there is a simple Glossary.

Glossary

The course is prescribed in Rules C.

It comprises (1. (1)) attendance on not fewer than 20 labours, including nursing of 20 lying-in women and their infants for 10 days after labour (1. (2)).

Regulations
governing
training

The certificates for the above are found in Schedule, Forms III. and IV.

These can be signed by (C. 1. (2)):

- (a) an approved medical practitioner;
- (b) a certified midwife, being the Chief Midwife or Matron of an Institution recognised by the Board;
- (c) a certified midwife, being the Matron or Superintendent Nurse of a Poor Law Institution;
- (d) a certified midwife approved by the Board.

It will be seen that certificates can be signed either by (1) officials of an approved institution or (2) by approved doctors or midwives.

The approval of an Institution carries with it the approval of its proper officers, but these are only approved so long as they remain attached to the Institution.

The approval of an individual doctor or midwife attaches to the individual as long as the approval lasts.

These approved lists are revised yearly.

The practice of the Board is to approve Institutions when of a certain size and importance, such as the large Lying-in Hospitals, whose staffs can be trusted to be thoroughly competent; and to approve the individuals attached to smaller Institutions.

In addition to this, in country districts especially, it is necessary sometimes to approve the best individual available, though unattached. This is particularly the case in Wales, where large mining populations exist apart from any large town. But in these cases the Board depends largely upon the Medical Officers of Health as to the desirability of approval.

In the earlier stages of the history of the Board great pressure was sometimes put upon the Board to add a small Institution to the list of "approved Institutions," which were inclined to look down upon similar Institutions in which individuals had to be approved.

I remedied this by altering the title and putting all Institutions, whether approved *en bloc* or individually, into one list, and the trouble instantly ceased.

The "course of instruction," by lectures, demonstrations, etc., is prescribed in Rules C. 1. (3), and the subjects are scheduled in C. 4.

The course must extend over not less than 3 months (C. 1. (3)), and must consist of not less than 15 lectures. (Schedule, Form V., p. 37).

The question of general education was carefully considered by the Board, and it was decided not to insist upon any standard higher than that mentioned in the Schedule: "that she possesses sufficient elementary education to enable her to read and to take notes of cases."

Any higher standard would undoubtedly deprive the country of some of the best women practising as midwives.

Lectures

The Board believes that, so far as lectures are concerned, it is well to encourage large classes, and that for the following reasons:

1. A large class means more adequate payment to the lecturer, and this makes it easier to secure one who is skilled in the difficult art of lecturing.
2. A large class certainly reacts upon the lecturer, stimulating him, while nothing is more depressing than to lecture to a very small class. This does not apply to practical instruction, in which moderate numbers are more satisfactory.
3. A large class probably reacts favourably upon its individual members.

For this reason the Board approached the Lying-in Hospitals of London, and some other large Institutions, asking them whether they could not see their way to admit outside pupils for lectures only.

All the Lying-in Hospitals, however, but one, declined.

The Board greatly regrets their decision. Their acquiescence might have given a real help towards the better training of the poorer midwives, who, it seems, are those who chiefly undertake the work of real midwives, and especially in rural districts.

A difficulty arises at times in connection with the distribution of the cases of midwifery and of the lectures. It is intended that these should be fairly distributed throughout the 3 months of training, and not be crowded into a very short time, the object being to secure that the candidate should live for a time in an obstetric atmosphere.

As deviations from the desired course were known to occur, the Board has issued instructions that the dates of the 20 confinements shall be sent in with the Schedule filled up before the Examination.

Examinations are held in London in February, April, June, August, October, and December ;

The examination of midwives

In Provincial centres (Birmingham, Bristol, Leeds, Manchester, and Newcastle) in February, June, and October.

The Examination is both written and oral, the papers being set in London and sent down to the provinces.

In some cases the papers are allowed to be written, under proper supervision, at other places, the candidates going to the authorised centre for the Oral Examination. As several days elapse between the Written and Oral Examinations this saves the expense of a double journey.

The examiners consist of the rising obstetricians of the country, and of many who have already attained to eminence.

