Report of Departmental Committee on the Training and Employment of Midwives.

Contributors

Great Britain. Ministry of Health. Department Committee on the Training and Employment of Midwives.

Publication/Creation

London : H.M.S.O., 1929.

Persistent URL

https://wellcomecollection.org/works/tgwvh9wx

License and attribution

This work has been identified as being free of known restrictions under copyright law, including all related and neighbouring rights and is being made available under the Creative Commons, Public Domain Mark.

You can copy, modify, distribute and perform the work, even for commercial purposes, without asking permission.

wellcome collection

Wellcome Collection
183 Euston Road
London NW1 2BE UK
T +44 (0)20 7611 8722
E library@wellcomecollection.org
https://wellcomecollection.org

KR
19·1

G. F. McCleary

THE ROYAL SOCIETY
for the Promotion
OF HEALTH
LIBRARY

MINISTRY OF HEALTH.

Report

OF

Departmental Committee on the Training and Employment of Midwives.

LONDON:
PRINTED AND PUBLISHED BY HIS MAJESTY'S STATIONERY OFFICE.
To be purchased directly from H.M. STATIONERY OFFICE at the following addresses:
Adastral House, Kingsway, London, W.C.2; 120, George Street, Edinburgh;
York Street, Manchester; 1, St. Andrew's Crescent, Cardiff;
15, Donegall Square West, Belfast;
or through any Bookseller.

1929.

Price 1s. 0d. net.

32-286

KR 19·1

THE ROYAL SOCIETY
FOR THE PROMOTION
OF HEALTH
90 Buckingham Palace Road, London, S.W.1
Class No. KR/19.1 Acc. No. 23543
This book is returnable on or before the last date Marked below
HISTORICAL
22900330097

Med
K44714

MINISTRY OF HEALTH.

Report

OF

Departmental Committee on the Training and Employment of Midwives.

LONDON:
PRINTED AND PUBLISHED BY HIS MAJESTY'S STATIONERY OFFICE.
To be purchased directly from H.M. STATIONERY OFFICE at the following addresses:
Adastral House, Kingsway, London, W.C.2; 120, George Street, Edinburgh;
York Street, Manchester; 1, St. Andrew's Crescent, Cardiff;
15, Donegall Square West, Belfast;
or through any Bookseller.

1929.

Price 1s. 0d. net.

32-286

CONSTITUTION AND TERMS OF REFERENCE OF COMMITTEE.

I hereby appoint :—

Sir Robert Bolam, O.B.E., Hon.LL.D., M.D., F.R.C.P.,
J. W. Bone, Esq., M.B.,
Dame Janet M. Campbell, D.B.E., M.D., M.S.,
Lady Cynthia Colville,
W. A. Daley, Esq., M.D.,
J. S. Fairbairn, Esq., F.R.C.S., F.R.C.P.,
T. Eustace Hill, Esq., O.B.E., M.B.,
Miss Alice Gregory,
A. B. Maclachlan, Esq.,
F. N. Kay Menzies, Esq., M.D., F.R.C.P.,
Mrs. Bruce Richmond,
Miss Stephenson, C.B.E., J.P.,

to be a Departmental Committee to consider the working of the Midwives Acts, 1902 to 1926, with particular reference to the training of midwives (including its relation to the education of medical students in midwifery) and the conditions under which midwives are employed.

I further appoint Sir Robert Bolam to be Chairman, and Mr. W. H. Howes, of the Ministry of Health, to be Secretary, of the Committee.

(Signed) N. Chamberlain.

22nd May, 1928.

Mrs. E. Barton, J.P., was subsequently appointed by the Minister as an additional member of the Committee.

WELLCOME INSTITUTE LIBRARY
Coll. welMOmec
Call No.

The cost of the preparation of this report, including the expenses of the Committee, is £885 17*s.* 5*d.*, of which £75 18*s.* 6*d.* represents the gross cost of printing and publishing the report.

DEPARTMENTAL COMMITTEE ON THE TRAINING AND EMPLOYMENT OF MIDWIVES.

REPORT.

To the Right Hon. ARTHUR GREENWOOD, M.P.,
Minister of Health.

INTRODUCTION.

SIR,

1. We have the honour to submit the following report and recommendations dealing with the subjects of the inquiry referred to us in the minute dated the 22nd May, 1928, of your predecessor in office, namely :—

> " To consider the working of the Midwives Acts, 1902 to 1926, with particular reference to the training of midwives (including its relation to the education of medical students in midwifery) and the conditions under which midwives are employed."

We have held 22 meetings, at 13 of which we have taken oral evidence. A list of the bodies and persons who furnished us with written statements and of the 74 witnesses who appeared before us is given in Appendix D to this report.

PART I.

HISTORICAL SURVEY.

2. Before the passing of the Midwives Act, 1902, the midwife was in most cases a woman whose only claim to knowledge of her art was based upon experience derived from actual practice. She was often illiterate, often incapable even of reading a thermometer, and usually quite ignorant of modern methods of nursing and of the meaning of " cleanliness " in the surgical sense. The work of instructing midwives had for many years been carried on in London and other large provincial towns by medical officers connected with lying-in hospitals, and a certain number of well-educated women had taken advantage of these facilities to receive a proper training before embarking on practice. These were, however, in a minority. The Obstetrical Society of London, in addition to pioneer work in laying down rules of practice and conduct, had as early as 1872 instituted a voluntary examination for midwives, the passing of which was rewarded by the issue of a diploma guaranteeing that its possessor was " a skilled midwife, competent to attend natural labours." This diploma, whilst conferring a distinction of real value, was not in any way officially registered. No standard qualification

in fact existed. No criterion was available as a safeguard for mothers against the pretensions of incompetent and ignorant women. It was only when the Act of 1902 " to secure the better training of midwives and to regulate their practice " became law, following long years of agitation and the fruitless introduction into Parliament of a series of measures having similar objects, that these examinations were superseded by those prescribed in accordance with statute by the Central Midwives Board. The early examining practice of the Board and its first rules and regulations no doubt were largely based on the voluntary work of the London Obstetrical Society.

3. The Midwives Act, 1902, which came into force on 1st April, 1903, restricted as from the 1st April, 1905, the use of the name or title of midwife to persons certified under the Act. It prohibited from and after the 1st April, 1910, an uncertified woman from attending women in childbirth habitually and for gain, otherwise than under the direction of a qualified medical practitioner. Special provision was made to safeguard the position of midwives who held a certificate for midwifery granted by certain examining bodies and those who could produce evidence to the satisfaction of the Central Midwives Board that they were of good character and had been in *bona fide* practice for at least one year at the passing of the Act. Women in these two categories, provided that their claim was made within two years from the date on which the Act became operative, were entitled to be certified.

The Central Midwives Board, the body constituted under the Act for the purpose of carrying out its provisions, consists solely of nominated members. Although certain changes have been made by later legislation, the powers and duties of the Board are mainly governed by Section 3 of this Act. These include the framing of rules for certain well-defined purposes, of which the more important from the point of view of this report are, perhaps, those regulating its own proceedings; regulating the issue of certificates and the conditions of admission to the Roll of midwives; regulating the course of training and the conduct of examinations; and regulating, supervising, and restricting within due limits the practice of midwives. The Board was also given power to decide upon the removal from the Roll of the name of any midwife for disobeying the rules from time to time laid down by the Board, or for other misconduct, and also to decide upon the restoration to the Roll of the name of any midwife so removed. A midwife aggrieved by any decision of the Board in the removal of her name from the Roll has a statutory right of appeal to the High Court. The Act provides that all rules framed by the Board shall be valid only if approved by the Minister of Health,* and that

* All the powers under the Midwives Acts, 1902 and 1918, of the Privy Council, which was the body originally responsible for the approval of rules, were transferred to the Minister by the Ministry of Health Act, 1919.

the Minister before approving any such rules shall take into consideration any representations which the General Medical Council may make with respect thereto.

The Act constituted each County and County Borough Council throughout England and Wales to be the Local Supervising Authority* over midwives within its area. There are at present 62 County Councils and 83 County Borough Councils. The Local Supervising Authority is charged, *inter alia*, with the duty of exercising general supervision over all practising midwives in accordance with the rules of the Board; of investigating charges of malpractice, negligence, or misconduct on the part of any midwife and, should a *prima facie* case be established, of reporting the facts to the Board; of reporting to the Board the name of any midwife convicted of an offence; and of supplying the Secretary of the Board during the month of January of each year with the names and addresses of all midwives who, during the preceding year, have notified their intention to practise within its area. The Local Supervising Authority may, in addition, prosecute any offence under the Act punishable on summary conviction.

4. A Departmental Committee was appointed in 1908 by the Lord President of the Council to consider the working of the Midwives Act, 1902. This Committee which reported during the following year gave a generally favourable account of the Act and of its administration. It found that there had been "singularly little effective criticism directed against its main provisions," or the methods sought to give effect to them, and expressed the view that "the extensive powers enjoyed by the Central Midwives Board, in spite of the experimental character and somewhat fortuitous constitution of that body," had on the whole been exercised "with judgment, prudence and sympathy." Among the recommendations made by the Committee were the following, viz., that a secure expectation of payment should be given to a medical practitioner summoned on the advice of a midwife in a case of emergency, that the poor law authority should be responsible for payment and that a scale of fees in this relation should be fixed by Order of the Local Government Board†; that it regarded the provision and maintenance of an adequate supply of midwives mainly as a question of organisation and distribution, which should be undertaken by the co-ordinated action of Local Authorities and voluntary agencies; that the possibility in some cases of combining with the functions of a district nurse midwife the duties of health visitor and, perhaps, also of school nurse should be borne

* There are seven Local Authorities, other than County or County Borough Councils, which also act as Local Supervising Authorities. These are Authorities to whom supervising functions were delegated by certain County Councils under a provision contained in the Midwives Act, 1902, which was subsequently repealed by the Midwives Act, 1918.

† The Ministry of Health Act, 1919, also transferred all the powers and duties of the Local Government Board to the Minister.

in mind by Local Authorities; and that the powers of the County Councils should be extended so as to enable them to aid the training of midwives. Other recommendations were made with the object of ensuring that the Roll of the Central Midwives Board should be an accurate record and of giving the Local Supervising Authorities further disciplinary powers over midwives in the exercise of their supervisory functions.

5. The second Midwives Act passed in 1918 empowered the Central Midwives Board to pay all or any part of the expenses of any midwife called to attend before it in her own defence; to frame rules authorising it to suspend a midwife from practice in lieu of striking her name off the Roll, and to suspend from practice until the case has been decided, and (in the case of an appeal) until the appeal has been decided, any midwife accused before the Board of disobeying the rules or of other misconduct; to frame rules authorising the Local Supervising Authority which takes proceedings against a midwife before a Court of Justice, or reports a case for consideration by the Central Midwives Board, to suspend her from practice until the case has been decided; and where the Board decides to remove the name of a midwife from the Roll, to prohibit her from attending women in childbirth in any other capacity. The Act placed an obligation firstly on the midwife to call in a medical practitioner to her assistance in the case of any emergency as defined in the rules of the Board, and to report the fact to the Local Supervising Authority in each case; and secondly on the Local Supervising Authority to pay the fee of the medical practitioner so called in, in accordance with a scale prescribed by the Local Government Board (now the Minister of Health). The medical practitioner was required, in order to be entitled to his fee, to state in his claim to the Local Supervising Authority the nature of the emergency. The Local Supervising Authority has the power to recover the fee from the patient, or her husband, or other person liable to maintain her, unless it be shown to its satisfaction that the patient, or her husband, or such other person is unable, by reason of poverty, to pay the fee. Provision was also made under the Act to enable the Local Supervising Authority to aid the training of midwives and to make grants for the purpose.

6. The Midwives Act, 1926, essayed to strengthen the law against practice as a midwife by an unqualified person (whether man or woman), making it an offence for such a person to attend a woman in childbirth otherwise than under the direction and personal supervision of a duly qualified medical practitioner, unless he or she satisfies the Court that the assistance was given in a case of sudden or urgent necessity. A midwife who is, in accordance with the rules of the Board, suspended from practice (not being herself in default) in order to prevent the spread of infection has the right, by virtue of a provision contained in this Act, to recover reasonable compensation from

the Local Supervising Authority. The Act made the payment by the Local Supervising Authority of the fee of a medical practitioner called in by a midwife in a case of emergency dependent upon the further condition that he must submit his claim within a period of two months from the date on which he was called in. Provision was also made in the Act enabling the Local Supervising Authority to make arrangements under which an expectant mother can, by the prior payment of an agreed sum, insure against the liability for the payment of the fee of a medical practitioner summoned by a midwife to attend her in emergency.

PART II.

Maternal Care.

7. It has been found impracticable to enter upon the detailed consideration of the matters with which our enquiry is mainly concerned, namely the training of midwives and the conditions of their employment, without first attempting to find answers to two questions which inevitably arise. They are, "What form of midwifery service should be aimed at in this country?" and "What place therein should the midwife be given?" We have felt constrained, therefore, to give some attention to certain relevant aspects of the much wider issue intimately bound up with our allotted problems, that is the national effort to combat the mortality and morbidity attendant on maternity. Amongst those things which concern the health and well-being of a community, maternal welfare must be given a first place, and the disquieting fact that during the last ten years approximately 3,000 mothers in England and Wales have died each year in giving birth to children has rightly awakened the public conscience to the magnitude of the dangers of maternity. And the number of deaths, alarming though they are, affords no true index of the full extent of these risks, since a very much larger number of women suffer permanent injury or invalidity in the fulfilment of this physiological process. In spite of all the efforts which have been made during the past decade to lessen the death rate amongst women in childbirth, the position is now little better in this respect than it was twenty years ago. The importance of elevating the standard of practice of midwives and of improving the conditions under which they work cannot be doubted, but the major question is how to fit the midwife into the general framework of a comprehensive maternity service, so as to use her talent and knowledge to the best possible advantage for the benefit of her patients. We cannot think that any measures directed solely to the better training of midwives and to the amelioration of their lot would materially contribute to the reduction in maternal mortality and morbidity, unless they were accompanied by measures of a wider character to deal with the problem on a broad, even on a national, basis.

8. We have been much impressed by the large volume of evidence given both by witnesses representing professional organisations and by those expressing independent views who stressed the desirability of the formulation of some scheme, preferably based on insurance principles, whereby the mother would be assured of adequate medical, midwifery and nursing care during pregnancy, confinement and the puerperium. The Royal Commission on National Health Insurance, which reported in 1926, gave considerable thought to this matter in their survey of the health services in connection with the payment of maternity benefit under the National Health Insurance Acts. The following is taken from paragraph 114 of the Majority Report of the Royal Commission :—

> " On a review of all the evidence we have heard we have come to the conclusion that the present elements of maternity benefit should be ultimately dissociated from each other, that is to say, any cash payment made on confinement should be separated from the medical, nursing and institutional services of all kinds provided in connection with the condition of pregnancy. The former should, we think, continue to be administered by the Approved Societies. The latter would be provided as an integral part of the medical service and would be administered by the appropriate local authority. The general practitioner, the midwife, the nurse, the specialist and the institution would all take their respective parts in the scheme of extended medical services."

And the following is an extract from paragraph 334 of the same Report :—

> " It is not so much the money payment that is of importance as the question of taking steps to secure that every woman receives proper attention from doctor or midwife in suitable surroundings during a reasonable period centred on the confinement. In other words the character of the benefit should change from ' cash ' to ' health ' and it should be linked up with the other related health services. This is not to say that there should be no cash payment at the time of confinement. Such a payment is undoubtedly of value and will be utilised wisely by most mothers; but other elements must, we think, eventually be introduced."

With the principles of a reconstitution of maternity benefit we are in entire agreement. These can be re-stated as firstly, division into a " cash " benefit and a " midwifery " benefit; secondly, such " cash " benefit to be administered by the Approved Societies as heretofore and paid to the mother; and thirdly, the " midwifery " benefit comprising the services of the doctor, the midwife, the obstetric specialist and the institution, to be linked up with other related services and administered by the appropriate Local Authority. They represent in

our view the foundation upon which the edifice of a satisfactory maternity scheme can best be built up, and we venture to assume that a development on the lines indicated will, without undue delay, be brought about.

9. We therefore proceed to consider first of all what, in the light of present day knowledge, may be regarded as the ideal provision for the mother in a maternity scheme linked up with National Health Insurance. This should consist of a comprehensive service organised on a local basis in which the midwife, the doctor and the specialist should each have their part. The midwife as the person responsible in the majority of cases for the care of the mother throughout pregnancy, confinement and the puerperal period is the one upon whom the main burden would rest. In all such cases there should be available the services of a doctor, with certain well defined duties towards the mother, to whom the midwife should be able at all times to look for assistance when she is faced with difficulties beyond her ordinary competence and skill, and an obstetric specialist who would be called in by the doctor to deal with exceptional emergencies.

The value of proper medical supervision of the mother throughout the whole period of pregnancy and lying-in, whether the actual confinement be in the hands of a doctor or a midwife, cannot be stressed too highly. Unfortunately the old idea that the precise moment of childbirth can be regarded and provided for as a thing apart still persists. Nothing is so certain as the conclusion, to which scientific enquirers are now driven, that the health of mother and child may depend very largely on investigation by the doctor and midwife in the early days of pregnancy, on supervision all through the months of childbearing, on diligent attendance at and about the time of the birth and on watchful care during the puerperium till there be assurance that the normal routine of life may be resumed.

It is not to be expected that an ideal complete service can be speedily instituted. The cost of such provision, however desirable it may be, must receive consideration, and in the formulation of any maternity scheme, thought must be given to the money which can be reasonably made available for it. We believe, however, that important and, in our opinion, necessary steps can immediately be taken toward the attainment of an ideal service without incurring expenditure which would be deemed unjustifiable at the moment.

The first basic requirement is naturally an arrangement for the full services of a qualified midwife throughout the whole period. The extent of the duties of the midwife in the antenatal sphere, at the birth and in the post-natal period, together with the important question of the remuneration to which she should reasonably be entitled for her attendance on women under an insurance maternity scheme on comprehensive and national lines, we propose to defer to a later part of our report.

10. It is convenient, however, at this juncture to outline the extent of the medical practitioner services that might fairly come within the scope of a national scheme. Whilst medical supervision is undoubtedly necessary during the ante-natal period, it is to the midwife that the mother must look for ordinary care and advice during this time. The midwife should, nevertheless, be able under proper safeguards at any time to refer to the doctor a case in which she has reasonable doubt of its normality.

There are two occasions during every pregnancy when a systematic medical examination will usually be of the greatest value—the first at the earliest possible stage when a general medical examination would furnish important information, and the second at about the seventh or eighth month when a full obstetrical examination should be undertaken.

Thus for the ante-natal phase we can summarise the medical desiderata as follows :—

(*a*) Provision for advice on the call of the midwife in case of abnormality or doubt.

(*b*) Early general medical examination.

(*c*) Late full obstetrical examination by the doctor about one or two months before the birth is expected.

In regard to (*a*) this service is already in fact available. If it be asked, on grounds of economy, which of the two remaining provisions should be first put into operation and which might be held over for the present, we should say that the obstetrical examination (*c*) might take precedence of the general medical examination (*b*).

Women who are themselves insured persons under the National Health Insurance Acts are, of course, entitled to medical services, which would include an examination as to general health in the early days of pregnancy. It is to be remembered also that conditions other than those directly associated with pregnancy, perhaps aggravated by the strain of childbearing, often demand for the mother medical attention. But insured women form only a small proportion of those for whom a national maternity service is desirable. Having in view the importance to the nation of caring fully for the mother, there is much to be said for a plan which would provide for her not solely a medical maternity service, but also a medical general practitioner service (comparable to that of the present insurance scheme) during the ten months which comprise the time of pregnancy and lying-in.

It is highly desirable that the doctor undertaking the supervision should not only be conversant with modern ante-natal work but have special experience in its methods. Steps should be taken to see that examinations are not perfunctory and that the data obtained thereby are so registered as to be available subsequently throughout the progress of the case. A special panel of practitioners willing to undertake maternity service would probably be a feature of any scheme.

Facilities are already provided for calling the help of a doctor during the confinement and the post-natal period, but it is advisable in addition that the doctor on call, or in attendance, should make a final systematic examination of the patient after the expiration of, say, six weeks from the date of the birth. Such examination might take place in the patient's home, at the doctor's surgery, or at a clinic.

There are undoubted advantages in the doctor responsible for the ante-natal work being also the doctor who may be on call, or in attendance, during the confinement and the puerperium.

An obstetric specialist should be available at the request of the doctor to deal with exceptional complications at any time in the case. Such assistance can be provided by Local Authorities under the Maternity and Child Welfare Act, 1918, but full advantage has not yet been taken of these powers.

11. Coming now to the position of the mother in relation to this scheme, it is obviously essential in order to ensure successful working that the mother should have an unfettered liberty of action not only in choosing the doctor who would be responsible for the ante-natal and post-natal examinations, but also the right to engage a doctor and a midwife acting as maternity nurse for the confinement rather than a midwife alone. This would necessitate special financial adjustments.

12. Then again arrangements, both administrative and financial, would have to be made for institutional care in certain cases during pregnancy, and for the confinement in a maternity institution firstly of mothers whose home conditions are unsuitable and secondly of those who by reason of some abnormal condition require institutional treatment. Other women might elect to be confined in an institution irrespective of their home circumstances, or of the need for the specialised care that an institution can provide. This is probably a matter of administrative machinery, but it would seem necessary that some cash equivalent of the value of the professional services that would ordinarily be rendered in normal cases should be payable direct to the institution providing alternative facilities. Due precautions might have to be taken to ensure that institutions giving such services were, in fact, fully qualified to do so.

13. If, as has been suggested, the scope of maternity benefit is widened to include medical and midwifery services in addition to a payment in cash, it would be pertinent to give some attention to the question of the most appropriate body to administer these services locally. We do not hesitate to recommend that these duties should be entrusted to the Local Supervising Authorities responsible for the supervision of midwives under the Midwives Acts. These are the County and County Borough Councils throughout England and Wales who are already engaged in administering public health services of a

similar nature and who will, under the provisions of the Local Government Act, 1929, take over as from the 1st April, 1930, the work in connection with the relief of the poor that has hitherto been in the hands of Boards of Guardians.

PART III.

Training of Midwives.

Preliminary.

14. The development by the Central Midwives Board of the system under which pupil midwives now receive training has been a process of very gradual growth. All that it was possible for the Board in the beginning to do was to approve such facilities as were already existent. The large maternity hospitals which were then few in number, existing only in London and some large provincial centres, could train but a small proportion of the numbers necessary to maintain the supply. Out-door maternity charities, small schools directed by midwives in private practice, and even doctors and midwives who took but one pupil at a time were accepted as providing a complete training. As provision for training increased, the approval of the last mentioned class was discontinued, and now only a few practising midwives are recognised for the specific purpose of giving experience in out-door work to pupils who have had the major part of their training in an institution. Private maternity homes are no longer recognised. Lengthening of the period of training had also to be gradually effected, and time had to be allowed for institutions to accommodate their administrative and financial arrangements as each extension was put into force. It was only after overcoming many difficulties that it became possible to make in-door and out-door training compulsory for all candidates for the examination.

