Nursing midwifery and handywomen

Nursing

One of the first people that residents would turn to if unwell, being less expensive than the doctor, was the village nurse and, in Chinnor, Mabel Howlett remembered the district nurse who lived in a council house in Station Road. During the 1920s Mabel visited the nurse following an accident with her sledge when she required splinters to be removed from her behind.

Associations for the provision of nursing care to the poor had been in existence for many years, provided by the religious sisterhoods and deaconesses who had created a nursing service based on piety and devotion.
The associations were responsible for employing district nurses, paying their salaries, and undertaking fund raising to meet their costs.

The Queens Nursing Institute did not train nurses, but gave existing hospital nurses training in working in the home and operated a national system of affiliation and inspection. In 1897 the institute created county affiliates and affiliated two other associations, the Cottage Benefit Nursing Association and the Rural Nursing Association, which provided and co-ordinated small rural associations.[1] This was in recognition of the fact that the institute's standard of training was not necessarily appropriate for rural communities. This enabled the rural employment of nurses as village nurses who combined nursing with midwifery (which Queen's Nurses did not necessarily do), and were employed on local terms by the Rural Nursing Association. This affiliation was available to county nursing associations which provided and co-ordinated small rural associations. There was clear distinction between village nurses and Queen's Institute district nurses.

District nursing has always been done in the home by family members or perhaps assisted by their neighbours. The Oxford District Nursing Federation supplied district nurses to Chinnor District Nursing Association. The fees for this service were recorded in Burdett's Hospitals and Charities (1899) regarding the Acland home in Oxford whose Nursing Association charges were, for ordinary cases: £1 1s, infectious cases £2 2s per week, mental and massage (sic) £2 2s per week, and maternity cases £10 10s to £15 15s per month. Funding for Nursing Associations came from midwifery fees. The fees were collected by the village nurse and paid into the Association. The nurse in turn was paid a salary by the Association.[2]

Midwifery

A note should be made here of the use of professional titles. Before the *Midwives' Act, 1903* the term midwife was used in relation to the handy woman and when professional midwives evolved, they preferred the title 'nurse' to distinguish themselves from the handy women. As the profession gained in status, they reclaimed the title midwife to distinguish themselves from nurses. However, according to Irvine

Loudon rural midwives would be lucky to earn £25 a year from midwifery alone having an average of 40-50 cases a year. As a result, many midwives combined their work with district nursing becoming a village nurse.

A qualified midwife following the *Midwives Act, 1902* would charge between 7s. 6d. to 21s. and an unqualified midwife 5s. In respect of midwifery and nursing care, Chinnor was fortunate in the arrival of Dr. Leverkus in 1928, and the services of Nurse Tizzell, Nurse Rogers and Nurse Gubbins between 1920-1938, whilst the village handy woman was Mrs. Munday. Before World War 1 until the middle of the 1930s, most working- class women were delivered by the local 'handy woman' rather than by a doctor or professional midwife. This was predominantly down to the costs incurred by the patient. For example, fees for independent midwives around 1912 were in the range of 10-21s. whilst doctors charged 30s. the 'handy women', on the other hand, could charge 2s. 6d. or no fee at all.[3] In the 1930s, it could cost £2 for the midwife who attended for 10 days post partum, and £2 for the 'woman that did' who also came in for 10 days and attended to household chores. A delivery in a nursing home in 1920 was quoted as costing £2 10s, whilst in the late 1930s a charge of £5 was levied and the mothers stayed in for a fortnight. By 1937 55% of the children in Oxfordshire were delivered by village nurses.

It is not clear from the records whether Chinnor had a Queen's Nurse or a village nurse-midwife. However the annual salary of £141 noted in the receipts of the Oxfordshire District Nursing Federation (1922/23) suggested that she was not a Queen's Nurse, who could command a salary of £200-250 per year. By 1937 the Chinnor nurse's salary had risen to £180 per year.

Mabel Howlett recorded that whilst it was usual for women in Chinnor to be delivered at home by the district nurse she remembered that, unusually, her granny, who had 9 children, had to have a doctor for her confinements. An examination of the admissions register of Watlington Cottage hospital of patients who gave their home address as Chinnor from 1919 to 1945 demonstrated a steady increase in hospital based maternity care from none to two in 1931, increasing to 17 in 1940, possibly due to evacuee mothers, with 10 in 1941, 17 in 1942 and nine in 1943.