I visit practically every oral examination in London and listen at all or most of the tables, and I have been struck by the fairness and patience with which the Examinations are conducted.

It occasionally happens that the number of examiners in a particular centre is short for an examination. In such cases an examiner is generally sent from or to London, as the case may be.

This brings the various centres into touch with each other, and also helps to keep the standard uniform.

But it is interesting to record the fact that when the standard at a centre has appeared to differ from the average (as, for instance, by an unusually high or low percentage of rejections) the provincial examiners who have taken part in London Examinations have always been able to assure me that the standard was practically identical.

In some cases the Board has sent an expert to visit an Examination and report. This has never revealed any serious discrepancy between standards, nor any serious defect.

In arriving at a conclusion no percentage of marks is recognised, but examiners are requested to weigh the whole examination,

written and oral, and to decide on the one question : " Is the candidate safe to be allowed to practise as a midwife ?"

Examiners are reminded that a candidate must never be asked where she was trained ; each candidate appears as a number only.

Each candidate has a card with her examination number. This she is obliged to produce or she is not allowed to enter the Examination Hall.

The Board has felt obliged to enforce this rule strictly ever since two candidates, relying on their memory, gave wrong numbers, with the result that an erroneous announcement of the result was made, leading to confusion and very undesirable comment.

The length of training of midwives is certainly very short.

Three months is a very short time to turn an ignorant, untrained woman into a competent midwife fit to deal with matters of life and death.

It is certainly desirable that the duration of training should be prolonged, but the difficulty is the expense. As it is, a woman who is trained at an Institution has to pay fees for her keep and instruction for at least 3 months, during which is is earning nothing, and this is often difficult.

The supply of midwives

It early became likely that a large number of women who became candidates for the certificate of the Board had no intention of practising as midwives.

In 1907 I instituted an inquiry, with the approval of the Board, into this question, having slips given to all the candidates, on which was written the question whether or not they intended to practise as midwives.

In 1910 the additional question was added whether, if so, they intended to practise in Rural Districts.

The results of these inquiries are seen in Table I.

TABLE I.
STATISTICS OF SUCCESSFUL CANDIDATES INTENDING TO PRACTISE AS
MIDWIVES FOR THE YEARS 1905—1913.

	Total successful Candidates	No. of successful candidates intending to practise as midwives	Per cent of successful candidates intending to practise as midwives	No. of successful candidates intending to practise as midwives who intend to practise in rural districts	Per cent of total successful candidates intending to practise, who intend to practise in rural districts	Per cent of total successful candidates intending to practise in rural districts
1905 ...	589					
1906 ...	1527					
1907 ...	1559	826	53			
1908 ...	1854	1057	57			
1909 ...	2159	1214	56.2			
1910 ...	2281	1252	54.8	624	49.8	27.4
1911 ...	2301	1078	46.8	546	50.6	23.7
1912 ...	2268	968	42.7	522	54	23
1913 ...	2109	882	41.8	437	49.5	20.7

From this it will be seen that the percentage of successful candidates intending to practise as midwives was 53 in 1907 and has sunk to 41·8 in 1913.

The percentage of the total intending to practise in rural districts has fluctuated; but

The percentage of the total successful candidates intending to practise in rural districts has sunk from 27·4 in 1910 to 20·7 in 1913, the decline being steady in each year.

It is plain from this that the number of women intending to act as real midwives is steadily diminishing. Whether the supply will be equal to the demand remains to be seen, and I cannot at present make any sure statement on this point.

For the last two years I have had a table drawn out showing the destination of the successful candidates from various Institutions.

The tables are here appended :—

TABLE 2.

LONDON.

A TABLE SHOWING FOR 1912 THE PERCENTAGE OF SUCCESSFUL CANDIDATES, APART FROM THOSE IN POOR-LAW INSTITUTIONS, WHO ANNOUNCED THEIR INTENTION OF PRACTISING AS MIDWIVES.