15. Under the present rules framed by the Board an intending candidate for examination must, before commencing training, produce to the training institution or teacher evidence of having passed some recognised examination, or in some other way satisfy the training institution or teacher that her general education is adequate.

Among the documents which a candidate is required to submit in order to be entitled to sit for the examination are certificates, in the form prescribed by the Board, showing that she has, under supervision approved by the Board, undergone a course of training in midwifery extending over a period of not less than twelve months, comprising instruction in certain specified subjects laid down in the rules. She must, in particular, satisfy the person certifying that she has :—

(*a*) Examined and received instruction in the supervision of not less than twenty pregnant women (including booking and keeping of records).

(*b*) Witnessed not fewer than ten labours and, in addition, attended and watched the progress of not fewer than twenty labours, making abdominal and vaginal examinations during the course of labour and personally delivering the patient. Of the twenty patients personally delivered, the first five must be attended within an institution where there is training approved by the Board, and of the remaining fifteen at least five must be attended in their own homes.

(*c*) Nursed twenty lying-in women and their infants during the ten days following labour. Of these at least five women must have been nursed in their own homes.

(*d*) During the period of training, attended a course of not less than thirty lectures on the subjects enumerated in the rules, extending over a period of not less than four months and delivered by a registered medical practitioner or practitioners recognised by the Board as lecturers.

The certificates required for (*a*), (*b*) and (*c*) must be filled up and signed either by a registered medical practitioner approved by the Board for the purpose; or by the chief midwife, or, in the absence of such an officer, by the matron (being a certified midwife) of an institution recognised by the Board; or by a certified midwife approved by the Board for the purpose. The certificate required for (*d*) must be signed by the person or persons who delivered the course of lectures.

The period of training is reduced to six months in the case of a woman who produces, in the form prescribed by the Board, a certificate of training as a nurse in a hospital or hospitals approved for the purpose of general training by the General Nursing Council for England and Wales, or the similar bodies acting for Scotland, Northern Ireland and the Irish Free State; or in a general hospital approved by the Board having not less than 100 beds during the whole of the period of such training. The certificate must be signed by the matron or secretary of the hospital or hospitals concerned.

Standard of Education.

16. We have been informed in evidence given on behalf of the Central Midwives Board that the Board has felt it difficult to lay down any hard and fast educational standard for pupil midwives, and has preferred to throw on the teachers the onus of satisfying themselves that the pupil, before being accepted for training, has sufficient general education to enable her both to pass the examination and afterwards to fulfil the obligations laid upon her by the Midwives Acts. This, it is stated, allows the teacher either to refuse to undertake the training of an illiterate pupil, or to refuse at an early stage in her studies to allow a pupil to continue with the training as soon as the inadequacy of her education becomes obvious.

17. The other evidence which we have received on this matter, though not entirely unanimous, is an indication that those who have the interests of the midwives at heart, including organisations representative of them, lean towards the establishment of a common educational test for all prospective entrants to the profession. Various standards have been suggested, of which mention might be made (1) of the certificate gained as a result of passing the Oxford Junior or Cambridge Junior Local Examination, and (2) a certificate of having passed through the highest standard of an Elementary School. We believe it would be difficult to insist on the first standard on the ground that it would, at any rate at this stage of development, prove unduly high. And the second seems also impracticable owing to its variable and ill-defined character. Moreover, the test which may be appropriate to a child of fourteen on leaving school affords little guarantee of the educational state of the woman of 21 years or upwards who has in many instances made no progress in the intervening years. A few witnesses who are disposed to doubt the wisdom of adopting any definite standard are, in general, in favour of the principle, but are concerned with the possibly deterrent effect which such an innovation might have on the supply of pupils, which even now under present conditions is not, they suggest, so large in some training schools as could be desired.

18. It is understood that many training schools make a practice of accepting candidates on trial for a month, and even in some cases for three months, before definitely deciding whether they should be turned away or, alternatively, allowed to complete the training course. In one school which has come before our notice the suitability or otherwise of any particular pupil for training is judged to a large extent upon the manner in which, after a probationary period of three months, she answers a general knowledge paper on simple everyday matters. Sometimes at this school a pupil whose educational knowledge may be deficient is, if she is found to be trustworthy and to possess practical common sense, given special tuition in spelling and simple composition during the evening. This system of selection can only lead to lack of uniformity in practice and, if the teacher or training institution is inclined to adopt an elastic standard of scholastic attainment, to the entry into the profession of persons who are not really fitted for midwifery work.

19. We cannot but feel that the elevation of the status and efficiency of members of the profession depends to a large extent upon the recruitment of women of a good type, and nothing can be gained by the pursuit of the policy of inaction which has hitherto prevailed. After weighing all the evidence which has been placed before us, we have reached the conclusion that it is not entirely satisfactory to leave the selection of pupil midwives entirely to the training schools or teachers because they

must necessarily be regarded as, to some extent, interested parties. By personal interview the heads of schools and teachers may estimate the probable suitability of applicants for the arduous and responsible duties which midwifery practice entails. Some kind of preliminary educational test, however, is obviously needed in order to eliminate those women who have neither the intelligence nor elementary knowledge to justify them entering upon a course of training which, by reason of economic factors, is intensive and of short duration. At the same time there are disadvantages in setting the standard too high if, as is essential, it is not to exclude women who, although not well educated in the ordinary sense, have a calling for midwifery and a natural aptitude for the work. There should, accordingly, be some examination of an elementary kind, the syllabus and standard of which should be authoritatively laid down by some central body, to ensure that the candidate is able to fill in forms intelligently, to understand weights and measures, including percentages, and to profit by the instruction that she will receive in the science of her future profession. For this purpose it would probably be sufficient if the examination were to be restricted to such subjects as reading, writing, spelling and dictation, and simple arithmetic.

Any candidate who is in the possession of a certificate gained as the result of passing a higher examination, e.g., the Oxford Junior or Cambridge Junior Local Examination, should automatically be exempted from taking the entrance examination. Exemption should also be granted to those women who, by virtue of holding a certificate in nursing, are only required to undertake a course of training lasting for six months. It is desirable that the examination, which should be held in all parts of the country, should be placed in the hands of the Local Education Authorities.

Age of Entry.

20. The only restriction in connection with this matter laid down in the rules of the Central Midwives Board is that which precludes a candidate from sitting for the examination until she has attained the age of 21. It will be generally agreed, as one witness pointed out, that a person who takes up study at an advanced age has not usually the adaptability in learning a new subject possessed by one in earlier life. A maximum age of entry is, on general grounds, equally as important as a minimum age and if, as we suggest, the age in both cases is in future fixed by reference to the time of commencing training, the minimum should be 20 years and the maximum 40 years.

Type of Pupil.

21. It has been urged by many witnesses that as an ideal to be aimed at in the future, all midwives should be required to possess the general nursing qualification. They argue that a

good deal of a midwife's work is nursing of a special order and that a knowledge of the principles and practice of sick nursing would be of the greatest advantage in giving her a full appreciation of the value of surgical cleanliness and care and in teaching her to recognise symptoms of general illness. There can be no question but that if such an end could be brought about it would be good for the profession as a whole and for the community at large. But we have grave doubts as to its practicability, at all events for a comparatively long time to come, and we feel that at present it would be injudicious to disturb the existing arrangements under which both trained nurses and untrained women are equally eligible for training as midwives.

Duration of Training.

22. The period of training has undergone successive increases in a relatively short space of time. Up to the year 1916 it was three months for all pupils. From 1916 to 1926 it was six months for the untrained woman and four months for the woman who had had certain general nursing or special training. Since 1926 it has been, as stated in paragraph 15 above, twelve months for the untrained woman and six months for the trained nurse. Some of those who gave evidence before us advocate a further extension of the periods of training to two years for the pupil midwife without nursing training and one year for the pupil having the general nursing qualification. We feel, however, that sufficient time has not yet elapsed to allow a fair judgment to be made of the value and effects of the present periods and that it would be premature at the present time to suggest any radical change.

If, in the future, it is considered expedient to increase the length of training, the importance of arrangements being made for pupil midwives other than trained nurses to obtain more adequate instruction in general nursing as an essential part of their professional education should be borne in mind. This might be provided to some extent in the county and municipal hospitals to be made available under the Local Government Act, 1929, if the necessary facilities cannot be secured in voluntary general hospitals.

Clinical Examination.

23. Whilst recognising the practical difficulties in instituting a clinical examination for the large number of candidates presenting themselves before the Central Midwives Board, we are of opinion that it would form a most valuable addition to the present methods of testing the practical knowledge of aspirants.

Such a test is now an ordinary feature of the final examination for students in medicine. This was only recommended in 1907

when a Committee of the General Medical Council reported in words which are equally appropriate to-day to the midwife :—

> " We are of opinion that an adequate Clinical and Practical Examination can be arranged for, and that such Examination, even if the standard be reasonably low to begin with, would bring about a great improvement in the teaching and study of midwifery and also in the practice of those entering upon their professional work."

Both the course of study and the form of the examination should be framed so as to ensure that qualified persons possess the requisite knowledge and skill for the efficient practice of midwifery.

Post-Examination Experience.

24. Several witnesses have urged the advisability of devising some practical method by means of which every midwife, in order to qualify for independent practice, would be obliged to obtain a certain amount of clinical and administrative experience under supervision immediately after examination and provisional certification. The main reason for this proposal is that the newly trained midwife is not ordinarily fitted to undertake full responsibility on her own account for the well-being of her patients as soon as she emerges from her school, and the additional practical experience which she would receive by working for a time with a more experienced colleague, whom she could consult when faced with difficulties with which she is not accustomed to deal, would give her self-confidence and the necessary degree of proficiency in midwifery practice.

25. In principle the proposal is one deserving of the highest commendation as calculated to contribute very largely to what is so greatly to be desired, namely, the raising of the general standard of midwifery practice in the country as a whole. There are, doubtless, difficulties in the way of its consummation, although it is felt that these are by no means insuperable. In the first place it would seem that the object in view cannot be achieved unless the actual passing of the examination and the resulting certification, as at present obtaining, are treated merely as the intermediate step towards the production of the fully qualified midwife. If provision were made to postpone registration and, in consequence, licence to practise independently until the prescribed period of experience under supervision is completed, this would probably be sufficient for all practical purposes. The most suitable way of ensuring the smooth working of a scheme on these lines would appear to be, firstly, to require the midwife after passing the examination now held to practise under supervision in accordance with the conditions laid down and, secondly, to arrange for the certificate of the person responsible for the supervision to be furnished

to the Local Supervising Authority which would thereafter certify to the licensing body—the Central Midwives Board—the fulfilment of the conditions. The midwife would then have her name placed on the Roll of the Central Midwives Board and be fully licensed for independent practice.

26. The post-examination experience could not of itself be regarded as fully meeting the needs of the midwife who received it if she did not at the same time assume the full responsibility appropriate to her calling. It is important that she should be permitted to carry out during her apprenticeship all the duties of a midwife in relation to the Local Supervising Authority, and that she should not be subject to too much control. Probably the best method of attaining this object would be to make arrangements for midwives during this period of apprenticeship to be appointed as members of the staff of small maternity institutions specially recognised for the purpose, or as assistants to competent and experienced independent midwives specially approved for the same end. If these institutions and midwives were not at the same time approved for the training or teaching proper, there would be the great advantage that clinical material required for the ordinary training of both pupil midwives and medical students would not be thereby absorbed. Indeed the scheme might help to use such material to better advantage by putting an end to the tendency of certain large training institutions in which medical students and pupil midwives are taught to provide opportunities for the latter to gain practical experience and self-confidence by attending more cases than the prescribed quota. In any event it would make the staffing of the smaller institutions a simpler problem and would tend to a higher standard of practice therein.

27. In view of these considerations, we think it not unreasonable to recommend as a minimum a period of three months' compulsory post-examination experience, with the further condition that each midwife should, during that period, be made personally responsible for the conduct of labour in not less than five cases. This supervised experience should be undertaken immediately after the passing of the examination, or at all events, within such period thereafter, not exceeding six months, as would ensure that it did in fact constitute the final stage of training and an introduction to the individual responsibility of independent practice. The onus of providing suitable opportunities for post-examination experience would naturally fall mainly on the training schools. We have suggested in paragraph 36 below a method by means of which the schools could be assisted in the performance of this function. The remuneration to be paid to the midwife, either as a member of the staff of a recognised institution or as an assistant to an approved independent midwife, might be in the nature of an improver's wage.

Training in large Institutions.

28. The Central Midwives Board has made it a policy during the past few years to reduce the number of centres at which pupil midwives may be trained by seeking to concentrate so far as possible the training in the larger institutions. The Board lays stress in its evidence on the maintenance of a proper obstetric atmosphere and on the importance of every pupil being given a full opportunity of an intensive training in all the various aspects of midwifery practice. This policy which we consider to be well founded has evoked little criticism on the part of those who gave evidence before us. There are indeed obvious advantages in pupil midwives being trained in institutions sufficiently large to give a variety of experience and which possess an adequate supply of apparatus, whilst the smaller maternity institutions, as has already been mentioned, can usefully supply facilities for post-examination experience after the training proper has been completed. We hesitate to specify what might reasonably be regarded for practical purposes as an institution sufficiently large for training midwives. But if it be defined as one with at least twenty maternity beds, together with an adequate number of deliveries in an attached extern district, this might, perhaps, be accepted as a guide for the future.

Lecture Courses.

29. The attitude of the Board to the provision of systematic lectures for pupil midwives is an indication that here also concentration is favoured wherever practicable. The view is held that it is preferable to amalgamate lecture classes into centres at which pupils from various training schools in the surrounding area may attend, on the ground that amalgamation makes for uniformity and that a large class is more stimulating both to the lecturer and the pupils. It has also been thought that a united lecture class, especially in towns with two or three small institutions, might serve the further purpose of acting as a centre around which a common midwifery school might be formed, by pooling the resources in teaching material of each unit and making them available for all students. It has, in the opinion of the Board, been found by experience that lectures to a few pupils within the institution where the practical training is given are liable to become either stereotyped or too informal and to be subject to interruptions caused by the demands made on the pupils' time by other duties. Great importance is attached to the desirability of lectures in such specialised subjects as infant hygiene, the duties of the midwife to the Local Supervising Authority, the measures to be taken in regard to ophthalmia neonatorum and to venereal disease, being delivered by persons who have expert knowledge of these matters—knowledge which, it suggests, is not in general possessed by medical

officers on the staff of the institutions where the practical training is provided.

The effect of this policy has been to deprive certain institutions of the privilege that they had for many years enjoyed of providing their own lecturers and to cause some dislocation in administration. The application of the principle of amalgamation of lecture classes has been felt most acutely in a few of the large provincial cities where the Board has arranged for the lectures to be given under the aegis of lecturers employed by University Authorities. There has in consequence been dissatisfaction, as shown by the evidence which we have received on the question, on the part of some of the institutions penalised in this way, against what they consider to be unnecessarily harsh and arbitrary treatment.

30. We cannot help feeling some sympathy with this point of view, though we fully recognise the endeavours made by the Board to improve and widen the theoretical side of the midwife's training. The tendency nowadays is for the teaching authorities in medical schools to place less importance as a factor of value upon the systematic lectures as such than was formerly the case. If this be true in its application to the medical student, it should be even more true in regard to the pupil midwife who cannot be expected, either from the point of view of education or from the aspect of scientific knowledge, to be capable of assimilating the details of a formal lecture to the same degree as a medical student. It would not be accurate, in our view, to say that a small class necessarily has a cramping effect on the lecturer by depriving him of initiative or of the urge to give of his best. If a lecturer is interested in his work, is competent and has the progress of his pupils at heart, the size of the class, whether sixty or six, has little bearing on the spirit in which that work is carried out. It would scarcely be equitable to deprive a teacher of this kind of his position as a lecturer to pupil midwives merely because a University happens to be near at hand, unless there is reason to believe that the facilities and equipment at his disposal are so inadequate as to affect adversely the standard of the teaching. In some districts, of course, centralised lectures with relatively large classes for certain purposes may be the best arrangement that can be made, so that no definite policy in this relation can fairly be laid down. All cases should be treated on their merits.

31. It will be generally agreed, for instance, that there is a place for classes of a considerable size for a certain part of the midwifery curriculum, another place for lecture demonstrations with smaller classes and a further place for tutorial work admitting of a greater degree of individual teaching. The general principle may be formulated that provision should be made

in every area to secure the highest possibly quality of instruction available. This objective, however, should not be pursued to such an extent as seriously to incommode any training institution whose pupils are required to attend frequent classes at an inconvenient distance away from the institution. The institution may be thereby denuded of the personnel requisite for the proper nursing care of patients receiving residential treatment and disorganisation may be caused in the administration. Both of these results might be avoided if approval as a lecturer could reasonably be given to a person on the staff of the institution who has adequate apparatus and clinical material in sufficient quantity at his command. We recognise, however, that certain parts of the curriculum, such as those dealing with the relationship of the midwife to the Local Supervising Authority, with venereal disease and with ophthalmia neonatorum call for the services of lecturers of a special type, and for this purpose common centralised lectures for all the pupil midwives receiving training within a considerable area would be the obvious and proper arrangement.

Differences in Training, Examination and Certification in certain cases.

32. Our evidence has shown a distinct cleavage of view on the somewhat controversial question as to whether pupils who do not intend to practise as midwives should or should not be subject to a different procedure in relation to training, examination or certification from those who propose subsequently to take up practical midwifery work. This situation owes its genesis to the agitation which has arisen in different parts of the country with respect to the utilisation of clinical material for the training of persons who do not put such training to any real practical use. These persons fall into two main classes. Firstly there are those who require the certificate of the Central Midwives Board in order to be eligible for appointment as health visitor, and secondly there are those who, having secured the general nursing qualification, acquire the midwifery certificate more or less as an ornament to enhance their prospects of advancement in the various branches of nursing work. It is understood, for example, that many of the highest positions in the nursing world and a large number of positions abroad require the applicant to be a certified midwife, and that in the majority of these posts there is no reason to anticipate that the holder will ever be called upon to put into action the knowledge of midwifery she has gained.

The point at issue, according to the information that has been placed before us, is that these women absorb a considerable amount of the available training material, to the detriment of the interests of medical students in schools which are sometimes hard pressed to obtain adequate facilities to comply with

the training recommendations laid down by the General Medical Council. No shortage of material appears to exist in areas other than those in which medical schools are situated, so that the problem is entirely localised in London and a few of the large provincial centres. We have learned from one medical witness who recently made exhaustive enquiries in connection with the matter, that in London in particular the shortage has on occasions been acute, and that in the provinces it has also given rise to concern. Other evidence from medical teachers of midwifery to pupil midwives and medical students in London, Manchester and Liverpool goes to show that the difficulty is one calling for an early settlement. We have been given to understand that a large proportion of the pupil midwives who receive training at maternity hospitals at Leeds and Liverpool do not, in fact, practise after certification, so that to all intents and purposes the material used in training them is, from a purely midwifery aspect, wasted. What is true for these two areas seems in a greater or less degree to be true for the remainder.

33. We cannot think that any good purpose would be served by the establishment, as a few witnesses suggested, of a diploma of a lower order for non-practising midwives which would be granted after a shorter course of training and a correspondingly smaller amount of practical experience than that normally applicable to the prospective practising midwife; or that there should be any differentiation in respect of registration. Neither do we believe that it would be at all practicable to reserve vacancies for training in the large institutions for those who intend to put their training to practical use. The lower diploma would create confusion and would be of little value to its recipients, and the reservation of vacancies in the large training institutions in the manner contemplated is based on the somewhat dangerous presumption that every pupil who undergoes training is sure at the outset in what direction her after career will lie. All pupils, irrespective of their future intentions, should, in our view, be treated alike as regards training, examination and certification, including, if our previous recommendation be adopted, the post-examination experience. If a woman is to be a health visitor, she should be in a position to meet the widwives with whom she may come in contact on equal terms. It would accordingly be in her own interests to take the full training course and to widen her knowledge of practical midwifery by going on to take the three months' further experience under supervision.

Methods of remedying shortage of clinical material.

34. We do not propose to examine in detail all the remaining suggestions which have been submitted in evidence with a view to remedying the shortage of clinical material where it is found

to exist. One is that the sphere of influence of the hospital schools should be extended by the purchase of the practices of independent midwives, thereby enabling the schools to draw upon increased facilities for training purposes. A similar proposal in a slightly different form advocates the establishment of extern homes to be used solely for the district training of pupil midwives and medical students in areas taken over by purchase from independent midwives. A third emphasises the advisability of the development of independent maternity units, each of which would have a large central hospital for the theoretical and special training which only a large institution could provide, with affiliated smaller satellite training schools grouped around it for practical instruction. A fourth visualises the better utilisation of the clinical material available in poor law institutions following upon the transfer of the functions of Boards of Guardians to the County and County Borough Councils under the Local Government Act, 1929, and the resultant closer association of the medical teaching hospitals, the midwifery schools and the rate-aided hospitals. The point has been made in reference to London that several populous districts are not served by teaching practices, and that if the material in these districts, of which little or no advantage is at present being taken, were to be made available for the use of pupil midwives by co-operation between the various training institutions concerned, the facilities for training would not be found to be insufficient. The same condition no doubt exists in other large urban areas.

35. Whilst we do not wish to disparage any of these suggestions which, indeed, offer valuable possibilities for future investigation and consideration, the problem with which the medical schools are faced is too pressing to warrant delay in finding an effective solution. And it would be unwise to rely on palliative measures designed merely to serve the needs of the moment. The impetus which has been given during the last few years to the movement towards the production of increased institutional accommodation for maternity cases shows no sign of diminution and it is reasonable to assume that public opinion will not be satisfied until a very much greater number of beds than at present exist have been provided. The effect of recent developments is indeed now becoming apparent, and is reflected in the larger number of women who are being confined in institutions. This must ultimately tend still further to reduce the facilities available for the extern training of medical students and pupil midwives in respect of which the shortage of material is felt most acutely.

It is not merely in the interests of medical education, but in the interests of the mothers that the obstetric training of the medical student should be as thorough as possible. Taking a broad view of the whole position and having due regard to

the future as well as to the present, we have reached the conclusion that, as urged by a few witnesses, some restrictions upon the training of pupil midwives in hospitals attached to medical schools are necessary. We recommend, therefore, that students in a medical school area should have preference in the apportionment of material, and that pupil midwives in that area should be allowed to make use of such material only in so far as it is in excess of the needs of medical students. If pupil midwives in course of training in connection with a medical school are not able to obtain a sufficient number of cases to qualify for entrance to the examination of the Central Midwives Board, they should be required to go elsewhere for this purpose.

Central Clearing House.

36. If effect were given to the previous recommendation without proper safeguards, pupil midwives who were not able to secure the whole of the necessary practical experience in a district in which the clinical material was largely earmarked for medical students, would be faced with difficulty unless they knew where they might go to make up the deficiency. This resolves itself into a matter of distribution, and a central clearing house, possibly under the auspices of the Minister of Health, in order to collate up-to-date information as to the vacancies which occur from time to time in the various training schools and to superintend the work of distribution, would inevitably be required. The functions of the central clearing house need not be limited to this one specific purpose. Its scope might be enlarged without giving rise to any administrative difficulty to include all general matters of distribution and, in particular, it might be given the responsibility of advising training schools throughout the country as to the recognised maternity institutions and the approved independent midwives to whom after certification pupil midwives might be sent for their post-examination experience.