Power rested primarily in the town councils who, were dominated by the landed and commercial gentry. These people employed the medical officer of health and decided how much money to spend on public health. Their wives ran the voluntary charitable organisations including the Oxford Nursing Federation, which employed the county's village nurse-midwives. Of its 60 village nurses employed in 1937 only one was employed by a local authority. Financial support for the Nursing Association came from County Council grants (almost all County Councils supported midwifery after the implementation of the *Maternity and Child Welfare Act, 1918),* as well as various forms of provident funding, with local residents contributing a small regular sum of money to support the association. However some rural districts could not always raise enough contributions, even allowing for the midwifery fees that the village nurse attracted. In

spite of the continued efforts of the Women's Institute this would appear to have been the case in Chinnor.

Examination of the receipts for fees charged by the Oxford District Nursing Federation issued to Chinnor District Nursing Association showed that in 1922-23 the salary of permanent nurses was £141 1s. and a temporary nurse cost £4 12s. 6d. Against this, voluntary subscriptions amounted to £26 15s. 6d., donations £6 2s., benefit subscriptions and other fees £20 3s.10d., with a County Council grant of £55 17s. 6d. and a grant from the Ministry of Health of £5. In addition, midwifery fees amounted to £9 11s. and maternity nursing fees £7 9s. In 1923-24 costs included: salary for nurse £131 10s. and two temporary nurses at £7 2s. and £7 11s. 4d. Subscriptions £29 19s., benefit subscriptions £15 13s., midwifery fees £15, midwifery nursing fees £17 2s. 6d., Ministry of health grant £5. After 1924, no further receipts were available.[4] At this time, 1924, *Kelly's Directory* listed a Miss Ethel Borman, nurse (no other information), as living in the village and in 1928 it recorded Miss L. Patrick, a nurse midwife, resident in the village 1926-32. In Chinnor, the Nursing Association organised collections for a village nurse but apparently this was discontinued in 1929 due to a decrease in central funds and weekly collections for the Radcliffe Infirmary, which had made collecting further funds difficult. However, it was hoped that the nurse would 'stay on privately'. In November 1925 the Women's Institute held a jumble sale to raise money for the District Nursing Fund. Mabel Howlett remembered that in addition to the previously mentioned district nurse who lived in the council house there were two other nurses who lived in the village but who retired before the war.

At a December meeting of the WI in 1926, the issue of having a village nurse was discussed again; but with no subscriptions forthcoming, the WI wondered if it was worthwhile to have a nurse. This entry is a little ambiguous, as it implies that Chinnor did not have a nurse at this time. However, the *Inspectors Register of Midwives* indicated that Chinnor had nursing cover throughout the 1920s and 1930s, either with a resident nurse, or cover from Thame. Village nurse cover resident in Chinnor at the time included: Nurse Rogers,1913-14, Nurse Borman, 1920-23, Nurse Tizzell, 1920-25, Nurse Patrick, 1926-32, and Nurse Gubbins,1933-36. In addition, according to the marriage register, three nurses had married into the village between 1918 and 1923, and their knowledge and expertise may have been available on an informal basis. However, the WI members felt that the nurse was necessary (although there were no further comments on funding recorded). The issue of a village nurse was repeatedly addressed by the WI, and in July 1927 they hosted a speaker from Oxford who gave a talk on the new system of district nursing, but no further details were given in the minutes.

Throughout 1924 the debate continued, but with little in the way of historical details. In December 1927 £2 10s. was donated to the Nursing Association. In February 1934, a statement was made by the branch president about the village nurse, but no further details were given. Nothing more was done until May 1937 when the president contacted the superintendent in Oxford for information. At the June meeting in 1937 there was a general feeling that the WI, along with other women's organisations,

should take their share of supporting a nurse and that a letter would be sent to the enrolling member for the Mother's Union. At the July meeting, a committee was to be set up to start the village nurse fund again. In April 1939 a jumble sale was held to raise funds for the district nurse and in June a letter was received from the treasurer of the Nursing Association with thanks for the £11 raised. Chinnor was by now affiliated to the Thame Nursing Association. In 1892, a cottage hospital for Thame had been discussed due to the distance from the Radcliffe Infirmary Oxford, and the South Oxfordshire Benefit Association had been formed to supply cottage nurses to Thame and nineteen South Oxfordshire parishes. The nurses' home was subsequently expanded to accommodate patients and, on the celebration of the Queen Victoria's Diamond Jubilee, presented to the South Oxfordshire Nursing Association as the Victoria Nursing Home.