	Total successful Candi- dates		Total No. intending to prac- tise	% of those intending to prac- tise
Woolwich, Home for Mothers and				
Babies	8	...	6	75·0
New Hospital for Women	7	...	5	71·4
Clapham Maternity Hospital	39	...	20	51·3
Regions beyond Missionary Union ...	12	...	6	50·0
Salvation Army Maternity Hospital ...	33	...	16	48·5
General Lying-in Hospital	153	...	71	46·4
Woolwich, Military Families' Hosp.	8	...	3	37·5
East End Mothers' Home	46	...	13	28·3
Maternity Nursing Association	35	...	9	25·7
City of London Lying-in Hosp.	60	...	10	16·7
London Hospital	48	...	8	16·7
Guy's Institution	23	...	3	13·0
Queen Charlotte's Hospital.....	147	...	18	12·3
British Lying-in Hospital	18	...	1	5·5
Middlesex Hospital	21	...	—	—

ENGLAND (except London).

Worcester County Nursing Assoc.	15	...	15	100·0
Norwich Maternity Charity	9	...	9	100·0
Kingswood Nurses' Home	6	...	6	100·0
Gloucester District Nursing Society ...	13	...	12	92·3

Newcastle-on-Tyne Maternity Hosp....	13	...	12	...	92'3
Monmouthshire Training Centre	23	...	21	..	91'3
Devon and Cornwall Training School	31	...	26	...	84'0
Plaistow Maternity Charity	144	...	120	...	83'3
Windsor, H.R.H. Princess Christian's Maternity Home	3	...	2	...	66'7
Chester Benevolent Institution	7	...	4	...	57'1
Derby Royal Nursing Association.....	25	...	14	...	56'0
Birmingham Maternity Hospital	44	...	22	...	50'0
Essex County Cottage Nursing Soc. ...	18	...	9	...	50'0
Portsmouth Military Families' Hosp.	4	...	2	...	50'0
Manchester, St. Mary's Hosps.	52	...	22	...	42'3
Shorncliffe, Helena Hospital	5	...	2	...	40'0
Cheltenham District Nursing Assoc....	13	...	5	...	38'5
Birkenhead Maternity Hospital	20	...	7	...	35'0
Leicester Maternity Hospital	9	...	3	...	33'3
Wolverhampton Q.V.N.I.	9	...	3	...	33'3
Leeds Maternity Hospital	27	...	7	...	26'0
Louise Margaret Hospital	21	...	5	...	24'0
Ipswich Nurses' Home	11	..	2	...	18'2
Liverpool Maternity Hospital.....	59	...	9	...	15'3
Jessop Hospital for Women	16	...	2	...	12'5
Brighton and Hove Hosp. for Women	45	...	5	...	11'1
Bristol General Hospital	18	...	—	...	—
Bristol Royal Infirmary	23	...	—	...	—
Chatham Military Families' Hosp. ...	6	...	—	...	—
Devonport Military Families' Hosp.	3	...	—	...	—
Hull Lying-in Charity	5	...	—	...	—
Northampton Q.V.N.I.	4	...	—	...	—
York Maternity Hospital	7	...	—	...	—

WALES.

Cardiff Q.V.J.N.I.	16	...	12	...	75'0
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SCOTLAND.

Glasgow Maternity Hospital	48	...	5	...	10'4
Edinburgh Royal Maternity Hosp. ...	23	...	1	...	4'3
Aberdeen Maternity Hospital	6	...	—	...	—
Dundee Maternity Hospital	20	...	—	...	—

IRELAND.

Dublin National Maternity Hospital...	1	...	1	...	100'0
Dublin, Coombe Hospital	2	...	1	...	50'0
Belfast, Incorporated Maternity Hosp.	2	...	1	...	50'0
Dublin, Rotunda Hospital	33	...	9	...	27'3
Curragh Camp Military Families' Hospital	4	...	—	...	—

PRIVATE TEACHERS.

	375	...	186	...	49'6
Total.....	1896	...	751	...	39'6

TABLE 3.

A TABLE SHOWING FOR 1912 THE PERCENTAGE OF SUCCESSFUL CANDIDATES WHO INTEND TO PRACTISE AS MIDWIVES FROM THE LYING-IN INSTITUTIONS COLLECTIVELY, MEDICAL SCHOOLS COLLECTIVELY, AND VARIOUS OTHER INSTITUTIONS COLLECTIVELY.