Post-Certificate Training.

37. Post-certificate training, the present facilities for which are of an extremely limited nature, should be encouraged and arranged for midwives at regular intervals by all Local Supervising Authorities. This might take the form of lectures or of lecture demonstrations, either of which could be attended by midwives without any great interference with their practice, or of whole-time residential courses lasting from two to eight weeks. Residential courses are naturally the most useful and instructive of all, but it would only be practicable so to provide for a relatively small proportion of midwives. They would be especially valuable for women whose circumstances compel them to work alone for long periods out of touch with any institution and even without the opportunity of contact with any colleague, or for those who through lack of opportunity feel the need of

refreshing their knowledge by an intensive study, both on the theoretical and practical side, of the methods of present day science in its application to their work. The cost incurred in the provision of post-certificate training, together with midwives' expenses and any expenditure that might be involved in the provision of a locum tenens, should be borne by the Local Supervising Authority. It is essential, in order that proper advantage may be taken by midwives of the benefits to be derived from post-certificate training, that courses should be organised in easily accessible centres, e.g., in London and the large provincial towns throughout the country, so as to avoid dislocation and to minimise travelling.

We have been greatly impressed with the good work that is being done at the Post-Certificate School, Camberwell, by the General Lying-in Hospital, York Road, Lambeth, London, S.E.1, in connection with specialised training of the kind under consideration. And we have taken the opportunity to obtain from the Hospital Authorities details of the methods of training which have been found by this School to be most suitable, together with particulars of the charges made to midwives participating in the courses. This is set out in Appendix A to our report, in the hope that it may prove useful as a guide for others who may be set the task of undertaking similar work.

Examination for non-medical teachers.

38. There is a consensus of opinion that the time has come for the institution of a prescribed examination for non-medical teachers of midwifery. The Incorporated Midwives Institute, a purely voluntary body, has done good service in its pioneer work of organising as from the year 1926 an examination for teachers of this kind and of granting a diploma to successful candidates. But this body considers that it is only "breaking ground" and hopes that the development which has been initiated "foreshadows" the establishment of a "one-portal official examination." Such an examination should be designed to ascertain the teacher's knowledge of the subject and, in particular, her capability of imparting it to pupils. For this latter purpose an actual inspection of her methods of teaching whilst she is taking a class would be essential. The question as to the body which should be responsible for laying down the standard of the written part of the examination and the one which should be given the duty of inspecting and reporting on her teaching capacity will be dealt with in a later part of our report.

Miscellaneous Training Matters.

39. It has come to our knowledge that certain training schools allow senior pupils, with a view to inculcating self-reliance, rather more freedom of action than is, in our opinion, desirable. To this end a senior pupil is often permitted to undertake the

responsibility of directing the work of a junior pupil in connection with extern midwifery cases. We think that the necessary supervision should at all times, whether within or without the training institution, be exercised by a person fully competent and qualified to do so.

40. Special hospitals, such as those set aside for the treatment of persons suffering from venereal diseases, are admirable for giving pupil midwives facilities to obtain experience in the observation of women who are being treated for such diseases. Hospitals of this character are, however, by reason of their limited scope not suitable for the whole of the training.

41. It has been put to us in evidence that there are certain advantages in pupil midwives and medical students being taught together in relation to the systematic instruction in their training. We do not hesitate to dissent from this expression of opinion, on the ground that the requirements of the two classes are too divergent to justify any development on such lines. The same objection cannot, we believe, be raised with regard to the clinical part of the training and, indeed, if, as is so desirable, the pupil midwife and the medical student are to co-operate later on in their career, there is a good deal to be said for bringing them into association with one another at the earliest possible moment both in the maternity wards of the training hospital and on its extern district.

42. We have received evidence to the effect that certain hospitals make a practice of allowing medical students to attend district midwifery patients without being accompanied by a properly certified midwife to undertake their nursing work. This practice is, in our view, open to grave objection and should be discouraged.

As regards the arrangements for the midwifery training of medical students generally, the recommendations promulgated by the General Medical Council in the year 1923 are based on reasonable and progressive lines, but the mode and extent of their application by different medical schools seem to vary considerably. Unfortunately in some cases the training does not yet fully conform with the recommendations.

At the instance of the Departmental Committee of the Ministry of Health on Maternal Mortality, the General Medical Council has obtained information as to the steps taken by the various Licensing Bodies to carry out the Resolutions and Regulations of the Council regarding the requirements in midwifery for medical qualifications. The whole of the information so obtained was circulated to the Licensing Bodies in the form of a Special Report in June, 1929.

43. A good deal of stress has been laid in evidence submitted by a few medical witnesses on the lack of adequate facilities for the post-graduate training of medical practitioners. Although

this matter is rather outside our terms of reference, we feel that it would not be out of place to draw attention to the importance of steps being taken by medical schools to develop, so far as may be practicable, suitable courses to meet what is undoubtedly a real need.

PART IV.

Employment of Midwives.

Midwifery Grants.

44. The administrative measures which have been introduced to stimulate the provision and maintenance of local midwifery services have an essential bearing on the conditions under which midwives are employed. It may be convenient to give brief details of these measures in so far as they relate to the subject with which this part of our report will be mainly concerned. The Minister of Health is empowered to make grants to Local Authorities and voluntary agencies in respect of the provision of a midwife for necessitous women in confinement and for areas which are insufficiently supplied with this service. The arrangements under which midwifery grants are now paid will be replaced as from the 1st April, 1930, by the payment of a consolidated grant to Local Authorities under the Local Government Act, 1929, and by the payment of contributions to voluntary agencies by the appropriate Local Authorities.

For urban areas the grant at present amounts, as regards voluntary agencies, to half the deficit on a domiciliary midwifery service maintained by an institution or nursing association approved by the Minister for the purpose, and as regards Local Authorities to (1) half the deficit on salaries paid or guaranteed to midwives employed or subsidised by Local Authorities and (2) half the fees paid to midwives by such Authorities in respect of cases in which the woman attended cannot afford to pay the full fee.

For rural areas where the midwifery services are largely provided by nursing associations, grants are at present paid by the Minister either direct to a county nursing association, or to a County Council which undertakes, either wholly or in part, financial responsibility for the maintenance of the midwifery service within its area, in respect of :—

(*a*) the midwifery and maternity nursing cases attended by midwives employed by district nursing associations affiliated to the county nursing association, and by emergency midwives on the staff of the county nursing associations;

(*b*) the administrative expenses of the county nursing association attributable to midwifery;

(*c*) the cost of establishing new district nursing associations.

In the case of district nursing associations which are not affiliated to the county nursing association, or of district nursing associations in counties where there is no county nursing association, the grants are usually paid to the County Council for distribution to the district nursing associations. For a small number of rural areas, County Councils have made arrangements to assist nursing associations to pay the salaries of midwives in their employ. The County Council may also make contributions to the county nursing association (or to district nursing associations in areas not covered by a county nursing association) to aid the provision by such association of trained midwives for service in the area of the Council.

The Duties of the Midwife.

45. Under existing statutory arrangements, the midwife is required to conform to certain specific requirements laid down in detailed form in Section E of the rules of the Central Midwives Board, if the standard of her work is to be regarded as satisfactory. The general criticism received in evidence from many quarters that the rules of the Board as a whole need to be re-arranged and revised is, we find, directed mainly to this particular Section, which has been the subject of considerable comment in regard both to its form and content. That much of this criticism is well founded is not open to doubt.

We have set out in Appendix B such objections and criticisms as have been offered by witnesses and seem to be reasonably founded, together with some suggestions as to the way in which these might be met in any revision of the rules in Section E. It must be clearly understood, however, that the Appendix does not profess in any way to cover fully the questions which arise in regard to the directions in which these rules might be amended. Nor must it be assumed that in drawing attention to possible amendment and, in some cases, amplification of these rules, we desire to add to the restrictions which already encompass the practising midwife. We have, on the contrary, reached the conclusion that the time has arrived when the present system of discipline based as it is on a code of rules setting out in precise language what a midwife may and may not do should be reconsidered, and, we suggest, superseded. Such a code was, no doubt, necessary in the past, but we cannot regard the mode of its application as altogether consistent with the improved status and responsibility of the midwife which we believe it is in the national interest to promote. Recommendations showing how the system may conveniently be altered are contained below in that part of our report relating to the administrative and judicial functions of the Central Midwives Board.

46. The scope of the measures which we believe to be essential for the well-being of the mother during pregnancy, labour and the puerperium has already been indicated in Part II of this report. The following paragraphs deal with the application of such measures in relation to the duties of the midwife.

An early general medical examination and a late full obstetric examination by the doctor about one or two months before the birth is expected would necessarily react to some extent upon the duties of the midwife in the ante-natal sphere. At present she is required under the rules of the Central Midwives Board to keep notes of ante-natal visits in a definite form approved by the Board. We feel that there would be advantages in encouraging her to continue to make preliminary observations on the mother's condition and to record such observations in accordance with the existing procedure. The verification of the data thus obtained would be useful to her from an educational point of view. But in order to admit of the fullest possible measure of co-operation between doctor and midwife, it would be desirable for the form as it now stands to be revised and re-arranged.

The services of the doctor on call or in attendance would be available to deal with such contingencies as inter-current disease arising during pregnancy, or for the treatment of any woman found by the midwife to be suffering from an abnormal condition during labour and the puerperal period. It should be the duty of the midwife in these circumstances to send for the doctor without delay, whilst, in the exercise of her discretion, taking steps to deal with emergencies until his arrival.

47. The rule of the Board which defines the duties of a midwife during the lying-in period has proved to be drawn on lines so general as to leave room for interpretations tending to laxity in practice. The present day view of attention to the " cleanliness, comfort and proper dieting of the mother and child " makes it clear that the duties should include—

(*a*) The washing of the baby, attention to the cord, and other matters, such as an inspection of the eyes and mouth, and enquiry concerning the bowels and the taking of breast milk.

(*b*) A blanket bath for the mother each morning for the first week, the making of the bed, the taking of the mother's temperature, pulse and respiration, attention to the genitals, any treatment, such as the passing of a catheter, that may be needed according to the stage reached in the puerperal period, and lastly, the giving of instruction regarding diet, care of the bowels, etc.

Moreover, it is not sufficient that the midwife should merely be required personally to supervise the performance of these duties by someone in the household. She should actually carry out the work herself, or if she is unable to do so, a properly qualified assistant, that is one certificated in midwifery, should be engaged as a substitute.

Further, the second paragraph of the rule may give rise to the impression that the attendance of the midwife should normally cease on the tenth day following the birth of the child. In any event it is desirable that an increased amount of nursing care, beyond that at present accepted as the ordinary standard,

should be indicated as the usual practice to be observed by the midwife. This should, we consider, provide in a normal case for morning and evening visits for the first three days of the puerperium, one visit thereafter up to and including the tenth day and single visits on at least the twelfth and fourteenth days. It should be understood that the midwife, or her assistant, should not necessarily feel that even on the fourteenth day she has finished with the case, if circumstances show additional care to be necessary.

48. We have been at some pains to ascertain the usual amount of time that is devoted by the midwife to the adequate nursing of the mother and child during the puerperal period. On the facts that have emerged in evidence, it is gathered that the ordinary morning visit takes slightly over an hour for the first few days, a little under an hour for the following days, and that the evening visit generally lasts about thirty minutes. This is, however, by no means the invariable procedure. In many cases the midwife, especially if she is a busy woman, does not visit more than once a day; indeed she often has not the time at her disposal to do more. We have some hesitation in making any recommendation as to the precise time that should ordinarily be spent by the midwife in the performance of any necessary nursing duties when she visits the patient's home. She must during the periods of stress inevitable in midwifery practice be allowed a reasonable discretion as to the attention that can be given to individual patients. But it is evident that in practice there is lack of uniformity, and some authoritative guidance is needed. One of the most cogent arguments in favour of improving the conditions of employment of the midwife lies in the fact that by so doing it may be possible to ensure that she is thereby enabled to give more adequate attention to her important nursing duties than is possible at present.

49. Much misapprehension appears to exist in regard to the rules which purport to define normal labour, and the abnormalities and illnesses occurring during pregnancy, labour or lying-in, which necessitate the midwife calling a doctor to her aid. Detailed comment is made on these in Appendix B. An exhaustive list of the contingencies in which medical help should be sought would manifestly be a formidable one. Opinions will differ as to the relative prominence to be given to certain forms of emergency and, with the advance of knowledge, these may gain or lose in urgency from time to time, whilst fresh types may be recognised. All these considerations go to show how difficult it is to frame a code of standard practice, when departure therefrom has to be regarded as meriting disciplinary action.

50. There is, we find, a good deal of controversy concerning the question whether midwives should be allowed to administer sedative drugs entirely on their own responsibility. We do not propose to enter into any discussion as to the merits of the case put forward by either of the two strongly opposing schools of

thought on this matter. The subject can, in our submission, only be approached in a satisfactory manner by considering what is best in the interests of the mother. There is a consensus of opinion that there can be no absolute ban on the administration of drugs by midwives, because of the occasional emergencies with which any midwife may be faced when the services or advice of a doctor are not available. At the same time, if the well-being of the mother be the prime consideration, midwives cannot be regarded as persons fitted either by training or experience to be given complete freedom in the use of drugs. The solution to this problem may well be found in the closer association of the midwife and doctor and the proper co-ordination of their activities under a comprehensive scheme of maternity services, such as has already been outlined. We feel bound, however, to place on record that, in our opinion, the midwife is not the person upon whom, in the ordinary course, the responsibility for the administration of hypodermic injections, e.g., of morphia or pituitrin, should lie. As, however, she must occasionally use drugs, either in her capacity as agent for the doctor, or acting herself in emergency, she should therefore be carefully instructed during her training in the action of the drugs used in obstetric practice, the mode of application of such and the occasions on which they should be administered.

Present conditions of employment.

51. The midwives practising in rural areas are largely those employed by nursing associations. These are divided into two classes—fully trained nurses and village nurse midwives. The first group is largely made up of women engaged and trained by the Queen's Institute of District Nursing, a central voluntary organisation responsible for co-ordinating and directing the work of district nursing associations generally. Those eligible for such training are fully trained nurses who, in return for a special six months training in district nursing, agree to serve for a period of one year. When they receive in addition training in midwifery, they must be prepared to serve for a further year. Queen's nurses, as these women are termed, are drafted by the Queen's Institute of District Nursing to nursing associations in various parts of the country where their services are needed, either to fill vacancies or to undertake work in the area covered by a nursing association newly affiliated to the central body. The nursing association is responsible in each case for the nurse's salary, for her bag and equipment and for the provision and upkeep of a bicycle, motor-cycle or motor car as may be necessary. The minimum commencing salary of a Queen's nurse practising midwifery is £68 rising by £3 annually to £80, with £8 a year for uniform, £1 1s. 0d. a week for board and laundry and the cost of providing at least two furnished rooms, including fire, light and attendance. There is no maximum salary and nursing associations are encouraged to pay as much as their financial circumstances allow.

Village nurse midwives are engaged and trained by county nursing associations and supplied to affiliated district nursing associations. They differ from Queen's nurses in that they do not hold the general nursing qualification so that the midwifery training appropriate to women of this class is of twelve months duration. They are also given practical and theoretical instruction in district nursing, extending ordinarily over a period of six months, in some cases of three months and in some cases twelve. The whole cost of training, less the midwifery training grant paid by the Minister of Health, is borne by the county nursing association concerned, and the village nurse midwife agrees in return for free training to serve in her county for two and sometimes for three years. Her salary during the term of the agreement is from £30 to £40 a year, exclusive of uniform, laundry, and board and lodging, this varying in accordance with the cost of accommodation and of living in the area in which she works. On the completion of the agreement she is usually able to earn a higher salary, either in her own county or elsewhere.

52. The great majority of county nursing associations are affiliated to the Queen's Institute of District Nursing; a few prefer to retain independence. Excluding a small number of district nursing associations, e.g., those operating in a county where the county nursing association is not affiliated to the central voluntary organisation, local associations are, with certain exceptions, affiliated both to the county nursing association and to the Queen's Institute. Among the exceptions are district nursing associations in counties where there is no county nursing association and in large towns; these affiliate to the Queen's Institute alone. We did not invite representatives of any of the independent nursing associations as such to give evidence before us, as we understand that the arrangements under which these bodies carry on local midwifery services are similar to those applicable to nursing associations affiliated to the Queen's Institute.

It is a condition of affiliation to the Queen's Institute that village nurse midwives should not be employed by nursing associations in districts having a population of 3,000 or more. Queen's nurses must always be engaged to work in such districts although, provided that the supply of Queen's nurses permits, there is nothing to prevent any association from employing a Queen's nurse in a district with a population of under 3,000, if the association is in a position to pay the nurse's salary and allowances. But, generally speaking, such associations cannot afford to employ Queen's nurses, so that the majority of midwives practising in rural areas are of the village nurse midwife type.

The midwifery fee charged by a midwife in the employment of a nursing association, which is in all cases handed over to the association, ranges from 20s. to 42s., the fee being ordinarily a few shillings less to annual subscribers to the association. The

policy of the Queen's Institute and of county nursing associations generally is to charge the ordinary fee of the district, and where an actual case of " undercutting " the fees of independent midwives is brought to their notice, steps are taken to remedy the matter locally, if possible.

53. Most village nurse midwives act in the dual capacity of midwife and district nurse. In several county areas the County Council is accustomed to utilise their services for the purpose of health visiting and/or school nursing duties. It is possible as a rule to arrange for them to be relieved in an emergency either by a colleague practising in a neighbouring district, or by a member of the special staff of emergency midwives retained for this and other purposes by every county nursing association. Sometimes when the district is reasonably populous and compact and provides enough work to keep two nurse midwives occupied, one is responsible for the district nursing and the other for midwifery. In such cases relief during emergency and for off-duty times can without dislocation be arranged. The same holds good with regard to districts where more than two nurse midwives are working together. There is, on the other hand, often acute difficulty in relieving the nurse midwife working alone, with no other within easy reach, on the occasions when she is ill or needs a rest. The emergency staff kept by the county nursing association is usually not large enough to provide regular relief and the midwife has perforce to wait until a deputy can be provided, when a longer period off duty is allowed in compensation. It is understood that the off-duty time, both for Queen's nurses and for village nurse midwives, is one month in every year, together with one half day per week and a " week-end occasionally."

54. We understand that at the present time about 34 county nursing associations have initiated a pensions scheme for village nurse midwives; others have the matter under consideration. By joining at an early age the nurse midwife can secure a superannuation payment of from £45 to £50 a year on attaining the age of 55. Pension rights are now usually transferable if any particular nurse midwife moves from one county to another. The Queen's Institute has also a separate scheme termed " The Long Service Fund " for Queen's nurses, whereby each nurse is entitled to a small annuity of £30 a year on retiring after 21 year's service. This Fund is non-contributory, and has been found of value, particularly for those who entered the service of the Queen's Institute before the establishment of superannuation schemes. All Queen's nurses and village nurse midwives are insured under the National Health Insurance Acts. During sickness they are for a limited period allowed full salary by the nursing association concerned, the sickness or disablement benefit due to them in respect of health insurance being usually deducted before the salary is paid.

55. We are indebted to the Ministry of Health for statistics which show that approximately 20 per cent. of the rural population of England is unprovided with the services of trained midwives. It is understood that in a number of counties the ground is almost or entirely covered by midwives, the uncovered areas in the other counties containing from a small proportion to as high as 88 per cent. of the population. It may be expected that in the process of time the progressive expansion of the work of nursing associations, without the aid of which the deficiency would undoubtedly have been much larger than it is, will to a very large extent overcome the shortage. But there are some sparsely populated districts, e.g., in Lancashire, Westmorland and Yorkshire, where the means of communication are so difficult, owing to the geographical configuration of the country, that the establishment of nursing associations in such districts must, we feel, be regarded as out of the question. In these cases special arrangements, possibly on some such plan as that adopted with regard to the medical service in the Highlands and Islands of Scotland, will have to be made.

56. Independent midwives establish themselves in the vast majority of cases in areas of an urban character where there is material in sufficient quantity to justify them in embarking upon the practice of their profession. It is ordinarily not possible or them to attempt to build up a lucrative connection in country districts, owing to the low density of the population which would preclude the possibility of anything but a small and infrequent demand for their services. Even in the towns under the most favourable conditions the lot of the independent midwife is usually not enviable. She may be one of those comparatively fortunate women who are so popular and so busy that they are hard pressed to fulfil the engagements which come their way; or she may be, and generally is, amongst those who cannot, for various reasons, find enough work to guarantee them a reasonable competence. We have been informed in evidence that some few midwives working in big provincial cities conduct on the average as many as from 200 to 250 confinements per annum, and one midwife who appeared before us stated that she usually succeeds in attending between 190 and 200 cases during the year. But these cases are very exceptional. Normally the midwife has to be content with a very much smaller practice.

57. Her position is not made any easier by the fact that a large number of midwives, who are not solely dependent upon midwifery work for a livelihood, make a point of notifying their intention to practise to the Local Supervising Authority, in order that they may be enabled to attend a few confinements during the year, as and when opportunity offers. This is borne out by statistics which the Society of Medical Officers of Health has been good enough to furnish. The statistics, which were

compiled from recent returns relating to several selected County Boroughs situated in different parts of the country, disclose that in the case of one County Borough, nine midwives attended in one year from 20 to 50 confinements each, and five midwives from 10 to 20 confinements each. With regard to a second County Borough, the statement is made that "besides the 56 midwives in general practice, there were 17 others on the books who did very little or no work." In yet another County Borough six midwives attended about 33 confinements each and five shared about 100 confinements between them. A medical witness who gave evidence on a similar point stated that during the year 1927 in the County Borough in which he resides, 20 midwives each attended from 10 to 25 confinements and 32 midwives were responsible on the average for less than five confinements each. The average number of confinements per annum per midwife attended in the County Borough areas cited in the list submitted by the Society of Medical Officers of Health ranges from 29 to 72 and in the County of London which, of course, is wholly urban and very congested in many parts, we find that, according to the information given by the London County Council, the average number of confinements attended by the 870 midwives who notified their intention to practise in the year 1927 was slightly under 40. Independent witnesses who are able to speak from their knowledge of the conditions obtaining in other large centres of population have added their testimony to the keen competition for midwifery work which is usually found to exist in such centres. We have little reason to doubt that the supply of midwives in the County Boroughs and other large Boroughs is generally excessive, and that even if it were possible to leave entirely out of account the women in intermittent practice, the supply would still in a considerable number of instances not prove to be insufficient to cope with the demand.