Handywomen

Background

As noted in the section on costs before World War 1 until the middle of the 1930s, most working-class women were delivered by the local 'handy woman', rather than by a doctor or professional midwife. The handy woman attended births, often not charging a fee, and laid out the dead: both events being seen as normal events of life rather than a medical episode. Apart from the cost, the advantages of having the handy woman was that she was from the same social class as the patient and was not assumed to be judgmental, however poor the patient's situation in life. She was also known to the mother, trusted and accepted within her community. Many gave medical advice as doctors were expensive. By the 1930s they had ceased to use the title midwife and phrases used in connection with the handy woman were, 'the woman who goes about nursing' 'the woman that does' 'the woman who would go' or the 'woman you called for'. Mrs Munday's daughter in law referred to her as 'the person to go to' as it seemed she helped out in many other ways. Over time, the handy woman became more of a mother's help during the lying-in period and helped to care for other children and carried out household duties. After the inception of the NHS these women were provided by the state as mother's helps.

The role of the handy woman was facilitated by the unregulated state of midwifery in the nineteenth century, which was addressed by a group of concerned women of upper class and aristocratic lineage who, in 1881, formed the Midwives Institute and initiated the first *Midwives Act, 1902.* This Act allowed midwives to attend normal births, complications being referred to doctors, the aim being to minimise the competition between the two professions.

Background

The formation of the Central Midwives Board (CMB) in 1903 ensured that a strict supervisory and regulatory apparatus was in place. The CMB recognised three groups of midwives: firstly, certified midwives who had undergone training in an approved institution and were enrolled by virtue of 'prior certification'. Secondly, new recruits who had passed the CMB examination and, thirdly, those enrolled by virtue of bona fide practice. In 1908 out of 27,234 midwives on the roll: 43% were bona fides, 36% certified midwives and 21% held the CMB certificate. When the 1903 *Midwives Act*

came into being, provision was made for handy women who had been practising for at least a year and were of good standing to be added to the roll of midwives and were known as *bona fides.* This move was sanctioned in order to bridge the staffing gap until enough midwives could be trained to replace them. For example, HW, a bona fide midwife based in Thame and working in the Thame neighbourhood including Chinnor, had been in practice since 1901 and continued working until 1924 aged 73.

This training and supervision of midwives was the death knell to the handy woman. However, many continued to practise until the Second World War. By the middle of the 1930s their role had changed to one of nurses help, and they mostly worked alongside the midwife. In spite of the good intensions of the *Midwives Act, 1903 (*which included bona fides and anticipated competition with doctors), professional collusion occurred. After 1910, under the act no person could attend a woman in childbirth 'for gain' unless she was a certified midwife except when under the direction of a doctor. The later injunction was interpreted rather loosely, and many doctors in rural areas worked with the local handy woman for a reduced fee, rather than a nurse, and forfeiting the full fee. This practice continued even if a nurse was available.

One key issue raised by an inspector writing in the midwives journal *Nursing Notes,* and cited by Leap and Hunter, was that 'it was almost impossible for the bona fide midwives to comply with the rules as many of them could not read or write'. This meant that midwifery training almost completely excluded working class women, who apart from possibly being illiterate, would not be able to afford the tuition fees, examination fees or the equipment necessary for practice. The cost of equipping a newly qualified midwife in 1905 was estimated to be 1 guinea, which was a prohibitive amount for a working class candidate. Leap and Hunter listed the costs of a midwife's equipment as follows: the cheapest nurses bag was 25s. 6d, thermometer, 2s. 3d each medicine measure was 9d., and scissors, 3s. 6d.

Once qualified, midwives were subjected to a system of inspection, not by qualified midwives as now, but by local dignitaries who did not necessarily have any medical or nursing qualifications. Inspection included: hygiene of their houses, personal hygiene, the state of equipment and clothing, and their record keeping. Concern was also raised that their personal standards of hygiene were not up to middle class standards. Midwives were discouraged from heavy scrubbing and household cleaning to preserve their hands from abrasions, and one midwife, Margaret Tizzel, in practice from 1920-1925 in Chinnor, was reprimanded for clearing a manure heap at a neighbour's house. According to the Medical Officers Report for Oxfordshire, in 1912 there were 103 trained midwives, 43 untrained midwives, and the inspector of midwives was Mrs. Pearce.