LYING-IN INSTITUTIONS.

	Total successful candidates	Total No. intending to practise
General Lying-in Hospital	153	71
Birmingham Maternity Hospital.....	44	22
Manchester, St. Mary's Hospitals	52	22
Clapham Maternity Hospital	39	20
Queen Charlotte's Hospital	147	18
Salvation Army Maternity Hospital ...	33	16
East End Mothers' Home	46	13
Newcastle-on-Tyne Maternity Hospital	13	12
City of London Lying-in Hospital	60	10
Liverpool Maternity Hospital	59	9
Dublin, Rotunda Hospital	33	9
Birkenhead Maternity Hospital	20	7
Leeds Maternity Hospital	27	7
Woolwich, Home for Mothers and Babies	8	6
Glasgow Maternity Hospital.....	48	5
Leicester Maternity Hospital	9	3
Windsor, H.R.H. Princess Christian's Maternity Home	3	2
Jessop Hospital for Women	16	2
British Lying-in Hospital	18	1
Edinburgh Royal Maternity Hospital...	23	1
Belfast Incorporated Maternity Hospital	2	1
Dublin, National Maternity Hospital...	1	1
Dublin, Coombe Hospital	2	1
Hull Lying-in Charity	5	—
York Maternity Hospital	7	—
Aberdeen Maternity Hospital	6	—
Dundee Maternity Hospital	20	—
	894	259
		= 29%

MEDICAL SCHOOLS.

	Total successful candidates		Total No. intending to practise
London Hospital	48	.....	8
New Hospital for Women.....	7	.....	5
Guy's Institution	23	.....	3
Middlesex Hospital	21	.....	—
	99	.....	16
			= 16'1%

OTHER INSTITUTIONS.

Plaistow Maternity Charity	144	.....	120
Devon and Cornwall Training School...	31	.....	26
Monmouthshire Training Centre	23	.....	21
Worcester County Nursing Association	15	.....	15
Derby Royal Nursing Association	25	.....	14
Gloucester District Nursing Society ...	13	.....	12
Cardiff Q.V.J.N.I.	16	.....	12
Essex County Cottage Nursing Society	18	.....	9
Norwich Maternity Charity	9	.....	9
Maternity Nursing Association	35	.....	9
Kingswood Nurses' Home.....	6	.....	6
Brighton and Hove Hospital for Women	45	.....	5
Cheltenham District Nursing Assoc.	13	.....	5
Chester Benevolent Institution	7	.....	4
Wolverhampton Q.V.N.I.	9	.....	3
Ipswich Nurses' Home	11	.....	2
	420	.....	272
			= 64'8%

TABLE 4.

A TABLE SHOWING FOR 1913 THE PERCENTAGE OF SUCCESSFUL CANDIDATES, APART FROM THOSE IN POOR LAW INSTITUTIONS, WHO ANNOUNCED THEIR INTENTION OF PRACTISING AS MIDWIVES.

LONDON.

	Total successful candi- dates		Total No. intending to practise	% of those intending to practise
Woolwich Home for Mothers and Babies	4	...	2	50'
Clapham Maternity Hospital	37	...	17	46'
Maternity Nursing Association.....	29	...	13	44'8
East End Mothers' Home	53	...	17	32'
Salvation Army Maternity Hospital...	34	...	10	29'4

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	Total successful candi- dates	Total No. intending to practise	% of those intending to practise
General Lying-in Hospital	130	36	27'7
St. Bartholomew's Hospital	4	1	25'
Poplar, Regions Beyond Missionary Union	13	3	23'
British Lying-in Hosp. (2 Exams. only)	9	2	22'2
City of London Lying-in Hospital ...	68	13	19'1
Woolwich, Military Families' Hosp....	6	1	16'7
New Hospital for Women	8	1	12'5
London Hospital	44	5	11'4
Middlesex Hospital	18	2	11'1
Queen Charlotte's Hospital	107	11	10'3
Guy's Institution	26	—	—
University College Hospital.....	13	—	—

ENGLAND (except London).