58. Difficulties, however, do arise in some of the smaller Boroughs and other areas of an urban character, e.g., certain mining districts. The evidence which we have received in this relation indicates conclusively that mothers in particular districts have yet to learn that the care of an uncertified woman, however well intentioned and helpful in a domestic sense she may be, is dangerous both to them and the children for whose delivery this women is, it is to be regretted, so often largely responsible, since no doctor who is accustomed to working with an uncertified woman as his maternity nurse can always be sure that he will be at hand at the critical time. Certified midwives have the utmost trouble to establish themselves in areas of this character, and it is feared that the local doctors sometimes do not go out of their way to lend them any encouragement. We have been astonished to hear in connection with two large urban districts in the North of England each having a population of approximately 20,000, that there was not until recently

any certified midwife practising in either district. A midwife is now working in one of these districts, but only on the understanding that she will receive financial support from the Local Authority. We quote these cases as noteworthy exceptions. It would not be true to say that the deficiency of certified midwives is so well marked as a rule in areas of an urban type outside the large towns or, indeed, that the problem is of general application in respect of all such areas. So far as we are able to judge, the problem is confined very largely to certain parts of the country where the influence of the uncertified woman is unusually strong, by reason of the survival of old customs and of sentimental associations that have elsewhere in varying degrees broken down.

59. As the number of cases attended by independent midwives in district practice varies within wide limits, it is difficult to form any general opinion with regard to their average income. The fees which they charge are similar to those charged by midwives employed by nursing associations, except that in certain industrial towns where female labour is used to a large extent, the charges tend to be above the average owing, perhaps, to the fact that a double maternity benefit under the National Health Insurance Acts is paid to the mother in many instances. The charges made by midwives in one Lancashire mill town are, for example, as high as 42s. for the first confinement and 35s. for the second and subsequent confinements; in another large industrial centre in the Midlands the midwife's fee is, on the average, 25s. Much, of course, depends on the type of district in which the midwife practises. She can confidently expect better fees in a residential neighbourhood, but if she happens to work among the poor, she must be content to receive whatever the mother or the family can afford. We find from particulars submitted by the London County Council that the East End of London is not a profitable area from the independent midwife's point of view. There the average fee for primiparae is between 25s. and 30s. and for multiparae between 16s. and 21s. The Council states that the corresponding fees in West London would be between 42s. and 50s. and between 30s. and 35s. respectively.

Representatives of the Incorporated Midwives Institute who gave evidence before us, placed at our disposal information collated from returns sent in by 110 affiliated midwives' associations, comprising a membership of approximately 4,000. We learn that the earnings of the independent midwife vary from £30 to £275 per annum and that a large number of whole-time workers, excluding those who merely practise intermittently and derive their main income from other sources, earn only from £90 to £120 per annum. There is naturally a limited number of midwives with large practices who succeed in earning more than the amount of £275 referred to; one of these midwives stated in evidence that her income was approximately £350 a year.

60. It is only to be expected that the independent midwife should feel little encouragement to practise in poor neighbourhoods where she learns from experience that even if the mothers are in a position to make any contribution in consideration for her services, the fee which she is able to secure is usually a good deal less than those services, judged by present day standards, are worth. On many occasions she has to forego the fee entirely. Few Local Authorities have taken advantage of their power to guarantee the midwife against loss in these circumstances and the assistance given is generally confined to a fixed sum per necessitous case considerably lower than the full amount of the fee.

61. Varying arrangements have been made by Local Authorities for paying or guaranteeing the salaries of midwives in those areas either in which there is no nursing association, or where there is a deficiency of midwives, or where the Local Authority is not satisfied with the efficiency of the midwifery service, or where numbers of women are unable to pay a private midwife's fee. In certain areas Local Authorities employ whole-time salaried midwives, and in others they pay fixed subsidies to certain midwives, while in a few cases they guarantee minimum salaries to selected independent midwives. In the first group the salaries paid range from £50 per annum plus a payment for each confinement attended during the year, to an inclusive salary of from £150 to £250 a year, plus Civil Service bonus. The fees received, which are paid over to the Local Authority, are usually based on the charges made by independent midwives practising in the particular area. Sometimes their practice is restricted to those unable to afford a private midwife's fee. In the second group, midwives are paid a fixed subsidy, in one case as low as £10 a year and in another case as high as £80 a year. Under these arrangements the midwife retains her fees, but is not required to account for them. In the third group the guaranteed salary varies from £120 to £230 a year. Although the midwife in this group is allowed to keep her fees, she is required to account for them to the Local Authority.

62. Mention has yet to be made of midwives who serve as salaried officers on the staff of maternity institutions. Women in this class are, except in the case of poor law institutions, generally engaged in domiciliary midwifery work as well as on duties connected with the residential treatment of maternity cases. In the large institutions they commonly act as teachers to pupil midwives, and their services are often utilised in relation to the obstetric training of medical students. Compared with the independent midwife or the nurse midwife practising in a rural area, their life is relatively sheltered; they are neither exposed to the same rigorous conditions, nor do they suffer from the insecurities which make the lot of the independent practising midwife so trying.

Disadvantages attaching to midwifery practice.

63. According to recent information furnished by the Central Midwives Board, there are now approximately 56,670 midwives on the Roll of the Board, of whom 14,479 notified their intention to practise in the year 1927. It has been shown in an earlier part of this report that a large number of women obtain the certificate of the Board without having any intention of practising after certification. The fact that of the 2,811 persons who entered for the examination of the Board during the year 1928, 1,730 were women who possessed the general nursing qualification is of some significance. The great majority of these trained nurse midwives are generally able to find more attractive and lucrative positions in the nursing than in the midwifery profession, and may be regarded as non-effective so far as the maternity service of the country is concerned. The few who put their midwifery training to any use usually become members of the staff of maternity institutions or Queen's nurses A witness who gave evidence on behalf of the College of Nursing had no doubt that the income earned by the trained nurse as such is higher, generally speaking, than that of an independent midwife, and similar views have been expressed by other witnesses. We cannot but feel that the loss of these trained nurse midwives to the midwifery profession, symptomatic though it be of the conditions of service obtaining in that profession, is to be deplored, more especially from the point of view of the mothers who need the care of the most skilled attendant that can be made available for them during the stress and anxiety incidental to pregnancy, labour and the puerperium. The reasons why the better trained and better educated women do not practise as midwives, as submitted in evidence, are mainly as follows :—

(*a*) The heavy individual responsibility and arduous nature of the work, entailing as it does long and irregular hours with uncertainty of obtaining adequate rest and relief.

(*b*) The lack of reasonable remuneration, in part due to an insufficient standard fee and in part to competition, sometimes at rates considerably below the normal, by unqualified women, or by certain nursing associations, training institutions and hospitals. The want is also felt of any definite provision for superannuation or old age.

(*c*) The remote prospect of promotion or advancement in a profession as yet largely unorganised.

(*d*) The existence of certain forms of supervision by some Local Authorities which are deemed irritating and futile, together with a feeling that midwives are reported to the Central Midwives Board for errors of judgment with undue frequency and perhaps at times for matters asserted to be trivial.

64. The midwife occupies an exceptionally responsible position in the life of the community compared with women employed in the allied branches of the nursing profession, since she is directly answerable during the normal course of her everyday work for the lives of two patients, mother and child. She must at all times, by night and day, exercise untiring vigilance if the trust placed in her skill is not to be betrayed. Night calls, absence of adequate rest and recreation, and often of opportunity to take proper nourishment are her portion. This is by no means all. There is the ever-present anxiety that failure to exercise a wise discretion may result not only in disaster to her patients, but also in severe disciplinary action, involving possibly the withdrawal of licence to practise, on the part of those responsible for supervising her work.

If she is an independent midwife, her practice is in the large majority of cases not sufficiently remunerative to allow her to employ trained assistance, so that she must depend entirely on her own physical resources to carry out the onerous duties that fall to her charge. She can expect no relief when sickness falls upon her, nor can she look to the State for financial assistance on such occasions, in that she is debarred by reason of the conditions of her employment from becoming an insured contributor under the scheme of National Health Insurance.

65. If to these disabilities, surely serious enough in themselves to deter all but the most courageous from becoming practising midwives, be added the further disadvantage of insufficient remuneration normally gained for long hours of unremitting toil, there can be small wonder that the profession has failed to attract women who by education and training are best fitted to uphold its dignity and traditions. We have already shown that according to the testimony of the Incorporated Midwives Institute a large number of whole-time independent midwives earn from £90 to £120 per annum. If it be borne in mind that these are gross figures and bear no relation to the amount which actually remains for the midwife's personal use after paying, at a not inconsiderable cost, for domestic assistance in her own home, for drugs, dressings, appliances, and the various other items of equipment which she is bound to provide for her own use and the use of patients, it will be appreciated that she must of necessity often find the utmost difficulty in eking out a somewhat precarious existence. There can certainly be no margin to permit of an annual holiday, or of provision for the later period of her life when age forces her to retire from active practice. The fact that a few midwives feel the urge, at the cost of a good deal of mental and physical strain, to undertake more cases than they can properly attend, is a further indication of the financial pass to which an independent practising member of this inadequately remunerated profession is reduced.

66. Midwives in the employment of nursing associations are in several ways more fortunately placed. They have for example a settled income, unduly small though it may be; they have not to meet the cost of necessary equipment, or of travelling; they are not haunted by the thought that in sickness they will be entirely without the means to support themselves; all are in a position to enjoy the benefits derived as insured persons from National Health Insurance, and many are now covered to some further extent by superannuation schemes. The main point of difference and it is, we think, an important one, is that as compared with the independent midwife practising in the town, they are more exposed to the rigours of varying climatic conditions which may, and in fact do, give rise to considerable incapacity later on in life. The nurse midwife residing in a country district has ordinarily to rely on a bicycle to aid her in visiting her patients, and she must be prepared to answer a call at short notice, irrespective of the state of the weather at the time the call is made. Roads are often bad and the district is perhaps hilly, so that when she arrives at her destination she is often not in a wholly fit state to carry on the task for which her services are needed. Moreover, in the sparsely populated areas she is generally the only midwife for miles around and she is thus isolated from associations, interests and recreations that go to make residence in the towns more bearable. Since the salary is not tempting, the inevitable sequel is that some nursing associations find the utmost difficulty in keeping the supply of nurse midwives up to the requisite standard.

67. The independent midwife practising in an urban area has to contend with a further disability not felt by the midwife working in country districts. It has already been pointed out that she suffers from the competition of midwives who practise only occasionally, and mention has also been made of the extreme difficulty which she finds in establishing a connection in particular districts where the influence of the uncertified woman is at the moment paramount. But we do not believe that the full extent of the potential loss of practice caused by the activities of uncertified women in many of the large centres of population is fully appreciated. A good deal of education is, no doubt, still required amongst the public generally and even in the medical profession. On the other hand, it would be a mistake in our view to regard this as the sole factor to be taken into consideration. If the mother who prefers to be attended at confinement by a doctor could, without having to count the cost, choose whatever nursing attendant she desires, or is advised by the doctor to engage, this would probably contribute very largely to the elimination of the uncertified woman in most parts of the country. The mother in poor financial circumstances who, for any reason engages a doctor, has usually no alternative at the present time but to employ the cheapest

nursing services she can obtain, and the engagement of a midwife as the maternity nurse is therefore out of the question.

68. A further source of discontent in some areas is the tendency to under-sell independent midwives on the part of hospitals, or maternity homes, or nursing associations. It is gathered that these bodies carry on a district midwifery service in association with a training school for pupil midwives or medical students. The training school is naturally anxious to secure sufficient clinical material for training purposes and may find it necessary to achieve this object by charging low fees, to the detriment of the midwives in the neighbourhood who are trying to earn a livelihood. In order that "undercutting" of fees may be avoided, it is, we think, advisable that there should be an attempt to agree a uniform rate of charge in each training area.

69. The suggestion has been put forward that if means could be found to provide an avenue of promotion to posts carrying higher responsibility and increased remuneration for midwives deserving of preferment, it would make midwifery practice more popular. We agree, but we doubt whether the midwife can look for advancement except within the limits of her own profession. A certain number who after a period of good service have become proficient in their work might be suitable for appointment as members of the staff of ante-natal clinics, or of maternity institutions. Others might, if they were able to pass the examination which we have recommended should be instituted, be approved as teachers. A few who have the requisite qualifications and possess the necessary administrative ability and personality might well be selected for appointment to the post of assistant inspector of midwives.

70. We have not been able to discover that there is any weight of evidence in confirmation of the charge sometimes levelled against those entrusted with the duties of supervising midwives of reporting, with undue frequency, midwives to the Central Midwives Board for errors of judgment in their practice. It is stated that midwives are on occasions reported to the Board by the Local Supervising Authority for minor offences which might more properly be dealt with locally by the Authority. An example which has been quoted is where a midwife has been cited for not keeping her register in accordance with the rules of the Board, the contention being that if the inspector of midwives concerned had given kindly advice and criticism in the first instance, the offence would not have been committed. Whilst we have little doubt that some inspectors of midwives have not the personality, practical knowledge or judgment that are essential qualities for work of an inspecting character, and that a more sympathetic understanding of the midwife's difficulties would often avoid needless friction, we think it well to point out that, so far as it has been possible

to ascertain, these defects are confined to a few areas. Indeed, there is reason to believe that the other extreme obtains in some areas where the midwife is allowed to pursue her calling without that full measure of supervision which it is the duty of the Local Supervising Authority to provide.

Complaint has been made to us on account of the alleged practice of a very few Local Supervising Authorities which are said to demand in every case that midwives who have been in contact with infection, or are liable themselves to be a source of infection, should attend at a public disinfecting station for the purpose of disinfecting themselves, their clothing and their equipment. While we agree that the facilities of a well-equipped disinfecting station might properly be offered to midwives who have not adequate means of disinfection in their own homes, arrangements for the use of such stations should always be made with full consideration for the susceptibilities of the midwife and the necessity for maintaining her prestige in the eyes of her patients.

Methods to improve conditions of employment.

71. It will have been observed that about 34 county nursing associations have established superannuation schemes for midwives in their employ and if, as may be expected, similar schemes are adopted in due course by the remaining county nursing associations, the needs of this particular class will, to some extent, be met. Provision for pensions, inadequate though it may at present be, also exists in regard to Queen's nurses. Whole-time midwives in the service of Local Authorities and those serving as members of the staff of large institutions who may not as yet be covered by superannuation schemes could, we feel sure, without any great difficulty also be provided for in this respect.

The real problem is in relation to independent practising midwives. A proposal has been made that these women might be allowed to become voluntary contributors under the National Health Insurance Acts. This would be putting such persons in a very privileged position as compared with other classes of the community who might justly feel that they also should have the right to the same preferential treatment. It seems clear that any extension of the provisions of the National Health Insurance Acts applying to voluntary contributors would have to be dealt with on national lines, and that it would be out of the question to contemplate that such an extension should be limited to one particular section of the population. Midwives on the staff of the smaller maternity institutions are insured persons and consequently possess advantages denied to those in practice on their own account, even though they may not be sufficiently fortunate to enjoy the ultimate benefits conferred by an

established superannuation scheme. We feel strongly that it is of the utmost importance that all midwives should be guaranteed security in their old age, and every effort should be made to formulate schemes to achieve this very desirable end.

72. Adequate relief during sickness and emergency and for off-duty times, including an annual holiday, is probably more essential in the midwifery profession than in most others. As regards midwives working in rural areas, the suggestion submitted by the Queen's Institute of District Nursing is that the emergency staff employed by every county nursing association should be so increased as to ensure that every nurse midwife in regular practice may be given relief as and when it is needed. This body points out that at present county nursing associations have not sufficient funds at their disposal to provide the requisite emergency staff for relief purposes, and that no progress can be made in this respect unless financial assistance is forthcoming from other sources.

A further proposal, which we believe is worthy of careful consideration and investigation, is that the midwifery services in rural areas should be so organised by the aid of transport and telephone facilities as to enable midwives to serve a much wider district than would otherwise be practicable. By this means it would, it is suggested, be administratively possible to arrange in most areas for two midwives to live together and work together to their mutual benefit. One could replace the other in emergencies and both would be able to enjoy a reasonable amount of leisure without being subject to the strain of continuous anxiety.

But the question of providing relief during sickness and emergencies and for off-duty times is of equal importance to all who undertake practical midwifery work, whether in town or country. It must therefore be looked at from a broad point of view. We recommend that every Local Supervising Authority should address itself to the early consideration of this matter with a view to the adoption of local schemes on comprehensive lines, the cost of which should, so far as may be necessary, be defrayed out of public funds. We recommend further that aid towards the provision of transport and telephones for midwives practising in rural areas should be provided by each Local Supervising Authority, that is to say the County Council, concerned.

73. It has been brought to our notice that midwives sometimes have considerable difficulty in obtaining suitable housing accommodation. It would be helpful if Housing Authorities could see their way, in connection with the provision of schemes for new houses, to arrange for accommodation to be earmarked so far as possible for midwives who desire to practise in the neighbourhood of such estates.

74. Some financial inducement is, we consider, necessary to encourage midwives to take early action in referring to the proper quarter pregnant women who may require institutional treatment, in order that there may be no delay in sending them to hospital. Where a midwife's case has been taken out of her hands in this manner, reasonable compensation should be paid by the appropriate Local Authority. In most cases a woman found suffering from some abnormal condition during pregnancy who cannot with safety be attended in her own home would, if a full obstetrical examination by a doctor were made as a routine at about the seventh or eighth month, be sent to hospital for confinement in the natural course of events without any necessity for the midwife to report the case on her own initiative.

75. We come now to the consideration of what we regard as a matter of vital concern amongst the measures that are felt to be necessary to improve the conditions of service of midwives and to attract well-trained and well-educated women into the profession. We have suggested in Part II of this report that the first basic requirement to be laid down in connection with a national scheme of maternity is to arrange for the full services of a certified midwife to be available for the mother during pregnancy, labour and the puerperium. We have also indicated, when dealing with the duties of the midwife, certain desirable extensions of the scope of such duties which would result in the midwife giving considerably more attention and time to each of her patients than has hitherto been the case. The effect of placing increased responsibilities on the midwife would be at once to add materially to her already onerous burdens and thereby to foster the tendency which, by reason of economic factors, unfortunately now prevails in big practices for her to undertake more work than she can with efficiency perform. It is clear, therefore, that if mothers are on the one side to be protected against the slipshod methods of the midwife who sees in a large circle of patients the only opportunity to earn a reasonable income, and if the midwife is, on the other side, to be extricated from a position in which she cannot justifiably be expected to remain, two indispensable reforms are needed.

76. The first of these reforms would involve a limitation on the number of cases that the midwife should be allowed to attend. It is clearly desirable that no midwife should undertake to attend more patients than she can properly deal with, and we consider that if, and when, the duties of the midwife have been extended as is proposed in this report, it will be essential to take steps to limit the number of patients attended by a midwife in a given period. Some competent observers are of opinion that it would then be reasonable to restrict the number to not more than 100 cases a year, while others hold that

a larger number could be properly attended even under these conditions in favourable circumstances. We desire to emphasise that the ruling consideration must always be the welfare of the mothers. We make no specific recommendation but would record our opinion that even if, as may well be, it is found desirable to impose restriction by stages until such time as a definite maximum number can be laid down, that number should, in our view, not greatly exceed 100 cases per annum.

77. Whatever limitation be imposed, it would obviously tend to diminish the already inadequate income which the average midwife is able to earn unless it were accompanied by some measure to ensure that her fees are increased to such an extent as to compensate her for loss of income. But it is also desirable at the same time to take such steps as are practicable to raise the remuneration of the midwife to a scale commensurate with the strenuous and important work which she is called upon to do. It is our emphatic opinion that so long as the midwifery profession holds out such poor rewards for those who choose to follow it, so long will it tend to be regarded as a natural calling only for women whose standard of efficiency is too often lamentably low. Nothing is so certain as that women of good education will not be prepared to endure the hardships of night calls, long hours of toil, uncertainty of rest and, above all, the heavy personal responsibility that midwifery practice entails, unless steps are taken to guarantee them a reasonable financial return for their labour. It is clearly desirable that this class of women should be attracted to the profession, and we are of opinion that when the duties of the midwife have been extended as we propose and the suggested limitation on the number of cases attended by a midwife each year has been enforced, a considerable increase in her remuneration should be secured to her. We recognise that the improvements in midwifery practice will involve considerable re-adjustment and re-organisation in that practice. It is also necessary to take into account the financial position of the country and the money which is likely to be available for this particular service. We are of opinion that the fee of 30s. suggested for the midwife in paragraph 341 of the Majority Report of the Royal Commission on National Health Insurance is quite inadequate, and we trust that it will be immediately possible to secure a sufficiently substantial increase in the earnings of the average midwife by the institution of a considerably larger fee to enable some of those improvements in her standard of professional work to be effected which we regard as essential to the well-being of the patients she attends.

78. The position of the midwife who is accustomed to act as a non-resident maternity nurse under the supervision of a doctor requires special consideration. Apart from somewhat lighter duties during the ante-natal period and confinement, her work

would not be much less onerous than that of the midwife working alone, so that it would be advisable, in order to enable her to give full attention to her patients, that any restriction on the number of cases attended by a midwife during a given period should apply to the midwife who acts as a maternity nurse. When so acting she would, however, be very largely relieved of responsibility for the safety of her patient, and in any scheme for the provision of midwifery services the fee payable to a midwife acting as a maternity nurse should clearly be less than the fee fixed for the midwife who undertakes sole charge of the case.

It will be evident that, except in abnormal cases when medical advice and assistance would automatically be available, the mother who engages a doctor and a midwife acting as maternity nurse for the confinement would be placed in an unfavourable position as compared with the mother who prefers to employ a midwife alone to help her through childbirth, in that she personally would have to undertake the responsibility for the doctor's fee. We feel that in cases of this kind the mother would have a claim to some payment out of public funds as a contribution towards the cost of the alternative service she has selected, and some method of financial adjustment might be practicable in such instances.

79. There can be no question that even with an increased fee many midwives in rural areas, owing either to the small number of cases, or to the amount of time spent in travelling from one patient to another, would be unable to earn a reasonable competence, and the only way to solve this difficulty would seem to be the arrangement of subsidies, which might in part take the form of mileage allowances by the Local Supervising Authorities.

80. The Government Actuary's Department has, at our request, been good enough to furnish statistics showing that, on a computation which must necessarily be somewhat tentative in character, of the total confinements in England and Wales which numbered approximately 670,000 in the year 1927, maternity benefit is calculated to be payable in about 80 per cent.; and that of the remaining 20 per cent. about one-half, i.e., 70,000, occur in families whose economic status is equivalent to that of persons within the scope of the National Health Insurance Scheme. So that whilst under a maternity insurance scheme the number of confinements coming within the meaning of the term "necessitous," as now interpreted by Local Authorities in connection with the administration of schemes of maternity and child welfare, would be relatively small, a certain number would still remain outside the ambit of such a scheme. The problem of dealing with these would not be serious from the point of view of cost, and some action

should be taken to secure that mothers for whom no State service would be available, are not denied at the most critical time of their lives help which they are not able by reason of poverty to obtain on their own account. The duty of seeing that professional care is provided for such women, firstly by a midwife if the pregnancy, the confinement and the puerperal period show no deviation from the normal, and secondly by a doctor if any abnormal conditions arise, might be imposed as an obligation upon the appropriate Local Authorities. These Authorities should on their side be empowered, in order to guard against abuse, to make rules governing the administration of any scheme that might be adopted in pursuance of this requirement. It is desirable as a general principle that mothers to whom such a scheme would apply should be given a reasonable freedom of choice of midwife, and this end might be secured by the establishment on the part of the Local Authority of a panel of the competent midwives practising within its area. The acceptance by the Authority of liability for the midwife's fee might, in general, be made conditional upon the giving by the midwife of prior notice of each individual case in respect of which the patient is too poor to pay the fee, either in whole or in part. The Authority would then be enabled to investigate the financial circumstances of the patient and to assess the proportion, if any, of the fee that should be recovered from her or her relatives. No arrangement made, however, should preclude the obtaining of the services of a midwife in emergency when a necessitous mother has omitted to engage one and the Authority should be responsible for the payment of the midwife in such cases.