A number of midwives who covered Chinnor during the period under research were either based in Chinnor or Thame but also covered the surrounding areas. For example, Joan Aitkin, on the register 1914-17, was based in Chinnor but also covered the villages of Kingston Blount, Sydenham and Crowell, whilst HW, based in the Thame neighbourhood, covered Chinnor as well. Examination of the Medical Officer of Health for Oxfordshire's register of midwives gave an interesting glimpse of the state of midwifery at the time. Unfortunately, the records were occasionally incomplete, raising tantalising questions. For example, AC who lived in the Rectory in Chinnor left

as ‘unsatisfactory’ but no specific reason was given, and there was no record of any of her cases. The Medical Officer of Health in 1914 records ER, a midwife based in Chinnor, as being illiterate, her case notes being kept by her daughter (apparently very well). Other issues which came to light from ER’s records were that she failed to carry out basic hygiene procedures such as washing the baby’s eyes or mouth, she did not disinfect her hands and did not take the temperature or pulse.

One particular midwife’s record is recounted here. HW was a bona fide midwife based in Thame, but who visited in Chinnor (there is no record of any formal training on the record and she was already in practice in 1901). Remarks made in the midwives register following inspection in 1916 were that she had Lysol (a disinfectant) in a bottle labelled ergot (a powerful drug used to induce uterine contraction after birth in order to stop post partum bleeding). It was also noted on this inspection that she had difficulty in taking a temperature, pulse and respiration rate so the supervisor gave her a lesson on keeping a temperature and pulse chart. During an inspection in 1923 she was still unable to take temperatures and pulse rates accurately. In 1912 HW attended three still births out of 24 births and a still birth in 1914 evoked the remark that she ‘should have sent for the doctor sooner’. One entry, which was difficult to understand, was that in 1911 and in 1912 there were two incidents of her laying out the dead which was forbidden by the CMB unless related to the midwives’ practice, however no record was entered suggesting it was a mother who had died. As a handy woman she would have done this routinely to increase her income.

In 1913 there was a letter of complaint from Mr. Ashurst, Chairman of the Thame Board of Guardians to Mrs Pearce, Inspector of Midwives, referring to ‘a very bad case in the Thame workhouse brought in on the orders of Dr. Lee, who expressed his concern referring to the mother that ‘she will die’. He referred to HW as a ‘so called midwife’ and her ‘so called care’ of the woman during childbirth. The original letter and the midwife’s reply were illegible in places, and the texts reflected a low level of literacy which made the narrative difficult to follow. However, Mr. Ashurst goes on to say that ‘through her neglect and not knowing caring about her work… the woman into the state she is in’. Some of the rest of the letter was illegible but the essence was, that in the opinion of the Chairman, she should be removed from the list of nurses ‘as she cannot be fit to attend any further women.’

The midwife’s reply was difficult to follow but it appeared to indicate a complete mismanagement and miscommunication between herself, the doctor and the patient’s husband in recognising a placenta previa (the cause of death on her patient’s death certificate) which was followed by a still born baby. It seems that the mother had presented with intermittent bleeding which had been reported to the doctor who said she was to stay in bed and to send for him if she got worse. Following the delivery of a still born baby the mother collapsed and was admitted to the nursing home and subsequently to the workhouse infirmary. Both the patient and her husband had been repeatedly told to call for the midwife or the doctors if she got worse. The doctor claimed that he had not been sent for by the husband who stated that his wife ‘was better’. HW had spoken to the husband and reported that ‘he quite understood that if his wife was taken ill he was to go for the doctors’. In 1920 it was noted that HW had missed a small piece of retained placenta. (It is the midwife’s responsibility to check the placenta and note whether or not it has been expelled intact).

In 1911 a maternity benefit allowance was paid to allow more women to be attended by a doctor during childbirth. However, it seemed that immediately this was available, doctors and independent midwives, raised their fees. For example, for the independent midwives the range was 10s. to 21s. and for doctors, around 30s. The result of this was that the handy woman continued to be used in households where the professional fees were too high. From the medical officers records the largest number of midwifery cases recorded in one year in Chinnor was 24 in 1912, which were delivered by HW and, in the same year, she attended 5 nursing cases in order to increase her income. Other yearly totals for the area were on average less than 10 cases. From this small and uncertain income, qualified midwives had not only the initial outlay of buying their equipment but of maintaining it in good order. For example, EB 1920-23 Chinnor, was reported as not having a urine testing kit, whilst LP 1926-30, also of Chinnor, stated that whilst she had a urine testing kit, she could not afford to buy calipers so sent her patients to attend an ante-natal clinic for measurement.

Few women died at home as the result of childbirth with midwifery care, although approximately 3,000 women died every year in England and Wales in childbirth. A review of the causes of death from death certificates of the burial records in Chinnor, 1895-1947, indicated that after 1922 there were no recorded deaths attributed to childbirth after Mildred Witney died of eclampsia, although there is no record of whether the child survived on this occasion.