Devon and Cornwall Training School	29	26	89'6
Essex County Cottage Nursing Soc.	18	16	89'
Gloucester District Nursing Society...	13	11	87'
Norwich Maternity Institution	15	13	86'6
Monmouthshire Training Centre	13	10	77'
Plaistow Maternity Charity	159	122	76'7
Staffordshire Training Home for Nurses	15	11	73'3
Chester Benevolent Institution	7	5	71'4
Cheltenham District Nursing Assoc.	17	12	70'6
Newcastle-on-Tyne Maternity Hosp.	12	8	66'7
Worcester County Nursing Assoc.	12	8	66'7
Ipswich Nurses' Home	15	8	53'3
Devonport, Military Families' Hosp.	2	1	50'
Kingswood Nurses' Home	8	4	50'
Windsor, H.R.H. Princess Christian's Maternity Home	6	3	50'
Derby Royal Nursing Association.....	19	9	47'4
Manchester, St. Mary's Hospitals	61	27	44'3
York Maternity Hospital	7	3	43'
Birmingham Maternity Hospital	35	13	37'1
Portsmouth Military Families' Hosp.	3	1	33'3
Shorncliffe, Helena Hospital	6	2	33'3
Birkenhead Maternity Hospital	13	4	30'8
Leeds Maternity Hospital.....	26	7	27'
Hull Lying-in Charity	4	1	25'
Leicester Maternity Hospital	8	2	25'
Jessop Hospital for Women	17	4	23'5
Brighton Hospital for Women	43	9	21'

Liverpool Maternity Hospital	59	...	9	...	15'3
Louise Margaret Hospital	21	...	2	...	9'5
Bristol Royal Infirmary	21	...	2	...	9'5
Bristol General Hospital.....	15	...	—	...	—
Chatham Military Families' Hospital	4	...	—	...	—
Northampton Q.V.N.I.	1	...	—	...	—
Wolverthampton Q.V.N.I.	2	...	—	...	—

WALES.

Cardiff Q.V.J.N.I.	19	...	17	...	89'5
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SCOTLAND.

Aberdeen Maternity Hospital	7	...	1	...	14'3
Glasgow Maternity Hospital	38	...	4	...	10'5
Edinburgh Royal Maternity Hospital	29	...	3	...	10'3
Dundee Maternity Hospital	19	...	—	...	—

IRELAND.

Dublin, Coombe Hospital	4	...	2	...	50'
Dublin, National Maternity Hospital	2	...	1	...	50'
Curragh Camp Military Families' Hosp.	5	...	2	...	40'
Dublin, Rotunda Hospital	35	...	11	...	31'4
Belfast Incorporated Maternity Hosp.	3	...	—	...	—
Belfast, Ulster Hospital	1	...	—	...	—
Cork Lying-in Hospital	1	...	—	...	—

PRIVATE TEACHERS.

314	...	154	...	49'
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Total	1786	...	682	...	38'2
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TABLE 5.

A TABLE SHOWING FOR 1913 THE PERCENTAGE OF SUCCESSFUL CANDIDATES WHO INTEND TO PRACTISE AS MIDWIVES FROM THE LYING-IN INSTITUTIONS COLLECTIVELY, MEDICAL SCHOOLS COLLECTIVELY, AND VARIOUS OTHER INSTITUTIONS COLLECTIVELY.

LYING-IN INSTITUTIONS.

	Total successful candidates	Total No. intending to practise
General Lying-in Hospital	130	36
Manchester, St. Mary's Hospitals	61	27
Clapham Maternity Hospital	37	17
East End Mothers' Home	53	17
City of London Lying-in Hospital	68	13
Birmingham Maternity Hospital	35	13