Any midwife who might be called in to attend a woman within this category could not fairly be expected to accept a smaller fee than the standard applicable to insured confinements, if the case were automatically counted as one towards her quota. But if, as would sometimes happen, her services in an emergency case were to fall short of the normal, then the amount of the fee might be modified and the case would not necessarily be counted in the quota.

81. Although not germane to matters affecting the conditions of employment of midwives, we feel that it is scarcely possible to leave this particular section of our report without first giving some attention to the ancillary services which are an integral part of any scheme for the provision in necessitous cases of adequate care for the mother during the ante-natal, intra-natal and post-natal periods. Nourishing foods, e.g., milk and similar necessities, are essential for the mother during pregnancy and confinement and for the mother and child during the puerperal period. Such articles as sterilized outfits, disinfectants, maternity bags, sheets and, for premature births, oil and cotton wool are of especial importance at parturition. Domestic help in the home after the birth has taken place and whilst the mother is in the convalescent stage is undoubtedly the chief factor in

relieving the mother's mind of anxiety respecting the welfare of her family and so in promoting a speedy return to health. The services of a home help are, in a few cases, necessary during the period of pregnancy when the mother is, by reason of incapacity, prevented from carrying on her ordinary domestic duties.

The mother in the ordinary artisan home would in most cases be able to make her own arrangements for the provision of these services without cost to the State, and need not be encouraged to look to public funds for assistance. But there are many cases where the family is in such poor financial circumstances, as to preclude the possibility of this end being achieved without help from outside sources. Local Authorities should accordingly be encouraged and, if necessary, stimulated to make use of their powers under the Maternity and Child Welfare Act, 1918, in order to secure that any essential service is not withheld, when they are satisfied after due investigation that the mother or her relatives are so poor as to be unable to provide it themselves.

82. The conclusions reached in paragraph 80 immediately lead to the question as to what part should be played in this relation by a municipal service of salaried midwives. This development is of comparatively recent growth and is confined at the present time to only a very few urban areas. The formation of local panels of independent midwives, coupled with the initiation of a maternity scheme based on insurance principles, would seem largely to obviate the need for the employment by Local Authorities of a whole-time staff for the purpose of dealing with necessitous cases, which has in the main been the justification for the use of municipal midwives. On the other hand some elasticity might be allowed and if any particular Authority, more especially one which carries on a maternity home at which pupil midwives are trained, feels that a municipal midwifery service is the best and most convenient method of administration for its area, the Authority should not be debarred from establishing this service, provided that reasonable freedom of choice of midwife is always maintained.

Where a municipality which now employs whole-time midwives acts both as the Maternity and Child Welfare Authority and as the Local Supervising Authority under the Midwives Acts, the scope of the work of these women might be widened to include the relief during sickness, emergency and holidays of independent midwives practising within the area, and on the occasions when the latter are engaged in attending post-certificate training courses.

General.

83. It is very necessary that the services, both medical and nursing, rendered to the mother and child should be continuous. The evidence which we have received on this matter suggests

that this is by no means always the case owing, it is gathered, to a certain antagonism which sometimes exists between the midwife and the officials employed by Local Authorities in connection with the administration of maternity and child welfare schemes.

The first object must be to remove any suspicion from the mind of the midwife to the effect that the medical officer of health and his staff exist for the purpose of finding fault with and harassing the midwife in her work. Midwives and health visitors should regard themselves and each other as colleagues who are both parts of the machinery of the country for safeguarding the health of mothers and infants and, in consequence, midwives should look upon the medical and health visiting staff of the Local Authority as friends to be consulted and not as persons to be avoided; and health visitors should recognise that midwives have a relationship to their patients which must invariably be respected. When this spirit exists, there will be no need to lay down any hard and fast rules as to when a health visitor may call on a patient who has booked a midwife, and when she may not. The health visitor must recognise the midwife's full responsibility for the care of her patient, but should furnish her with any records or information which she may have in relation to the household, and should rely on the midwife to let her know of any special point which should receive the health visitor's attention when the time comes for the midwife to cease her attendance. This, to give two simple examples, might be to the effect that the mother appeared to be disinclined to persevere with breast feeding, or that the mother would receive benefit by admission to a convalescent home.

Each midwife should be supplied by the medical officer of health of the area in which she practises with a statement showing the provision made by the Authority for the welfare of mothers and infants. This would include, for example, particulars concerning the supply of dinners or milk for expectant and nursing mothers and young children, sterilised outfits, maternity bags, dental treatment, fireguards, patterns of model garments, how to obtain admission to a maternity home, arrangements for the supply of a midwife for women unable to pay the fee, and times and places of meeting of ante-natal and infants' clinics. A similar statement would also be very useful to doctors.

84. Ante-natal clinics are becoming very popular in certain parts of the country. Two kinds of work go on there, the medical and the non-medical or social. The medical consists of examination by a doctor with a view to detecting abnormalities and making appropriate arrangements, generally by reference to a private doctor or a maternity hospital, to ensure that the confinement will be as safe as possible. The non-medical work consists of instruction in mothercraft, including the clothing and feeding of infants, the giving of hygienic hints on healthy

living for expectant mothers and following up the doctor's advice by, for example, the supply and application of bandages for varicose veins and the treatment of constipation. A number of women would, doubtless, prefer to attend these clinics for medical examination, despite the arrangement proposed in this report under which every expectant mother coming within the scope of the National Health Insurance Acts would have the services of a private doctor for ante-natal examination; and, subject to the consent of the doctor responsible for treating any emergency which might arise in the course of the confinement, there would seem to be no objection to the patient attending such a clinic, provided full co-operation of the clinic with the doctor were ensured.

85. In cases of this kind the medical portion of the ante-natal record form, to which reference is made in paragraph 46 and Appendix B, would be completed by the medical officer of the clinic, but care should be taken to ensure that both the midwife and the private doctor are acquainted fully with the information gained by the medical officer of the clinic regarding the health of each pregnant woman whom he or she examines. This end would best be achieved, so far as the midwife is concerned, if she were encouraged to accompany her patient to the clinic in order that she may be present when the medical examination is made. Such an arrangement would be of great value to her from an educational point of view. The midwife should be treated by the clinic staff as a professional colleague.

If any private doctor has sufficient patients to warrant the holding of a special session, the Local Authority might allow him on agreed terms to have the use of the Authority's clinic and nursing staff, so that he may see his patients there.

86. It is obviously desirable that the Local Authority should be informed when the midwife ceases her attendance on a midwifery case, so that arrangements can be made for the early exercise of the proper activities of the health visitor. The most convenient method as a rule of securing this is through the medium of the existing procedure for the notification of births. Any urgent request from the midwife for the provision on behalf of mother or child of services which the Local Authority is in a position to give, would naturally be acceded to without waiting until the midwife has completed her attendance in the case.

It should be understood that the health visitor may visit during the puerperium any case where a municipal home help is employed, and the midwife would be expected to report any complaint or other observation concerning the home help's work. The health visitor or other officer of the Local Authority may also have to call while the midwife is in attendance for the purpose of obtaining financial and other information required

in connection with an application for free services, but the health visitor should recognise the midwife's full responsibility for the case and should in no way interfere with her duties.

87. Midwives who return to practice after abstaining from the work for a period of years, and those whose practice may be called sporadic in the sense that they attend only a few cases and these at long intervals, are a potential source of danger. There is nothing at the present time to prevent such women from practising, provided that they give notice of their intention to do so to the Local Supervising Authority. When a midwife has not in fact practised for a considerable period, or where a midwife although in practice has attended an insufficient number of cases to remain efficient, the Local Supervising Authority should have power to represent these facts to the Central Midwives Board in order that the Board may determine whether, on the merits of the case, the midwife should be required to undergo post-certificate instruction. The Local Supervising Authority should also have power to suspend from practice any midwife so reported to the Board pending the promulgation of the Board's decision.

PART V.

Administration.

Preliminary.

88. Since in this part of our report we recommend changes of some moment in the powers and duties of the Central Midwives Board, we wish to make it clear at the outset that the conclusions to which we find ourselves committed are not to be regarded as directed solely, or even to any considerable extent, to meet criticism of the manner in which the Board has, up to the present, carried out its statutory functions. It is idle to say that difficulties have not arisen in certain respects, but these are mainly the result of a system which we venture to think would tax the ingenuity of any body, however constituted, to adminster to the universal satisfaction of those intimately concerned in midwifery work. We believe, moreover, that the Board has, on the whole, in dealing with its intricate problems met the demands made upon it with good judgment, in spite of having to work under conditions which often hamper the finding of a solution not open to attack from interested parties. The situation which suggests the changes recommended has been brought about largely as the result of legislation dealing with maternity and child welfare. The transference of certain functions of the Board and the variation and elaboration of others appear to us a necessary consequence of the march of events in the evolution of the national health services.

Supervision of Midwives.

89. All County and County Borough Councils, as the Local Supervising Authorities under the Midwives Acts, have appointed inspectors for the purpose of supervising midwives practising in their areas, in accordance with the requirements of Section 8 of the Midwives Act, 1902, and the rules of the Central Midwives Board. The inspector of midwives, who is usually a woman, is charged with the duties of inspecting the records of midwives, their appliances and, if necessary, their homes. The inspector has also the right to investigate the methods of practice of midwives.

The arrangements for inspection vary widely. Many County Councils employ the superintendent of a county nursing association or her assistants who are always trained nurses and certified midwives. In some areas the work is performed by whole-time officers holding both the general nursing and midwifery qualifications. In others, the Local Supervising Authority utilises the services of health visitors and, although these officers are all certified midwives, they have sometimes little experience of midwifery practice. In some cases the work is carried out nominally by the medical officer of health or assistant medical officers of health; frequently in these cases assistance is given by the senior health visitors. Women medical officers are employed in several instances, and here also the services of senior health visitors are used to a varying extent for inspection purposes. In a certain number of areas there is a combination of two or more of the classes mentioned above.

90. This lack of uniformity, which is due to the absence of any definite standard of qualification for inspectors of midwives, is most undesirable, not only because inspection by a person without proper experience has a bad psychological effect upon the midwife, but also because it reacts unfavourably on her methods of practice. The tendency in these circumstances is for her to feel, we think with a good deal of justification, that criticism and advice, kindly though it may be, from an inspector whom she is aware knows less about practical midwifery than she does herself, is both unprofitable and irksome. This inevitably makes for bad feeling. What is perhaps more important is that the midwife is deprived of the opportunity for guidance on professional matters affecting the well-being of her patients. There are occasions in the practice of every midwife when she feels that a helping hand in finding a solution to a problem that causes perplexity is of great advantage.

91. We accordingly recommend that, wherever possible, every new appointment to the post of chief inspector of midwives should be given to a medical officer who has had actual experience of obstetric practice and who is engaged in other work of a similar nature, e.g., as an assistant medical officer for maternity and child welfare. We recommend further that subordinate posts

for routine inspections should be filled, as and when vacancies arise, by midwives who hold the general nursing qualification and have gained experience in the actual practice of midwifery over a prolonged period. If, as has previously been suggested in an earlier part of our report, an examination for non-medical teachers of midwifery is prescribed, applicants for appointment to the post of subordinate inspector might be required to hold the teacher's certificate. It is observed that under Section 59 of the Local Government Act, 1929, the Minister of Health is empowered to lay down the qualifications of health visitors, and it would make for uniformity and be in the interests of midwives generally if the Minister were also given the power to prescribe the qualifications that should be held by non-medical assistant inspectors of midwives.

92. We have received complaints from several witnesses who allege that some non-medical inspectors are not always as helpful or as tactful as they might be, and that the inspection at times resolves itself into a harassing criticism of the midwife's mode of practice and of her shortcomings. This serves no useful purpose, can only leave in its train dislike and distrust and cannot be too strongly condemned. Every inspector should direct her energies to the winning of the confidence and trust of the midwives under her charge; she should be their counsellor and friend, ready to give advice when needed, ready to instruct them in the various points of difficulty which arise from time to time in connection with their work and, in short, to make them feel that there is always someone to whom they can look for sympathetic understanding of the laborious nature of their chosen profession.

The arrangement adopted by the medical inspector of midwives employed in one County Borough, where it is her custom to set aside a certain time on one day each week for the purpose of meeting any midwives who may wish to discuss their difficulties with her, is one to be highly commended. It is important that any scheme of inspection should, where practicable, provide ready access of midwives to the medical inspector, so that they may know when they may interview her without difficulty or embarrassment on the occasions when they need her advice.

The employment of health visitors with little or no practical experience of midwifery for the purpose of inspecting midwives is wrong both in conception and principle and is strongly to be deprecated.

93. It is understood that the arrangement under which midwives in county areas are inspected by an officer on the staff of a county nursing association is working well in certain cases and there is no reason to doubt that it might continue to work well in the future. It has, however, to be borne in mind that there are possible disadvantages in this system of inspection

and that the Legislature has expressly imposed by Statute upon the Local Supervising Authority the duty of exercising general supervision over all the midwives practising in its area. It is not generally advisable that this important and responsible work should be delegated to any body, or to an official of any body, carrying out its objects under voluntary auspices. The application of this principle must necessarily be of deep concern to midwives in the future if, as has been recommended, the Local Supervising Authority is to be given wider powers and greater responsibility in relation to them.

In all the circumstances it is desirable that in all new appointments to the post of non-medical inspector of midwives and, as soon as may be practicable, in regard to all existing appointments, *ad hoc* officials should be appointed to these positions by the Local Supervising Authority in order to secure uniformity and to banish any possible elements of discord that may otherwise arise.

94. The dual routine inspection of particular midwives who practise in the area of more than one Local Supervising Authority is highly objectionable. In cases such as these the Local Supervising Authorities concerned should come to an agreement between themselves as to which Authority should perform the work. The Local Supervising Authority in whose area lies the bulk of the midwife's practice might undertake this duty, and any complaint or special circumstances arising out of a case in the area of the other Authority might be investigated in conjunction with the officers of the Authority undertaking the routine inspection.

Judicial functions of the Central Midwives Board.

95. Section 3 of the Midwives Act, 1902, expressly imposed on the Central Midwives Board the obligation to decide upon the removal from the Roll of the name of any midwife for disobeying the rules and regulations from time to time laid down by the Board, or for other misconduct. In all but a comparatively few cases, e.g., a midwife convicted of a felony, misdemeanour, or offence in a Criminal or other Court of Justice, the complaints in relation to midwives against whom penal proceedings are taken by the Board emanate, usually at the instance of the Local Supervising Authority, from non-compliance with the rules prescribed for the purpose of " regulating, supervising and restricting within due limits " their practice.

This system of bringing an offender to book for her misdeeds might have been, and no doubt was necessary in the past when a large number of midwives on the Roll were ignorant, incompetent women without that sense of *esprit de corps* which the members of the midwifery profession in a large measure now possess. To continue to apply the punitive methods suitable for former days to the midwife of the present and, more

especially, of the future, would probably prove to be a mistaken policy—a policy moreover which would militate in no small degree against the raising of her status to the level that all agree is her proper right and due. It is of doubtful wisdom to seek to apply, as the criteria on which a midwife shall be punished for a dereliction of duty, rules purporting to cover, so far as human ingenuity can devise, every possible contingency that might be thought necessary to circumscribe her practice within proper limits. For one thing, rules of this kind may become obsolete with the passage of time and at fairly frequent intervals require revision to meet changing conditions; there can be no finality about them. And, again, they are apt to be the target of criticism from those who on the one side consider that they need alteration in the direction of the imposition of still further restrictions, and those who, on the other side, complain of their inelasticity. The existing rules and directions of the Board have, in fact, been severely criticised in evidence. They appear to have suffered, as is natural, from piecemeal attempts at alteration designed to meet circumstances and cases arising from time to time. They may justly be characterised as in parts deficient, in parts diffuse, in parts meticulously detailed.

96. If the midwifery profession is to be placed in a position to enjoy privileges and advantages similar to those held by other professions in this country, a reasonable liberty of action should be extended to it within its own sphere. The Board, in the exercise of its disciplinary jurisdiction, must have power to suspend, or, when necessary, to erase from the Roll the name of any midwife found guilty of a felony, misdemeanour, or offence which in the opinion of the Board renders her unfit to practise. There should be general power given also to caution, suspend, or remove from the Roll a midwife who, after due enquiry, is judged by the Board to have been guilty of conduct in any professional respect, either by reason of neglect to comply with any statutory obligation or otherwise, which makes her unfit to pursue her calling, or of a midwife who carries on her work in such a way as to endanger the health or life of the mother or child.

If such general power were conferred by legislation (which would involve fresh enactments and consequential alterations in existing Acts) the way would be clear for the relegation of the existing rules, which regulate, supervise, and restrict the practice of midwives, from their present position of definite statutory authority and penal significance to a less commanding but still important place. The midwife would obviously need some guidance not only as to the scope of the duties which she would ordinarily be expected to carry out if she is to be regarded as an efficient practitioner, but also as to the faults, both of omission and commission, which may expose her to the danger of punishment in a Court of Justice or at the hands of the Central Midwives Board. For this purpose the Board

acting solely in its judicial capacity might issue to every midwife practising in England and Wales warning notices or instructions. Such a warning notice might recapitulate in a revised and rearranged form the detailed particulars now set out in Section E of the rules of the Board, as examples under the appropriate headings of the standard of practice to which the midwife should attain, with the intimation that any woman who does not in spirit conform with directions authoritatively laid down will be liable to be brought before the Board and to have her name erased from the Roll as a person acting in such a way as to endanger the health or life of mother or child. A warning notice would also direct attention to the various statutory obligations imposed upon the midwife under the Midwives Acts, and to the penalties for failure to observe such obligations. It might also give a list of examples showing acts of malpractice, negligence, or misconduct which have in the past been the subject of penal action; and finally it should contain a complete list of the forms of notification which the midwife is required to submit to the Local Supervising Authority in connection with her work.

97. Representations have been made in criticism of the procedure followed by the Board in connection with the hearing of penal cases, and we consider that the experience gained in the past suggests that some changes might well be made in this respect. Decisions of the Board would probably carry more weight with the public if there sat in an advisory capacity a legal assessor whose advice and opinion on matters of law would be available for all members of the Board at penal proceedings. For the purposes of a professional tribunal an independent legal assessor would, in our opinion, be preferable to the alternative of a legal member or a chairman with purely legal qualifications.

98. There can be no doubt that the Board has been seriously hampered in the performance of its judicial functions by its inability to subpoena witnesses, or to require evidence on oath or the production of documents. It is not an uncommon occurrence for the case against a midwife arraigned for malpractice, negligence, or misconduct to break down owing to the reluctance of essential witnesses to testify against her, even though there are strong grounds for the presumption that the midwife is in fact guilty of the charge of which she is accused. The Board has, in these circumstances, no option but to dismiss the charge, with the result that the midwife's name remains on the Roll and a person who may be a source of danger to the patients for whose care she may subsequently become responsible is again at liberty to practise without let or hindrance. The sole protection of mothers against the pretensions of incompetent and unqualified practitioners, that is to say the certification and registration of midwives as enforced by the law, is therefore in cases of this kind nullified.

It is observed from the Nurses and Midwives Registration Ordinance 1928 for the Territory of North Australia that the Nurses Board constituted under the Ordinance is empowered, when sitting in judgment on a midwife accused of an offence for which the penalty is the cancellation or suspension of her registration, to require the attendance of persons before them, and to examine any such persons upon oath, affirmation or declaration. Further, a summons issued by the Nurses Board requiring the attendance of any person, or the production of any documents, has the same effect as a subpoena ad testificandum or duces tecum, as the case may be, issued out of the Supreme Court in a civil action.

If it has been deemed advisable to give the Nurses Board of this Territory of the Commonwealth of Australia the powers to which reference is made above, it is, we believe, the more desirable that the Central Midwives Board, which necessarily has a much larger problem to face in this country, should be given similar powers.

99. Considerable comment has been made in evidence in relation to the procedure adopted by the Central Midwives Board, whereby the Board acts not only as prosecutor through its Secretary or other person appointed by the Board for the purpose, but also as judge in connection with the hearing of prima facie cases of malpractice, negligence, or misconduct on the part of the midwives reported to the Board by Local Supervising Authorities. There is no doubt that the fact that the Local Supervising Authority is precluded from conducting the prosecution of such cases before the Board has in the past engendered friction and has been the cause of much dissatisfaction. As one witness aptly put it in evidence, " the principle of a single body acting as both prosecutor and judge is repugnant to the general principles of the law of the land." We recommend that the present system should be revised, and that where the Local Supervising Authority represents a prima facie case of negligence, malpractice or misconduct to the Board, the prosecution of the charge should rest solely with the Authority.

The same principle might be applied to cover any other body, e.g., the Incorporated Midwives Institute, which, from its constitution and objects, may be regarded as closely interested in all that pertains to the well-being of the midwife and to the preservation of a high standard of practice. If, for example, as may well happen on occasions, a body of this kind becomes aware of a midwife whose conduct or mode of practice is calculated to bring discredit upon the profession, or to be a source of danger to her patients, that body should be entitled to make a complaint to the Board and, if necessary, to prosecute the case before the Board. It should also be competent for an individual complainant to bring a case before the Board in the same way.

There will always be a residuum of cases which come to the notice of the Board otherwise than through the medium of the Local Supervising Authority or other interested body, and in which the Local Supervising Authority is unable or unwilling to act after the Board has referred the case to the Authority for investigation. It is difficult to see how these cases can be dealt with except by the Board entirely on its own initiative. Whilst conflicting logically with the principle previously enunciated that the Board should not itself as a rule conduct prosecutions, it is felt that these cases may be so presented as not to prejudice the interests of the defendant midwife, who could be represented by her legal adviser. The person reciting the charge, i.e., the Solicitor employed by the Board as at present, would act in much the same way as an Advocate for the Crown, and it would then be for the Board to decide whether on the facts placed before them steps should, or should not, be taken to inflict punishment.

Approval and inspection of training institutions and teachers.

100. The arrangements made by the Board for the approval of training institutions and teachers vary with circumstances. The large lying-in hospitals and the large general hospitals with maternity wards are approved without enquiry as to the qualifications of the persons who conduct the practical training. All poor law institutions where pupil midwives are trained are approved as institutions by the Board in a similar way. In the case of the smaller institutions, the person actually giving the practical training receives personal approval and is deemed to be responsible for the adequacy of such training. The approval of independent practising midwives as teachers for the extern part of the training is also conferred in suitable cases. All approvals granted are current until the 31st March of each year, when they automatically expire. Re-approvals of institutions and teachers date in every case from the 1st April.

The disquieting feature in connection with these arrangements is the entire absence of any system of inspection; the Board has indeed no machinery for the purpose. Members of the Board have on a few occasions in the past carried out on the Board's behalf special inspections in the case of certain institutions, and that is all that has so far been achieved. A midwife seeking approval as a teacher is required to complete an application form containing certain questions. Her suitability or otherwise for approval rests to some extent on the manner in which these questions are answered, although due weight is given to the opinion, furnished each year at the Board's request, of the Local Supervising Authority in whose area she resides whether as an independent practising midwife, or as a member of the staff of a maternity institution where training is provided, in regard to her conduct as a midwife during the previous year. It is understood that the Local Supervising Authority is not, in

general, asked to enter into the consideration of the suitability of an institution as such from the aspect of training in regard to the facilities and equipment available for training work. The lack of any general inspection of institutions and teachers approved for practical training applies also to the registered medical practitioners recognised by the Board as lecturers.

101. When the first Midwives Act was passed in 1902, there was no Government Department concerned with the work of midwives and the powers given to the Privy Council by the Act were limited to the supervision of certain specified activities of the Board. But the position has changed entirely of recent years consequent on the passing into law of the various Acts connected with maternity and child welfare. The Notification of Births Act, 1907, provided for the notification of a birth within 36 hours thereafter by any midwife in attendance upon the mother at the time of, or within six hours after, the birth in those areas in which the Act was adopted. The Notification of Births (Extension) Act, 1915, put the Act of 1907 into force in every area in which it was not already in operation and, at the same time, conferred upon Local Authorities the power to exercise for the purpose of the care of expectant and nursing mothers, and young children, any of the powers of Local Authorities under the Public Health Acts. The Maternity and Child Welfare Act, 1918, empowered Local Authorities to make such arrangements as might be sanctioned by the Local Government Board (now the Minister of Health) for attending to the health of expectant and nursing mothers and of children under five years of age who are not being educated in schoools recognised by the Board of Education.

Provision was also made in 1918 enabling the Local Government Board, and subsequently the Minister of Health, to pay grants, in accordance with regulations laid down, in respect of, inter alia, the salaries of inspectors of midwives and the provision of midwives. Details of the grants in regard to the provision of midwives are set out in paragraph 44 above. The Minister was also empowered to pay grants in respect of ante-natal clinics and maternity hospitals and homes. As previously indicated, the arrangements under which maternity and child welfare grants have hitherto been paid will be replaced as from the 1st April, 1930, by the payment of a consolidated grant to Local Authorities under the Local Government Act, 1929, and the payment of contributions to voluntary agencies by the appropriate Local Authorities.

102. The success of ante-natal clinics is, to a large extent, dependent upon receiving the co-operation of the midwives in referring their cases to the clinics, whilst the maternity hospitals and homes are, of course, largely staffed by midwives. The development of the arrangements made by Local Authorities under the Maternity and Child Welfare Act, 1918, has included a gradual growth of the midwifery services for which

they are responsible, and the fact that the sanction of the Minister of Health is required to all such arrangements has enabled the Minister to exercise supervision over this development. A complete inspection of the arrangements in each district is made periodically by his Medical Officers and these inspections are followed by official communications to the Local Authorities when the reports of the Medical Officers show that some advice or prompting is required in connection with any particular service.

The administration of the grants* in aid of the training of midwives and of post-certificate courses for practising midwives were in 1925 transferred from the Board of Education to the Minister of Health. These grants are payable only to institutions which are recognised by the Minister for the purpose, two of the conditions upon which recognition depends being that the institution must be one that is for the time being recognised by the Central Midwives Board under the rules of the Board, and that the Minister must be satisfied that the premises, equipment and staff are adequate and suitable for the purpose. Every institution to which grants are paid by the Minister in aid of training is subject to inspection by his Medical Officers, in order that he may be advised whether the arrangements for training are in all respects satisfactory; and inspections are carried out from time to time with this object in view. There are at present 73 institutions in England and Wales which are in receipt of training grants and are periodically inspected by Medical Officers of the Ministry.

The total number of institutions in England and Wales recognised as training schools by the Central Midwives Board is 193, which include 24 general hospitals, 67 poor law institutions and 102 maternity hospitals and homes. It will be seen, therefore, that a large proportion of these institutions do not receive grants from the Minister in aid of training. But the majority are inspected by officers of the Ministry either in connection with other work (e.g., maintenance of maternity beds or the provision of a district midwifery service) in respect of which grants are also paid, or as part of the routine inspections of poor law institutions; and of the total of 193 institutions, 177 are at present subject to inspection by officers of the Ministry.

103. There can be no question but that the existing arrangements for the approval and inspection of teachers and training institutions by the Central Midwives Board are extremely limited in their scope and application, and that a considerable measure of extension and reform would be needed to place these on a satisfactory basis. This reform might perhaps in ordinary circumstances have been left to the action of the Board which

* The grants in aid of training are to be used by the institutions in reduction of the fees paid by pupil midwives who undertake to practise as midwives or health visitors.

could have obtained the desired result by setting up a staff of competent inspectors to undertake inspection work on its behalf. A solution on such lines would, however, immediately create a further and even more formidable difficulty. Teachers and training institutions would then be faced with the position of being subject to inspection by officers employed by two entirely separate and independent bodies, i.e., the Central Midwives Board and the Ministry of Health. It is clear that such a contingency, with the overlapping and the unnecessary expenditure which it would involve, is one to be avoided. The alternative of devolving upon the Board, in relation to institutions in receipt of training grants, the inspecting duties of the Minister cannot for good reasons be contemplated. In the first place the responsible Minister must always be in a position to take all steps that may be necessary to see that the public monies given by way of training grants are properly used for the purposes for which they are paid. Secondly, it would appear illogical to take out of his control what must necessarily be regarded as an integral and cardinal part of his functions in the supervision and co-ordination of schemes of maternity and child welfare. The growing interest in the efforts to reduce maternal mortality and morbidity and neo-natal mortality all tend to increase the Minister's concern with midwives and midwifery practice, and all that pertains to the training and employment of midwives must, in the natural course of events, be a matter of particular moment in dealing with this urgent and serious problem.

In these circumstances the only recommendation that can justifiably be made is that the whole of the work of approving and inspecting teachers and training institutions, which already in large part is carried out by the Minister of Health should be definitely declared a function of the Minister. It is desirable, however, that medical practitioners, midwives and persons responsible for examining pupil midwives should be closely associated with him in this work, owing to their deep interest in all to which it relates. An Advisory Committee might therefore be formed consisting of persons appointed by the Minister on the nomination of representative bodies (including the Central Midwives Board) to advise him regarding matters coming within the scope of his approving and inspecting duties.

Course and length of training.

104. On administrative grounds we feel it to be inadvisable that separate bodies should be responsible on the one hand for the approval and inspection of training institutions and teachers and on the other hand for laying down the training curriculum. Unless the liaison between these two bodies were close, such an arrangement would lead to difficulties and lack of uniformity. The two functions are, moreover, in essence interdependent and

should, to be carried out in an effective manner, be under the control of one body. The duty of formulating the course and length of training should, we consider, pass also to the Minister of Health who, with the assistance of the Advisory Committee, would decide from time to time what alterations in the curriculum are necessary to meet changing conditions.

Examinations.

105. No useful purpose would be served by transferring the work connected with the examining of pupil midwives from the Central Midwives Board. It is essentially a function proper to an *ad hoc* body of that nature and calls for qualifications of a highly specialised kind on the part of those entrusted with its performance. At the same time there is much to be said for keeping it apart, both in personnel and association, from the other functions on the judicial side which would remain the most important work of the Board. To this end provision should be made for the Board to appoint an Examinations Board composed of persons suitable by experience and qualifications to examine pupil midwives, which should be directly answerable to the Central Midwives Board for the conduct of its duties. These duties might be to determine the scope and extent of the examinations, to control the conduct of such examinations, and to arrange for the inspection, by inspectors paid and appointed for the purpose, of the examinations held at various centres in different parts of the country.

It would be of great advantage, in order to secure the fullest measure of co-operation between the Examinations Board and the Advisory Committee, which it has been recommended should be appointed by the Minister to assist him in the work of approving and inspecting training institutions and teachers and of laying down the training curriculum, for the Advisory Committee to be represented by one or more of its members on the Examinations Board. The Examinations Board might be required to make a report of its proceedings at regular intervals showing the work that has been done over a stated period, with particular reference to the experience that has been gained in regard to the general standard and capabilities of candidates sent up by the training institutions for examination. The report should be available for the information of the Advisory Committee.

It has been recommended in paragraph 38 of our report that an examination should be instituted for non-medical teachers of midwifery, which should in part consist of a written examination, and in part of an actual inspection of a candidate's methods of teaching while she is conducting a class. We consider that the examination should be prescribed and carried out by the Examinations Board. The examiners should take into consideration any reports which may have been made upon the candidate in the course of inspections by the Ministry of Health.

Constitution of the Central Midwives Board.

106. As has been pointed out, the position of the midwife in relation to essential health services has undergone material change in recent years, and it appears to us that the time is now opportune for the assumption by the Minister of Health of the sole responsibility for approving and inspecting training institutions and teachers and of laying down the lines of the curriculum of training in accordance with the recommendations made in paragraphs 103 and 104. The functions of the Central Midwives Board, besides keeping the Roll, would then be mainly disciplinary and examining. If the examining duties were devolved as suggested on an Examinations Board, it would then be possible to constitute the Central Midwives Board with a small compact membership, which is eminently desirable where judicial functions are concerned. A body of, say, nine members could probably contain the necessary personnel for the proper fulfilment of these functions. We suggest that it might be constituted as follows :—

(*a*) Three members elected by vote of the midwives on the Roll who have given notice of their intention to practise during the year preceding the election.

(*b*) Two members jointly nominated by the County Councils Association and the Association of Municipal Corporations, one of whom should be a medical officer of health and one a member of a Local Supervising Authority.

(*c*) Two members—registered medical practitioners—nominated by the British Medical Association, one of whom should be in general practice and one an obstetric specialist.

(*d*) Two members nominated by the Minister of Health, one of whom should be a mother who is neither a certified midwife nor a registered medical practitioner.

Members of the Board might serve for a period of five years and be eligible for re-election or re-nomination, as the case may be.

Under Section 4 of the Midwives Act, 1918, the Board is required to pay to members in respect of their attendance at meetings reasonable expenses on a scale approved by the Minister of Health. In our opinion, members of the Board should also be entitled to a specific fee for attendance, and we recommend that provision to secure this end should be made in connection with any new legislation that may hereafter be enacted.

PART VI.

General.

Payment of doctors' fees.

107. Every Local Supervising Authority is under a statutory obligation to pay the fee of a doctor called in by a midwife in a case of emergency as defined in the rules of the Central Midwives Board, but the doctor, in order to be entitled to his

fee, must state in his claim the nature of the emergency and must submit his claim within a period of two months from the date on which he was called in. Payment is made in accordance with a scale of fees prescribed by the Minister of Health under Section 14 of the Midwives Act, 1918.

The scale of fees at present in force has been subject to some criticism in evidence given by representatives of the medical profession. The contention is that the provision of the scale which precludes the doctor from receiving payment in respect of any services performed after the expiry of four weeks from the day of the birth of the child is inequitable, and that the receipt by him on the prescribed form of the demand for medical aid from the midwife should be treated as entitling him to his fee from the Local Supervising Authority, irrespective of the circumstances under which the demand is made, and without any limitation of the period of assistance found to be necessary in any individual case. We think it advisable that the scale should be reconsidered by the Minister in consultation with the Local Supervising Authorities and the British Medical Association.

The suggestion has also been made that the law should be amended so as to allow the doctor more latitude in regard to the time limit laid down for the presentation of his account to the Local Supervising Authority. The Local Supervising Authority has the power to recover from the patient, or her husband or other person liable to maintain her, the fee of a doctor called in by a midwife in emergency, unless it be shown to its satisfaction that the patient, or her husband, or other person is unable by reason of poverty to pay the fee. Any considerable extension of the time limit would, it is felt, embarrass the Local Supervising Authorities in their efforts to effect recovery in these cases, but some concession to meet the convenience of members of the medical profession, who do not usually make out their accounts every two months, might reasonably be made. We recommend that the time limit should be extended to three months.

Recovery of doctors' fees.

108. It has been stated in evidence that the system of the recovery of doctors' fees referred to in the preceding paragraph affects prejudicially the value of the service, because the mother is often unwilling to engage a midwife for the confinement, on the ground that if medical care is needed and a doctor is summoned to her aid, she will be responsible for the payment of a double fee, i.e. the doctor's fee as well as that of the midwife. In the result she dispenses with the services of a midwife and prefers to rely on the attendance of a doctor assisted by an unqualified woman to undertake the necessary nursing care.

The inference that there is a good deal of truth in this statement may be drawn from the fact that some Local Supervising Authorities have made arrangements under which an expectant mother can, by the prior payment of an agreed sum, insure against the liability for the payment of a doctor's fee, and a special provision was included in the Midwives Act, 1926, to give such arrangements legal sanction. But the phase may, we believe, be regarded as a passing one to which no special importance need be attached if, as is proposed, adequate provision is made both for confinements covered by a maternity scheme based on insurance principles, and for the relatively small number of confinements of a necessitous character which would be outside the scope of such a scheme. In that event, the occasion for the adoption by any Local Supervising Authority of arrangements for enabling pregnant women to insure against the liability for a doctor's fee would disappear.*

The practice of uncertified women.

109. It is difficult to escape the conclusion from the large volume of evidence submitted in regard to the practice of uncertified women as midwives, that the attempts which have been made by law to put an end to this abuse have largely failed in their object. And there would seem to be no advantage to be gained by further legislation in this respect. We believe that the remedy can only be found in the application of a State scheme of maternity.

Delay in the payment of maternity benefit.

110. One of the disadvantages from which practising midwives suffer arises, according to some witnesses, out of the great difficulty which they sometimes experience in obtaining their fees from patients for services rendered. These are usually cases where, it is alleged, there has been undue delay on the part of the Approved Society in the payment of maternity benefit. The midwife has perhaps ceased her attendance before the mother receives the benefit, with the result that the money may be used for purposes not connected with the confinement and the midwife may lose her fee. Another cause of delay in the payment of maternity benefit is attributable to the provision in Section 17 (1) of the National Health Insurance Act, 1924, whereby a woman confined in an institution of the kind mentioned in the Section is not entitled to the benefit until she has left the institution. Similarly this may have the effect of depriving the authorities carrying on the institution of the opportunity of recovering any sum towards the cost of treatment

* In this connection it is to be noted that on the suggestion of the Minister of Health, no attempt is made in many areas to recover the fee of a doctor summoned by a midwife to attend in cases of inflammation of, or discharge from, the eyes of an infant.

afforded in the institution, and debts which accrue more often than is necessary or desirable have to be written off as irrecoverable.

Whatever system may be considered convenient for the remuneration of doctors, midwives and institutions under any State maternity scheme, it is obviously important that the appropriate fee should in every case be paid with expedition.

Qualifications of a maternity nurse.

111. Whilst there may be occasions when the assistance of a general trained nurse with special experience of certain conditions, as e.g., puerperal fever, may be appropriate, the importance of the nursing of women during the puerperium being in general performed by a certified midwife cannot be overemphasised. A trained nurse who is desirous of practising as a maternity nurse in association with a doctor should, therefore, obtain the certificate of the Central Midwives Board in the first instance.

We recognise that there are women who, by virtue of a special training in maternity nursing received at a few hospitals which are accustomed to train such women, have established themselves in practice as maternity nurses in different parts of the country. These women cannot be regarded as suitably qualified to undertake in any ideal scheme work which properly comes within the sphere of a certified midwife, and we are strongly of opinion that the practice of training them followed by the institutions concerned should cease as soon as possible. There is no place in a maternity service for women devoid of proper nursing or midwifery training, except in the capacity of a home help.

At the same time we do not contemplate that a general ban on the employment of partially trained women, or of trained nurses who are not certified midwives can for the purposes of maternity nursing immediately be proclaimed, since the requisite supply of midwives to cope with the work that falls to be done does not exist in certain areas. But we consider that it should be possible within a reasonable time, when the deficiency in such areas has been made good, to insist as an invariable rule that the maternity nursing should, except in certain cases of medical or surgical emergency such as those referred to above, always be carried out by a certified midwife.

Maternity Nursing.

112. For the purposes of the rules of the Central Midwives Board a midwife is treated as acting as a maternity nurse " when a doctor has been engaged to deliver the patient and she has sent for him on the onset of labour and he arrives before she leaves the house." The midwife in these circumstances is subject only to certain of the rules. These are (1) that she must

at once notify the Local Supervising Authority when she has been in attendance upon a patient, or in contact with a person suffering from puerperal fevers or from any other condition supposed to be infectious, or is herself liable to be a source of infection, and must disinfect herself and all her instruments and other appliances and have her clothing thoroughly disinfected to the satisfaction of the Local Supervising Authority; and (2) that she must not lay out a dead body except that of a patient upon whom she has been in attendance at the time of death, and must in all cases notify the Local Supervising Authority when she has prepared or assisted to prepare a dead body for burial.

The midwife who works only in association with doctors in order to carry out the necessary nursing duties in their maternity cases is consequently in a very privileged position. She is, for example, not required to notify her intention to practise to the Local Supervising Authority, so that the Authority is completely in the dark as to her activities; she is entirely free from supervision and often escapes the consequences of an act which in the case of a midwife practising as such would involve that midwife in penal proceedings at the hands of the Central Midwives Board. It would be idle to contend that her work is always confined to purely nursing duties, since there must inevitably be occasions when, through some mischance, the doctor is not present at the actual time of the delivery. The position is most unsatisfactory from every point of view, as has been pointed out by witnesses who have given evidence on behalf of Local Supervising Authorities.

Special mention may be made of midwives practising as maternity nurses in a visiting capacity, that is to say those who go from house to house for the purpose of attending during the puerperal period the patients of more than one doctor. The fact that this type of nurse is not responsible to any particular doctor for exercising due precautions has undoubtedly in the past been the cause of outbreaks of infection, which would probably not have arisen had she been subject to proper supervision and had she been compelled to comply with all the rules of the Board. We desire, in particular, to refer in this connection to the so-called pemphigus neonatorum, a skin eruption of a highly contagious nature that is not notifiable as an infectious disease.

We recommend that except in cases where a midwife acts always as a maternity nurse and restricts herself to attendance on one maternity case at any one time, either in a residential capacity or otherwise, all women coming within this category should be subject to all the obligations applicable to midwives in the usual way. This means that they would be required to notify the Local Supervising Authorities of their intention to practise, and to observe the directions set out in warning notices (such as are visualised in paragraph 96 above) and that

they would be liable to punishment for failure to observe such directions.

We suggest also that steps should be taken to secure the notification to the appropriate medical officers of health of all cases of pemphigus neonatorum.

Home helps.

113. The duties of a home help should be strictly limited to the ordering and care of the household as usually carried out by the mother herself. Nursing duties do not come within her province. Particulars of a scheme of home helps which is, we understand, working with success in one County Borough are set out in Appendix C. It is probable that much invalidity might be avoided if domestic help could be provided for a longer period than is usually thought to be necessary, and this is especially the case where the labour has been accompanied by any abnormal circumstance.

Use of anaesthetics in confinements.

114. We have had brought before us certain representations in regard to the administration of anaesthesia in confinements, and the plea has been made for more general use of anaesthetics both in hospitals and in patients' homes, and, in particular, for freedom of administration in suitable cases, irrespective of the social position of the patient. A considerable amount of misapprehension seems to exist in relation to this matter, and it does not appear to be at all widely understood that the use of anaesthetics and other drugs is not without danger to mother and child in certain circumstances. We think that it would be in the public interest if some professional body would take upon itself the responsibility for issuing at an early date some pronouncement as to the advisability and place in labour not only of anaesthetics, but also of analgesic and sedative drugs generally.

SUMMARY OF CONCLUSIONS AND RECOMMENDATIONS.

We give below a summary of our main conclusions and recommendations. For convenience of reference the numbers of the appropriate paragraphs in the report are shown in each case.

Maternal Care.

(1) That any measures directed solely to the better training of midwives and the improvement in the conditions of their employment would not materially contribute to the reduction in maternal mortality and morbidity, unless they were accompanied by wider measures to deal with this problem on a national basis. (Paragraph 7.)

(2) That a material contribution to this end might be made by initiating a comprehensive maternity scheme related to National Health Insurance whereby, whilst retaining the principle of a cash payment as at present administered by approved societies, the scope of maternity benefit would be expanded to include the provision of essential health services, organised on a local basis and administered in co-ordination with other services of a similar nature by the Local Supervising Authorities responsible for the supervision of midwives under the Midwives Acts. (Paragraphs 8 and 13.)

(3) That the essential services referred to in (2) which, except as regards (*d*) below, are of general application throughout pregnancy, confinement and the puerperium, should, in part, consist of :—

(*a*) The full services of a certified midwife.

(*b*) Provision for a doctor's advice on the call of the midwife in abnormality or doubt.

(*c*) The provision on the doctor's request of the assistance of an obstetric specialist to deal with exceptional emergencies.

(*d*) The provision of administrative and financial arrangements for institutional care in certain cases during pregnancy, and for the confinement in a maternity institution of (i) women whose home conditions are unsuitable, (ii) those who by reason of some abnormal condition require institutional treatment, and (iii) those who may elect to be confined in an institution, irrespective of their home conditions and the need for specialised institutional care. (Paragraphs 9, 10 and 12.)

(4) That there should, as an ideal, be also available the following special medical services (of which, if economy is to be studied, (*b*) in the ante-natal period should take precedence over (*a*)) :—

Ante-natal Period.

(*a*) An early general medical examination of the expectant mother by the doctor.

(*b*) A late full obstetrical examination by the doctor about one or two months before the birth is expected.

Post-natal Period.

(*c*) A final systematic examination by the doctor after the expiration of, say, six weeks from the date of birth. (Paragraph 10.)

(5) That in connection with the ante-natal medical examinations referred to in the preceding paragraph :—

(*a*) The medical practitioner undertaking the supervision of mothers during pregnancy should not only be conversant

with modern ante-natal work, but have special experience in its methods.

(*b*) Steps should be taken to see that examinations are not perfunctory and that the data obtained thereby are so registered as to be available throughout the progress of the case.

(*c*) There are undoubted advantages in the doctor responsible for the ante-natal supervision being also the doctor who may be on call, or in attendance, during confinement and the puerperal period.
(Paragraph 10.)

(6) That every mother to whom maternity insurance would apply should be at liberty to select the doctor of her own choice for the purposes of the examinations specified in (4), and that she should also, even in a normal case, if she so desires, be assisted to engage a doctor and a midwife acting as maternity nurse to attend her during confinement rather than to rely on the services of a midwife alone. (Paragraph 11.)

(7) That there is much to be said for the introduction, in relation to the 10 months which comprise the time of pregnancy and lying-in, of a medical general practitioner service comparable to the medical service as at present provided under the National Health Insurance Acts. (Paragraph 10.)

The position of the midwife under a maternity scheme.

(8) That the midwife should give considerably more attention and time to each of her patients than has hitherto been accepted as the usual standard, and that the scope of her duties, particularly during the post-natal period, should be extended in certain important respects. (Paragraphs 46-48.)