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	Total successful candidates		Total No. intending to practise
Queen Charlotte's Hospital	107		11
Dublin, Rotunda Hospital	35	.....	11
Salvation Army Maternity Hospital ...	34	.....	10
Liverpool Maternity Hospital	59	.....	9
Newcastle-on-Tyne Maternity Hospital	12	.....	8
Leeds Maternity Hospital	26	.....	7
Birkenhead Maternity Hospital	13	.....	4
Jessop Hospital for Women	17	.....	4
Glasgow Maternity Hospital	38	.....	4
Windsor, H.R.H. Princess Christian's Maternity Home	6	.....	3
York Maternity Hospital	7	.....	3
Edinburgh Royal Maternity Hospital...	29	.....	3
Woolwich, Home for Mothers and Babies	4	.....	2
Leicester Maternity Hospital	8	.....	2
Dublin, Coombe Hospital	4	.....	2
British Lying-in Hospital (2 Exams. only)	9	.....	2
Hull Lying-in Charity	4	.....	1
Aberdeen Maternity Hospital	7	.....	1
Dublin, National Maternity Hospital ...	2	.....	1
Dundee Maternity Hospital	19	.....	—
Belfast Incorporated Maternity Hospital	3	—	.....
Cork Lying-in Hospital	1	....	—
	828	.....	211
			= 25·5%

MEDICAL SCHOOLS.

London Hospital	44	.....	5
Middlesex Hospital	18	.....	2
New Hospital for Women	8	.....	1
St. Bartholomew's Hospital	4	.....	1
Guy's Institution.....	26	.....	—
University College Hospital	13	.....	—
	113	.....	9
			= 8%

OTHER INSTITUTIONS.

Plaistow Maternity Charity	159	.....	122
Devon and Cornwall Training School...	29	.....	26
Cardiff Q.V.J.N.I.	19	.....	17
Essex County Cottage Nursing Society	18	.....	16
Maternity Nursing Association	29	.....	13

Norwich Maternity Institution	15	.....	13
Cheltenham District Nursing Assoc.	17	.....	12
Gloucester District Nursing Society ...	13	.....	11
Staffordshire Training Home for Nurses	15	.....	11
Monmouthshire Training Centre	13	.....	10
Brighton Hospital for Women	43	.....	9
Derby Royal Nursing Association	19	.....	9
Ipswich Nurses' Home	15	.....	8
Worcester County Nursing Association	12	.....	8
Chester Benevolent Institution	7	.....	5
Kingswood Nurses' Home	8	.....	4
Northampton Q.V.N.I.	1	.....	—
Wolverhampton Q.V.N.I.....	2	.....	—
	434	.....	294
			= 67·7%

It will be seen that, speaking generally, most of the great lying-in hospitals are principally engaged in training monthly nurses, while genuine midwives receive their training from other institutions. The one exception in London is the General Lying-in Hospital which trains many who intend to practise as midwives, many of these again in rural districts.

Now the Midwives Act was never intended merely to turn out gilt-edged monthly nurses, and it is plain that the work of the Board must be the training and supply of real midwives, especially for rural districts; and that institutions are valuable to the country in proportion as they subserve this purpose.

In studying the tables which I have had prepared for 1912 and 1913, regard must be had, not only to percentages, but to the actual numbers; for it is the numbers of midwives, actually recruiting the ranks for active service rather than the percentages which matter.

The energy of a small institution may give it a high percentage, but the numbers trained must always be small.

The table in which the various sorts of institutions are grouped together and their output of genuine midwives compared is instructive.

In 1912 the results were as follows:—

Medical Schools provided 99 successful candidates, of whom 16 intended to practise as midwives, or 16·1 per cent.

Lying-in Institutions provided 894 successful candidates, of whom 259 intended to practise as midwives, or 29 per cent.

Other Institutions (mostly rural, such as county nursing associations) provided 420 successful candidates, of whom 272 intended to practise, or 64·8 per cent.

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In 1913 the results were as follows :—

Medical Schools provided 113 successful candidates, of whom 9 intended to practise as midwives, or 8 per cent.

Lying-in Institutions provided 828 successful candidates, of whom 211 intended to practise as midwives, or 25·5 per cent.

Other Institutions provided 434 successful candidates, of whom 294 intended to practise as midwives, or 67·7 per cent.

For the year 1912 the number from these 3 groups intending to practise as midwives was 547.

In 1913 it was 514.