(9) That the effect of placing increased responsibilities on the midwife would be at once to add materially to her already onerous burdens and to foster the tendency prevailing in large practices for her to undertake more work than she can with efficiency perform, unless steps were at the same time taken to improve her position in other respects. (Paragraph 75.)

(10) That with this object in view two indispensable reforms are needed, viz. :—

(*a*) A limitation on the number of cases that the midwife should be allowed to attend.

(*b*) To enable improvements in her standard of professional work, essential to the well-being of her patients, to be effected, a sufficiently substantial increase in the earnings of the average midwife should be secured by the institution of a considerably larger fee than that now customary.

(Paragraphs 76-77.)

(11)—(*a*) That any restriction on the number of cases attended by a midwife during a given period should apply to the midwife who acts as a maternity nurse.

(*b*) That, except in abnormal cases when medical advice would automatically be available, the mother who prefers to engage a doctor and a midwife acting as maternity nurse for the confinement rather than a midwife alone should be allowed a contribution from public funds towards the cost of the alternative service she selects. (Paragraph 78.)

(12) That even with an increased fee many midwives in rural areas would be unable to earn a reasonable competence, and that arrangements should be made in such cases for the granting of subsidies by Local Supervising Authorities. (Paragraph 79.)

Necessitous Cases.

(13) That the duty of providing adequate medical, midwifery and nursing care for the comparatively few women in necessitous circumstances who would remain outside the ambit of a national maternity scheme, should be imposed as an obligation upon the appropriate Local Authorities, provided that each Authority concerned should be empowered to lay down safeguards governing the administration of a scheme adopted in pursuance of this requirement. (Paragraph 80.)

(14) That mothers for whom special arrangements would need to be made on the lines referred to in (13) should be given a reasonable freedom of choice of midwife, and that this end might be secured by the establishment on the part of the Local Authority of a panel of the competent midwives practising within its area. (Paragraph 80.)

(15) That the introduction of a maternity scheme based on insurance principles, coupled with the formation of local panels of independent midwives for attendance on necessitous cases, would seem largely to obviate the need for the employment by Local Authorities of whole-time municipal midwives. But that if any particular Authority, more especially one which carries on a maternity home at which pupil midwives are trained, should feel that a municipal midwifery service is the best and most convenient method of administration for its area, it should not be debarred from establishing this service, provided that reasonable freedom of choice of midwife is always maintained. (Paragraph 82.)

(16) That Local Authorities should make use of their powers under the Maternity and Child Welfare Act, 1918, to ensure that certain essential necessities during pregnancy, labour and the puerperal period are not withheld in the case of mothers who are in such poor financial circumstances as to be unable to provide such necessities themselves without assistance from outside sources. (Paragraph 81.)

(17) That a midwife who might be called in to attend a necessitous case to which maternity insurance would not apply could not fairly be expected to accept a smaller fee than the standard applicable to insured confinements, if the case were counted as one towards her quota, provided that if her services in an emergency case were to fall short of the normal, the amount of the fee might be modified and the case would not necessarily be counted in the quota. (Paragraph 80.)

(18) That the services, both medical and nursing, rendered to the mother and child should be continuous, and that there should accordingly be full co-operation between the doctor in private practice and the midwife on the one side, and the officials employed by Local Authorities in connection with maternity and child welfare work on the other. (Paragraphs 83-86.)

Training of Midwives.

Standard of Education.

(19)—(*a*) That there should be a preliminary examination of an elementary kind for women who desire to enter the midwifery profession, exemption being granted to persons who are in the possession of a certificate gained as the result of passing a higher examination and to those who are trained nurses.

(*b*) That the preliminary examination should be held in all parts of the country and should be placed in the hands of Local Education Authorities. (Paragraphs 16-19.)

Age of Entry.

(20) That a maximum age of entry to the midwifery profession is as important as a minimum age, and that if, as is suggested, the age in both cases is in future fixed by reference to the time of commencing training, the minimum should be 20 years and the maximum 40 years. (Paragraph 20.)

Type of Pupil.

(21) That the time is not opportune to restrict entrance to the profession to women who hold the general nursing qualification. (Paragraph 21.)

Duration of Training.

(22) That sufficient time has not yet elapsed to allow a fair judgment to be made of the value and effects of the present periods of training which were only fixed in the year 1926, and that it would be premature at present to suggest any radical change. But if in the future it is considered expedient to increase the length of training, the importance of arrangements being made for pupil midwives, other than trained nurses, to obtain more adequate instruction in general nursing should be borne in mind. (Paragraph 22.)

Clinical Examination.

(23) That a clinical examination for pupil midwives would be a most valuable addition to the present methods of deciding the suitability of the individual candidate for entrance to the profession. (Paragraph 23.)

Post-Examination Experience.

(24)—(*a*) That the present system of certification should be altered so that in future every pupil midwife would be required after passing the examination to undergo a period of three months post-examination experience under supervision, during which she would be made personally responsible for the conduct of labour in not less than five cases. Thereafter she would be eligible to have her name placed on the Roll of the Central Midwives Board and be fully licensed for independent practice.

(*b*) That the post-examination experience should be undertaken immediately after the passing of the examination, or within such period thereafter, not exceeding six months, as would ensure that it constituted the final stage of training and an introduction to the individual responsibility of independent practice.

(*c*) That midwives whilst obtaining the post-examination experience should be expected to assume the full responsibility appropriate to their calling, and that this end would best be achieved by making arrangements for them to be appointed as members of the staff of small maternity institutions specially recognised for the purpose, or as assistants to competent and experienced independent midwives specially approved for the same end; and that the onus of providing suitable openings for post-examination experience would fall on the training schools. (Paragraphs 24-27.)

Training in Large Institutions.

(25) That there are obvious advantages in pupil midwives being trained in institutions sufficiently large to give a variety of experience and which possess an adequate supply of apparatus. Such an institution should have at least 20 maternity beds, and should provide an adequate number of deliveries on an attached extern district. (Paragraph 28.)

Lecture Courses.

(26)—(*a*) That although provision should be made in every area to secure the highest possible quality of instruction available in regard to that part of the training curriculum which relates to systematic lectures, this objective should not be pursued to such an extent as seriously to incommode any training institution whose pupils are required to attend frequent lecture classes at an inconvenient distance away from the institution, if approval as a lecturer could reasonably be given to a medical officer on the staff of the institution who has adequate apparatus and clinical material in sufficient quantity at his disposal for teaching purposes.

(*b*) That certain parts of the curriculum, however, call for lecturers of a special type, and for this purpose common centralised lectures for all the pupil midwives receiving training within a considerable area would be the obvious and proper arrangement. (Paragraphs 29-31.)

Differences in Training, Examination and Certification.

(27) That it is both undesirable and impracticable to subject pupils who do not intend to practise as midwives to a procedure in relation to training, examination, or certification differing in any way from that imposed upon those who intend subsequently to take up practical midwifery work. (Paragraphs 32 and 33.)

Method of Remedying Shortage of Training Material.

(28)—(*a*) That in London and in large provincial centres where medical schools are situated, a considerable part of the available training material is absorbed by pupil midwives who do not intend to practise after certification, to the detriment of the interests of medical students in schools which sometimes find great difficulty in complying with the training recommendations of the General Medical Council.

(*b*) That it is not merely in the interests of medical education but in the interests of the mothers that the obstetric training of the medical student should be as thorough as possible, and to this end students in a medical school area should have preference in the apportionment of clinical material. Pupil midwives in course of training in connection with a medical school should be allowed to make use of such material only in so far as it is in excess of the needs of medical students. (Paragraphs 32, 34 and 35.)

Central Clearing House.

(29) That if effect were given to the recommendations shown in (24) and (28) a central clearing house, possibly under the auspices of the Minister of Health, would be required. The central clearing house would collate information as to the vacancies which occur from time to time in the various training schools and would superintend the work of distributing pupils who were not able to complete the whole of their practical training in connection with a medical school. It might also advise training schools as to the recognised maternity institutions and approved independent midwives to whom after certification pupils should be sent for their post-examination experience. (Paragraph 36.)

Post-certificate training.

(30) That post-certificate training, the present facilities for which are extremely limited, should be encouraged and arranged for midwives at regular intervals by all Local Supervising Authorities, and that the cost incurred in this relation should be borne by the Local Supervising Authority concerned. (Paragraph 37.)

Examination for non-medical teachers.

(31) That an examination for non-medical teachers of midwifery should be instituted. The examination should be designed to ascertain the teacher's knowledge of her subject and, in particular, her capability of imparting it to pupils. (Paragraphs 38 and 105.)

Miscellaneous Training Matters.

(32) That whilst there is no advantage to be gained by teaching medical students and pupil midwives together in relation to the systematic part of their training, the same objection cannot be raised with regard to the clinical part of the training, having regard to the desirability of bringing these two classes into association at the earliest possible moment in order to encourage them to co-operate later on in their career. (Paragraph 41.)

(33) That the practice followed by certain hospitals in allowing medical students to attend district midwifery patients without being accompanied by a properly certified midwife to undertake their nursing work is open to grave objection and should be discouraged. (Paragraph 42.)

(34) That as regards the midwifery training of medical students generally, the recommendations promulgated by the General Medical Council in the year 1923 are based on reasonable and progressive lines, but that the different medical schools do not yet fully conform with the recommendations. (Paragraph 42.)

(35) That there is a lack of adequate facilities for the post-graduate instruction of medical practitioners, and that medical schools should take steps to develop, so far as may be practicable, suitable courses to meet what is undoubtedly a real need. (Paragraph 43.)

EMPLOYMENT OF MIDWIVES.

Supply of Midwives.

(36)—(*a*) That, although in a number of counties the ground is understood to be almost, or entirely, covered by midwives, approximately 20 per cent. of the rural population of England is at present unprovided with the services of trained midwives, the uncovered areas in other counties containing from a small proportion to as high as 88 per cent. of the population.

(*b*) That with the progressive expansion of the work of nursing associations, without the aid of which the deficiency would have been much larger than it is, the shortage of midwives will to a large extent be overcome, but that the establishment of nursing associations in certain areas is out of the question, and that special arrangements will have to be made to deal with these. (Paragraph 55.)

(37)—(*a*) That the supply of midwives in the County Boroughs and other large Boroughs is generally excessive, the excess being attributable to some extent to the fact that a large number of midwives, who are not solely dependent upon midwifery work for a livelihood, engage in occasional practice to supplement income derived from other sources.

(*b*) That difficulties arise in some of the smaller Boroughs and other areas of an urban character where midwives have not been able to establish themselves owing to the persistence of the custom of employing uncertified women. (Paragraphs 57 and 58.)

Disadvantages attaching to midwifery practice.

(38) That midwives who are trained nurses do not in the great majority of cases practise after certification, because they are generally able to find more attractive and lucrative positions in the nursing than in the midwifery profession. (Paragraph 63.)

(39) That the better trained and better educated women are deterred from becoming practising midwives owing in the main to the heavy individual responsibility and arduous nature of the work, with its long and irregular hours and uncertainty of obtaining adequate rest and relief, and to the lack of reasonable remuneration normally to be gained. (Paragraphs 63-66.)

(40) That independent practising midwives are subject to other disadvantages, e.g., the competition of uncertified women, of certain nursing associations, training institutions and hospitals and the absence of any definite provision for superannuation or old age, all of which must be regarded as additional factors in preventing well-trained and well-educated women from entering the profession. (Paragraphs 63, 67 and 68.)

Methods to improve conditions of employment.

(41) That it is of the utmost importance that all midwives should be guaranteed security in their old age, and that every effort should be made to formulate schemes to achieve this end, (Paragraph 71.)

(42)—(*a*) That adequate relief during sickness and emergencies and for off-duty times is probably more essential in the midwifery profession than in most others, and that every Local Supervising Authority should address itself to the early consideration of this matter with a view to the adoption of local schemes of relief, the cost of which should, so far as may be necessary, be defrayed out of public funds.

(*b*) That the services of whole-time midwives employed in a few instances by a municipality which acts both as the Maternity and Child Welfare Authority and as the Local Supervising Authority under the Midwives Acts, might well be utilised in connection with a scheme of this character. (Paragraphs 72 and 82.)

(43) That aid towards the provision of transport and telephone facilities for midwives practising in rural areas should be provided by each County Council concerned. (Paragraph 72.)

(44) That it would be helpful if Housing Authorities could see their way in regard to the provision of new housing estates to earmark accommodation for midwives who desire to practise in the neighbourhood of such estates. (Paragraph 73.)

(45) That reasonable compensation should be paid by the appropriate Local Authority to a midwife when a patient for whose care she is responsible has been taken out of her charge and sent to a maternity institution for treatment. (Paragraph 74.)

General.

(46) That whilst there can be no absolute ban on the administration of sedative drugs by midwives on their own responsibility, because of the occasional emergencies with which any midwife may be faced when the services or advice of a doctor are not available, midwives cannot be regarded as fitted, either by training or experience, to be given complete freedom in the use of such drugs. (Paragraph 50.)

(47)—(*a*) That when a midwife has ceased to practise for a considerable period and desires to resume midwifery work, or where a midwife although in practice has attended an insufficient number of cases to remain efficient, the Local Supervising Authority should be empowered to represent these facts to the Central Midwives Board, in order that the Board may determine whether the midwife should be required to undergo post-certificate instruction.

(*b*) That the Local Supervising Authority should have power in cases of this nature to suspend the midwife from practice, pending the promulgation of the Board's decision. (Paragraph 87).

(48) That Section E of the rules of the Central Midwives Board, whether or not retained in its position of statutory authority, requires to be revised and rearranged. (Paragraphs 45 and 49 and Appendix B.)

ADMINISTRATION.

Supervision of midwives.

(49) That there is a lack of uniformity in the arrangements adopted by Local Supervising Authorities for the supervision of midwives, due to the absence of any standard qualification for inspectors of midwives, and that the following changes are desirable :—

Medical Inspectors.

(*a*) Wherever possible, every new appointment to the post of chief inspector of midwives should be given to a medical officer who has had actual experience of obstetric practice and who is engaged on other work of a similar nature, e.g., as an assistant medical officer for maternity and child welfare.

Non-Medical Inspectors.

(*b*) Subordinate positions for routine inspections should be filled, as and when vacancies arise, by midwives who are trained nurses and have gained experience in the actual practice of midwifery over a prolonged period. It would be in the interests of midwives if the Minister of Health were given power to prescribe the qualifications that should be held by inspectors of this class.

(*c*) If an examination for non-medical teachers of midwifery is established, applicants for appointment to the post of subordinate inspector might be required to hold the teacher's certificate. (Paragraphs 89-91.)

(50) That it is desirable that in all new appointments to subordinate inspecting positions and as soon as possible in regard to all existing appointments, ad hoc officials should be appointed by each of the Local Supervising Authorities concerned. (Paragraph 93.)

(51) That there is room for the exercise of much tact and judgment if, as is to be desired, the inspector is to win the confidence and trust of the midwives under her charge; that midwives should have ready access to the medical inspector; and that the employment of health visitors with little or no practical experience of midwifery for the inspection of midwives is wrong both in conception and principle and is to be deprecated. (Paragraph 92.)

(52) That the dual routine inspection of particular midwives who practise in the area of more than one Local Supervising Authority is highly objectionable, and that in cases of this kind the Local Supervising Authorities concerned should come to an agreement as to which Authority should perform the work. (Paragraph 94.)

Scope of the work of the Central Midwives Board.

(53) That the Central Midwives Board has dealt with the intricate problems confronting it with good judgment, but that circumstances have changed so greatly since the Board was established shortly after the passing of the Midwives Act, 1902, that certain alterations in its powers and duties are desirable. (Paragraph 88.)

Judicial functions of the Central Midwives Board.

(54) That the time has now arrived when the present system of discipline under which midwives are punished for failure to comply with the rules prescribed by the Central Midwives Board for the purpose of " regulating, supervising and restricting within due limits " their practice might, in view of the improved status of the profession, be altered on the lines indicated below :—

(*a*) The Board should be given general power (i) to suspend, or when necessary to erase from the Roll the name of any midwife found guilty of a felony, misdemeanour, or offence which, in the Board's opinion, renders her unfit to practise, and (ii) to caution, suspend or remove from the Roll a midwife who, after due enquiry, is judged by the Board to have been guilty of conduct in any professional respect, either by reason of neglect to comply with any statutory obligation or otherwise, which makes her unfit to pursue her calling, or of a midwife who carries on her work in such a way as to endanger the health or life of the mother or child.

(*b*) If the Board were given the powers referred to in (*a*) the way would be clear for the relegation of the existing rules which regulate, supervise and restrict the practice of midwives from their present position of definite statutory authority and penal significance to a less commanding, but still important place. To this end the Board might issue to every midwife practising in England and Wales warning notices or instructions. Such a notice might recapitulate in a revised and re-arranged form the detailed particulars now set out in Section E of the rules of the Board as examples of the standard of practice to which the midwife should attain. Attention would be directed to the various statutory obligations imposed on the midwife by the Midwives Acts. A list might be given of examples showing acts of malpractice, negligence, or misconduct which have been the subject of penal action in the past. The forms of notification which the midwife is required to submit to the Local Supervising Authority should also be scheduled. (Paragraphs 95 and 96.)

(55) That it would be an advantage if the Board were to appoint an independent legal assessor whose opinion and advice on matters of law would be available for all members of the Board at penal proceedings. (Paragraph 97.)

(56) That it is desirable that power should be conferred on the Board to subpoena witnesses and to require evidence on oath and the production of documents. (Paragraph 98.)

(57) (*a*) That where a Local Supervising Authority represents a *prima facie* case of negligence, malpractice or misconduct

to the Board, the prosecution of the charge should rest solely with the Authority, and that it should be competent for any other interested body or individual complainant to bring a case before the Board in the same way.

(*b*) That there will, however, always be a residuum of cases in respect of which the Board must take action on its own initiative. (Paragraph 99.)

Approval of training institutions and teachers.

(58) That the existing arrangements for the approval and inspection of training institutions and teachers by the Central Midwives Board are unsatisfactory by reason of their extremely limited scope, and that the whole of this work should be placed in the hands of the Minister of Health, on whose behalf the majority of the institutions recognised as training schools by the Board are at present inspected by officers of his Department, either in connection with grants in aid of midwifery services or the training of midwives, or as part of the routine inspections of poor law institutions. (Paragraphs 100-103.)

(59) That an Advisory Committee, consisting of persons appointed by the Minister of Health on the nomination of representative bodies (including the Central Midwives Board) should be formed to advise the Minister regarding matters coming within the scope of his inspecting and approving duties. (Paragraph 103.)

Course and length of training.

(60) That it is inadvisable that separate bodies should be responsible on the one hand for the approval and inspection of training institutions and teachers and on the other hand for laying down the training curriculum, and that the duty of formulating the course and length of training should also pass from the Central Midwives Board to the Minister of Health who, with the assistance of the Advisory Committee referred to in (59), would decide from time to time what alterations in the curriculum are necessary to meet changing conditions. (Paragraph 104.)

Examinations.

(61) That the work connected with the examining of pupil midwives should be carried on, as heretofore, by the Central Midwives Board, but that there is much to be said for keeping it apart, both in personnel and association, from the judicial functions of the Board. To this end provision should be made for the Board to appoint an Examinations Board which should be directly answerable to the Central Midwives Board for the conduct of its duties. (Paragraph 105.)

(62) That in order to secure the fullest measure of co-operation between the Examinations Board and the Advisory Committee mentioned in (59), it would be of great advantage for the Advisory Committee to be represented by one or more of its members on the Examinations Board. (Paragraph 105.)

Constitution of the Central Midwives Board.

(63) That if effect is given to the recommendations contained in (58) and (60) the functions of the Board, besides keeping the Roll of midwives, would be mainly disciplinary, and it would then be possible and advantageous to constitute the Board with a small compact membership.

(64) That members of the Board might serve for a period of five years and be eligible for re-election or re-nomination as the case may be.

(65) That provision should be made in connection with any new legislation to secure the payment to members of the Board of a specific fee for attendance at meetings. (Paragraph 106.)

GENERAL.

Payment of doctors' fees.

(66) (*a*) That the scale of fees prescribed by the Minister of Health under Section 14 of the Midwives Act, 1918, for the payment of the fee of a doctor called in by a midwife in a case of emergency, as defined in the rules of the Central Midwives Board, should be reconsidered by the Minister in consultation with the Local Supervising Authorities and the British Medical Association.

(*b*) That the time limit of two months imposed by Section 2 (2) of the Midwives Act, 1926, for the presentation of a doctor's account to the Local Supervising Authority should be extended to three months. (Paragraph 107.)

The practice of uncertified women.

(67) That the attempts which have been made by law to prevent the practice as midwives of uncertified women have largely failed in their object and it would seem that the remedy for this abuse can best be found in the application of a State maternity scheme. (Paragraph 109.)

Delay in the payment of maternity benefit.

(68) That in view of the difficulty which midwives and institutions are said to experience in obtaining fees for services rendered from patients who receive maternity benefit, it is important in relation to any system that may be considered convenient for the remuneration of doctors, midwives and institutions under a maternity insurance scheme, that the appropriate fee should in every case be paid with expedition. (Paragraph 110.)

Qualifications of a maternity nurse.

(69)—(*a*) That whilst there may be occasions when the assistance of a trained nurse with special experience of certain conditions as, e.g., puerperal fever, may be appropriate, it is highly important that the nursing of women during the puerperium should, in general, be carried out by a certified midwife.

(*b*) That the practice followed by certain hospitals of training women as maternity nurses is open to objection and should cease as soon as possible.

(*c*) That a general ban on the employment of partially trained women or of trained nurses for the purpose of maternity nursing cannot immediately be proclaimed, since the requisite supply of midwives does not at present exist in certain areas, but that it should be possible within a reasonable time to insist as an invariable rule that the maternity nursing should, except in certain cases of medical or surgical emergency such as those referred to in (*a*) above, always be carried out by a certified midwife. (Paragraph 111.)

Maternity Nursing.

(70) That apart from cases where a midwife acts always as a maternity nurse and restricts herself to attendance on one maternity case at any one time, either in a residential capacity or otherwise, all women who work with doctors in the capacity of a maternity nurse should be subject to all the obligations applicable to midwives in the usual way. (Paragraph 112.)

Pemphigus Neonatorum.

(71) That steps should be taken to secure the notification to the appropriate medical officers of health of all cases of pemphigus neonatorum. (Paragraph 112.)

Home Helps.

(72) That the duties of a home help should be strictly limited to the ordering and care of the household as usually carried out by the mother herself. Nursing duties do not come within her province. (Paragraph 113 and Appendix C.)

Use of anaesthetics in confinement.

(73) That it would be in the public interest if some professional body would take upon itself the responsibility for issuing at an early date some pronouncement as to the advisability and place in labour not only of anaesthetics, but also of analgesic and sedative drugs generally. (Paragraph 114.)

We desire in conclusion to record our unanimous, cordial appreciation of the unremitting zeal of Mr. W. H. Howes of the Ministry of Health whilst acting as Secretary of the Committee. Mr. Howes has met the varied demands of the Committee promptly, resourcefully, with exactness and with unvarying courtesy.

We have pleasure also in acknowledging our indebtedness among others to the Central Midwives Board for freely afforded information as to the activities of the Board, and to various members of the Staff of the Ministry of Health for special data requested from time to time.

(Signed) Robert Bolam, *Chairman.*
Eleanor Barton.
John W. Bone.
Janet M. Campbell.
Cynthia Colville.
W. Allen Daley.
John S. Fairbairn.*
Alice S. Gregory.
T. Eustace Hill.
A. B. Maclachlan.
F. N. Kay Menzies.
Elena Richmond.*
Katharine J. Stephenson.

W. H. Howes, *Secretary.*
10th July, 1929.

---

* Signatures subject to the Reservations which are appended.

RESERVATIONS BY DR. J. S. FAIRBAIRN AND MRS. BRUCE RICHMOND.

Our signatures express our assent to the report of the Committee with the exception of certain recommendations concerning the Central Midwives Board. With those suggesting improvements in the working of the Board, such for example as the addition of a clinical test to its examination (par. 23), the institution of a teachers' certificate (par. 38) and changes in penal procedure (pars. 95-99) we are in complete accord. The points in which we dissociate ourselves from the majority of the Committee concern those recommendations that involve the splitting up of the functions hitherto assigned to the Midwives Board and their distribution between a reduced Board, the Ministry of Health and an Advisory Committee (pars. 100-104). In our opinion the suggested changes have no necessary relation to the other recommendations contained in the report and are in no way essential to the midwifery service outlined therein. These proposals, if ever carried into effect, would, we think, be detrimental to the development of a midwifery profession of the kind envisaged by the report, to the maternity service and thus to the mothers of the country.

As briefly as we can we will put the reasons that have led us to make these reservations from the report which we have signed.

(1) No evidence to justify the drastic changes contemplated above (in pars. 103 and 104) was put before the Committee. The Ministry of Health was heard at an early meeting (June 27th, 1928) but no hint was given that a transference of any part of the work of the Central Midwives Board was desired or thought advisable. No suggestion of the need for such transference was brought forward by any bodies or individuals appearing before the Committee until late in the taking of evidence (February 13th, 1929), when a proposal to this effect was submitted by the London County Council. That body is the largest Local Supervising Authority in the country and its opinion on matters concerning practice by midwives naturally carries great weight. But it has no concern with or experience of the training of pupil midwives and its evidence in this regard is, therefore, much less valuable, particularly as it was not supported by similar evidence from representatives of other Local Supervising Authorities or from representatives of training schools. Further, owing to the late stage at which it was brought forward, the Committee had no proper opportunity of testing the suggestions of the London County Council by reference to those bodies most concerned in or affected by the removal of the formulation of the course and length of training and approval of training institutions and teachers from the Midwives Board to the Minister of Health, such as the representatives of the Central Midwives Board, the Midwives Institute, the Queen's Institute (the largest employer

of midwives), training institutions and obstetric teachers, nearly all of whom had already appeared. Yet the recommendations of the London County Council were incorporated into the report almost as they stood.

The grounds on which these recommendations are based are given in pars. 100-106 of the report and will be found practically to amount to (*a*) lack of regular inspections of training schools by officials of the Midwives Board and (*b*) the evils of dual inspection, if an inspectorate of its own was instituted by the Board.

(*a*) It may be granted that, with the greatly extended formation of maternity hospitals subsequent to the War, a stage has been reached when a closer supervision and inspection of training institutions is called for than it has been the custom of the Midwives Board in the past to exercise. We should have welcomed a recommendation that the Board should exercise a wider and more general inspection than it has done, especially if poor law institutions, none of which are liable to inspection by the Midwives Board, were included. We should also have preferred that the recommendation had suggested the employment by the Board to a further degree of those of its own members who are obstetricians, and are or have been teachers, and are otherwise experienced; of its examiners or former examiners, and of obstetric teachers of recognised standing, rather than the institution of a whole-time inspectorate.

(*b*) "Dual inspection" appears to us to be a bogey that loses its terrors when closely examined. If the Minister alone is responsible, the ordinary inspectors of the Ministry, who are neither teachers themselves nor engaged in the practice of midwifery, cannot be regarded as satisfactory critics of teaching hospitals, especially those with medical schools, or the old-established maternity hospitals, whose atmosphere that gives character and individuality to each one of them is the product of tradition and long experience. The only inspection that would be accepted by the teaching staff of such institutions would be that of fellow-teachers and colleagues of equivalent professional standing. The dread phrase "dual inspection" loses its force if the inspection of the teaching and training methods is carried out by an individual possessing outstanding personal experience while the general sufficiency and efficiency of the institution for its primary purpose is left to an official inspector. An adequate report to the Ministry of Health on structure and arrangements of an institution and that on training carried out in it must necessarily be made to different departments and must thus be always "dual."

We have not been able fully to appreciate the drift of the argument in pars. 101 and 102, beyond that the grants in aid of maternity services (half by Minister of Health and half by Local Authority and after April 1st, 1930, by a consolidated grant

to Local Authorities (par. 44)) and in aid of training call for inspection by the Minister and thus produce the dual inspection that would arise if the Midwives Board also inspected. Reference to par. 102 will show that only 73 institutions out of 193 are inspected to ascertain their suitability to receive pupil midwives in receipt of grant. It might here be as well to point out that the grants in aid of training are really grants to help women to train as midwives for the service of the country and not to institutions. Instead of the grant being paid direct to the pupil midwife for her training, it is paid to the training institution and deducted from the fee to be paid by the pupil, so that no more financial benefit is obtained by the institution from pupils in receipt of grant than from other pupils. The purpose of the grant being to enable the pupil to become a midwife, it can only be earned at a school approved by the Central Midwives Board, and, as it involves a contract on the pupil's part that she will practise, the grant to the school in part payment of her fees may be reclaimed if she breaks her contract.

(2) Not only do the reasons set out in the report fail to convince us of any advantage to be gained by the transference of the powers of approval to the Minister of Health, but the experience of the Central Midwives Board has shown that a similar transference in the past proved unsatisfactory and was given up. Training in all poor law hospitals was removed from the purview of the Midwives Board at an early stage in its history, on the ground that routine inspection of them was made by the inspectors of the Local Government Board and, ipso facto, they should be accepted as approved training schools. To quote from Reports on Public Health, Ministry of Health, No. 21, 1923 (Training of Midwives) p. 28, " Soon after the Midwives Act was passed, for reasons which at that time were doubtless good and sufficient, the training in Poor Law Institutions was exempted from the supervision of the Central Midwives Board " . . . " The time would seem to have arrived when the arrangements for the supervision of midwifery training in Poor Law Institutions should be reconsidered. I suggest that the training of midwives in these institutions should fulfil precisely the same conditions as obtain in non-poor law institutions under the Central Midwives Board." (Dame Janet Campbell.) In the report from which these quotations are made instances are given both of satisfactory and unsatisfactory training permitted under that system of inspection, (first by the Local Government Board, afterwards the Ministry of Health) and when the supervision of poor law institutions was resumed by the Midwives Board in 1924 a large number were struck off the approved list because they were wholly unfitted to be training schools and fell far short of the standard required of non-poor law institutions. Even when they came under the supervision of the Central Midwives Board the poor law hospitals were left with privileges not allowed to other institutions (as part of the agreement with

the Minister of Health) and among them was exemption from inspection of their hospitals by the Midwives Board. On this ground alone it has been felt that so long as this exemption was in force, regular inspection of non-poor law schools would be an inequitable differentiation.

In view of the considerable number of municipal and other maternity hospitals under the local health authorities—a number to be vastly increased when the poor law institutions are also taken over by them—and in view of the close relationship of the Ministry to these authorities, we urge that an outside and independent body like the Midwives Board should have the decision as to their efficiency as training schools. Otherwise there will be a return to the state of affairs described above.

(3) The determination of the duration and character of training, the approval of schools and teachers and the examination of candidates are not only all closely linked together, but form an integral part of the work of the Board, which formulates the rules under which the midwife works, determines the conditions under which she practises, adjudicates on charges of professional misconduct and keeps and purges the Roll. These functions are so inter-related that they should be retained in the hands of a single authority. The hearing of penal cases provides evidence of when and where alterations in rules are called for and gives information as to deficiencies in the education and training of midwives. In conducting the examinations, the candidates' schedules sent up from training schools and reports by examiners reveal weaknesses that are not otherwise likely to be discovered. Thus the penal and examining duties are linked up with the curriculum and the approval of schools and teachers, and to leave the former where they are and hand over the latter to another body with some device for liaison between them must be inferior to a unified control. This proposal to break up work that has, in the experience of a generation, been welded into a compact whole, and the distribution of its parts between an attenuated Midwives Board and a department of the Ministry of Health, with an Advisory Committee at its back, makes a dual control (or triple if the Advisory Committee is more than a shadow) that is not likely to draw women into a profession already groaning under a weight of official supervision (discussed in paras. 70 and 92).

(4) The Committee in its report has expressed itself as anxious to raise the status of the midwife and to make her vocation a real profession that will attract women of better education than it has hitherto done, but its recommendations regarding the Midwives Board appear to be wholly inconsistent with that ideal. It is the general rule for all professions—medical, legal and others—that they retain in their own hands the decision as to what is the proper training for and means of entry into them. The closely allied nursing profession affords the best analogy. Under the Nurses Registration Act, 1919, the General

Nursing Council was constituted to play a part in the governance of the nursing profession corresponding to that of the Central Midwives Board in the midwifery profession, including " regulating the conditions of admission to the register." The schedule to the Act constituted the Council of 25 members to be nine nominated and 16 " being persons registered as nurses under this Act " to be elected by those registered at the time of election. The nine nominated members are appointed respectively by the Privy Council, Board of Education and Minister of Health, and consist at present of five members of the medical profession and four persons not nurses or doctors.

The midwives should have control over their profession at least equivalent to that exercised by registered nurses over theirs, and it is scarcely disputable that a gradual increase in the elected representatives should be the aim, so that both, with some outside help from the medical profession and others, may ultimately be able, as other professions are, to determine conditions of training and entry and to maintain their own professional standards. Anything that lowers the status and prestige of the ultimate authority over them, anything that postpones the possibility of their obtaining the control over their profession that is granted to other professions, must cause deep and bitter resentment among midwives. They will also feel that the Midwives Board, depleted of most of its administrative functions, will no longer command the same services, hitherto voluntarily given, from medical practitioners, midwives and others.

We would urge that no such momentous changes as those recommended in this report should be made without full and open discussion, not only with the midwives, teachers, teaching schools and other interested parties in England, but also with the sister and similarly constituted Boards in Scotland and both divisions of Ireland, with which there has hitherto been complete reciprocity.

Regarding the reduction in numbers and constitution of the Midwives Board suggested in the report, the former would be reasonable with its depleted functions, and the revised constitution has the merit of increasing the proportion of midwives. We have some doubt as to the effectiveness of a general vote in a body as scattered and as yet unorganised as the midwives are and regret that the Midwives Institute, the only body representative of the midwives, is not given the election of either a midwife or the obstetric specialist.

In conclusion we venture to draw attention to the strong representation of the public health service (four medical officers out of seven medical practitioners and an official of the Ministry of Health) whereas the practising midwives, the body most affected by the proposals we contest, were almost without representation.

JOHN S. FAIRBAIRN.
ELENA RICHMOND.

APPENDIX A.

The General Lying-in Hospital, York Road, Lambeth, London, S.E. 1., provides, through the Post-Certificate School at the Branch Home at Camberwell, two types of post-certificate training courses for midwives, viz., a short annual intensive course lasting for one week, and a much fuller course lasting either for a period of four weeks or for a period of eight weeks.

The annual "Post-Graduate Week" has been held continuously for over 16 years, the fee now charged being 10s. for the course. The aims of the organisers are to refresh the memory of the students in the subjects taught during their ordinary midwifery training, to instruct them in new methods, to teach them to co-operate with Public Health Authorities, and to kindle in them a desire to extend their knowledge and to encourage them to study independently. The Hospital Authorities feel that, despite the impracticability of arranging for pupils attending these courses to be given very much personal practical instruction, the courses serve a useful purpose in awakening the midwife's interest in new aspects of her work and in bringing home to her the necessity for repeated courses if she is to remain efficient. Out of 103 midwives who attended the course during 1928, 28 per cent. consisted of women practising in London and district, and 72 per cent. of women practising in provincial or rural areas.

The longer courses were started in the year 1919 and are designed to meet the needs of (1) practising midwives of long standing, (2) midwives who have not practised for a long period after certification and (3) newly certificated midwives who require further experience. With the object, so far as possible, of setting a high standard of attainment for the midwife in similar conditions to those in which she is accustomed to work, the teaching is concentrated on the ordinary nursing and care of the lying-in mother delivered in her own home. For this reason ante-natal supervision is largely taught in patients' homes, together with such subjects as the advice to be given to mothers in preparation for the confinement and the principles of general hygiene. Ante-natal clinics held each week at the Post-Certificate School and at the Hospital are also attended. An important part of the training is that which deals with the co-operation of the midwife with Public Health Authorities and voluntary agencies carrying on local maternity and child welfare services, and with the methods of educating mothers in regard to their parental responsibility. Visits are paid to the Hospital where bedside demonstrations, including demonstrations in relation to women attended in the labour ward, are a feature. The models and specimens kept in the museum at the Hospital are found to be useful in giving pupils an opportunity of learning the theory of different aspects of midwifery practice. Periodical visits to the Mothercraft Training Society, Highgate, the St. Margaret's Eye Hospital, the Venereal Diseases Clinic at the Mothers' Hospital of the Salvation Army, the St. Giles' Poor Law Hospital, Lambeth, and the Royal College of Surgeons, are arranged from time to time. Lectures, which are delivered by specialists in the various subjects with which the midwife is concerned in her work, are organised at regular intervals.

Whilst the syllabus laid down for the four weeks' course is similar to that of the eight weeks' course, it is understood that proportionately a larger part of the time in the former case is earmarked for ante-natal work. The Hospital authorities take the view that the superior value of the longer course as compared with the shorter cannot be measured solely by the difference between the duration of the courses. It is found, for example, that the midwife from a rural area takes a little time to become accustomed to the change in the conditions of her mode

of life and to acquiring new habits and ideas, so that she often does not begin to grasp facts intelligently and to apply them readily until the second month of training. It has been estimated that 25 per cent. of the advantage is gained in the first month and 75 per cent. in the second. It is the practice of the Hospital to combine the post-certificate training with the ordinary midwifery training of pupil midwives. In this way it is possible to relieve the post-certificate pupils of a good deal of the actual nursing of midwifery cases and to allow them to devote more attention to outside work, such as attending ante-natal clinics and lectures.

Most of the women who receive post-certificate training at the Post-Certificate School, Camberwell, are of the village nurse midwife type who are sent there by county nursing associations. Normally six midwives are in training at any one time. The gross fees for the four weeks' and the eight weeks' courses are £8 8s. and £16 16s. respectively. In the case of a midwife in respect of whom training grant is paid to the Hospital by the Minister of Health, the net fee to be paid to the Hospital either by herself or on her behalf by a county nursing association is £4 8s. for the shorter course and £8 16s. for the longer course.

The Hospital Authorities have estimated that the expenditure attributable to the Post-Certificate School in any one year is approximately £1,636 and that, similarly, the approximate income is £1,390, leaving a deficit of £246. On the expenditure side of the account are included such items as provisions for staff, rent, rates and taxes, insurances, laundry, drugs and dressings, etc.; and on the income side of the account are shown training and district midwifery grants from the Minister of Health, fees paid by pupil midwives and post-certificate students and payments made by patients.

APPENDIX B.

SUGGESTIONS BY THE COMMITTEE DESIGNED TO MEET CERTAIN CRITICISMS AND OBJECTIONS TO RULES OF THE CENTRAL MIDWIVES' BOARD REFERRED TO IN EVIDENCE.

Rule E. 1.

The form of ante-natal record approved by the Board under this rule might be revised by division into two parts, one to be filled in by the midwife and the other by the doctor, or alternatively certain items in a composite form might be shown by an asterisk for completion in any case by the doctor on his own responsibility.

Rule E. 12.

The first paragraph might be amplified as shown in paragraph 47 of the report. Personal performance of these duties is indicated. Substitution in regard to them should only be by means of a duly qualified assistant.

The second paragraph requires modifications to make it clear that the attendance of the midwife is not necessarily restricted to ten days.

It might be desirable also to indicate in general terms the normal frequency of visits and the time necessary properly to carry out nursing duties.

Rule E. 12A.

The emphasis (in the note to this rule) placed on the importance of establishing breast feeding rather than on directions as to the procedure to be followed in notifying the departure from it might well be transferred to the rule itself.

Rule E. 13.

Deletion is suggested. See remarks on Rules E. 20 and 21.

Rules E. 20 *and* 21.

Rule E. 20 provides that in all cases of illness of the patient or child, or of any abnormality occurring during pregnancy, labour, or lying-in, a midwife must forthwith call in a doctor to her assistance. The rule (E. 21) which immediately follows is designed to furnish a list of outstanding examples of abnormality to which the attention of the midwife is specially directed. A good deal of misapprehension appears to exist regarding the application of this particular rule, owing to the fact that another rule (E. 13) defines a case of normal labour as meaning one in which there are none of the conditions specified in Rule E. 21. In the result there has been a tendency for midwives to regard the scheduled abnormalities given for their particular guidance as the sole criteria to be applied in deciding whether or not a doctor's advice is essential. It has been urged in evidence given by medical witnesses that "normal labour" cannot be defined and that in any event Rule E. 13 and Rules E.20 and 21 are mutually inconsistent. They suggest that the first mentioned rule be deleted and that the last be suitably revised. We agree on both points.

The note at the end of Rule E. 21 might be removed to the beginning of the rule and shown in leaded type to make it readily apparent to the midwife that she should call in a doctor in emergency from whatever cause arising, irrespective of whether the condition of the patient comes within any of the definitions contained in the prescribed list. Further, in the introductory sentence to each of the heads "Pregnancy," "Labour." "Lying-in" and "Child," the word "any" might be stressed by being set out in bold type; and there would be an advantage in placing a stop after the word "complication" which might then be followed by the words "Examples of such are."

There is a good deal to be said for not overloading the list of emergencies given in this rule, which might indeed be lengthend indefinitely without exhausting all the possible emergencies that might be an indication of the necessity for medical aid. Nevertheless provision should, in our view, be made for certain additional examples of abnormality which commonly occur in the practice of midwives. As regards "Pregnancy," there might be some indication in relation to "Deformity or stunted growth" to direct attention to cases in which disproportion exists between the head and the pelvis. As regards "Labour," one of the most common forms of emergency in respect of which a midwife summons medical aid is where labour is delayed owing to inefficient uterine action from whatever cause. The advisability of a midwife taking early steps to call in a doctor in time for him to give effective aid should be stressed. Again a disquieting feature of present day midwifery is the high foetal mortality which occurs in breech cases, more particularly in primiparae. It would be of service to re-introduce the example of abnormality formerly incorporated in the rule, namely, "Where in a primigravida the presentation is a breech."

Our attention has been directed to a Circular issued by the Central Midwives Board to teachers in May, 1927, which seems to go beyond the meaning of that section of the rules of the Board where certain of the requirements that must be complied with by pupil midwives with regard to practical training are set out. These are shown in paragraph 15 (*b*) of the report. The Circular advises the teachers that "no cases can be counted in which the pupil has not made abdominal and vaginal examinations (that is more than one), and has not personally delivered the head and body of the child and the placenta and membranes." The

Circular goes on to say that "this excludes all cases known as 'B.B.A.' (born before arrival) and also all cases in which the labour is too far advanced on arrival to make (repeated) abdominal and vaginal examinations possible."

If pupil midwives are to receive an efficient practical training, they must obviously be allowed to become familiar with the proper methods of making vaginal examinations, but it is inadvisable that too much stress should be laid upon the necessity for repeated investigations of this character in every case. The Circular accordingly appears to need revision in order to make it conform with the modern obstetric practice of limiting the number of vaginal examinations to the minimum consistent with the safety of patients, whilst at the same time indicating that adequate opportunity should be afforded for pupils to gain experience in making such examinations.

APPENDIX C.

This municipal scheme for home help is based on the employment of trustworthy, homely women of the artisan class solely for domestic work in patients' homes when the mothers are unable through incapacity incidental to childbirth to do this work themselves. A feature of the scheme is that the home helps are not required to undergo any special training in preparation for their duties. The Town Council regards this as important in view of the fact that, as a result of experiments made in other areas, it had been found that some helps to whom training was given not infrequently showed some disinclination to serve in homes where the conditions were below the average in cleanliness, that is to say, the homes in which their services were most needed.

The scheme, which was started in the year 1926, is said to have been very successful. Each home help is paid 5s. 6d. a day but only in respect of actual working days; she is required to supply and pay for her own food. During 1927, 49 cases were attended by 20 home helps. In the following year the cases attended rose to 120, the number of home helps then in employment being 29. The number of working days was 1,595 in the latter year as compared with 677 during the year 1927. The patient or her relatives are required to contribute towards the cost of the service in accordance with their means. Where the income of the family, after deducting rent:—

	Per day. s.	d.
Is below 9s. per head per week, the family pay the Town Council	1	0
Is between 9s. and 12s. per head per week, the family pay the Town Council	2	0
Is between 12s. and 15s. per head per week, the family pay the Town Council	3	0
Is between 15s. and 17s. per head per week, the family pay the Town Council	5	0
Is over 17s. per head per week, the family pay the Town Council	5	6

It has been found that there is little demand for this service for households where the charge per case exceeds 2s. per day.

The rules for the guidance of a home help are as follows:—

"1. She must attend daily at the home to which she is sent from 8 a.m. to 6 p.m. (Sundays excepted, save where Sunday occurs *within four days* after confinement.)

The usual period for which she will be required for each case will be 14 days.

2. She must

(*a*) keep the house clean and tidy;

(*b*) cook and prepare meals for the family;

(*c*) care for any children there may be, and see that those attending school do so punctually, and are clean and tidy;

(*d*) do the washing (except arrears) including linen soiled during the confinement.

3. She must not interfere with the instructions of the doctor or midwife, and must recognise that she is NOT a nurse, but simply a domestic help.

4. She must supply and cook her own food, and not use the food provided by the family for whom she works.

5. Where a case of infectious disease occurs in the house of a home help, or in the family of the patient, or should the home help in any way come into contact with infection, she must report at once to the HEALTH DEPARTMENT for instructions.

6. Payment will be made by the HEALTH DEPARTMENT as soon as proof is obtained of satisfactory service. The rate of pay will be 5s. 6d. per day, less Health Insurance. NO CHARGE MUST BE MADE TO THE PATIENT NOR PRESENTS ACCEPTED FROM THE PATIENT. Tram fares will be allowed in approved circumstances.

7. Where the Health Department has agreed to provide the services of a home help, a written order is issued stating the name and address of the household requiring her services. Without such written order, no payment will be made.

8. Any conduct on the part of the home help which is contrary to the interests of the household where she is employed, will, if brought to the notice of the Department, lead to her name being removed from the list.

9. Home helps are specially warned that THEY MUST NOT under any circumstances GOSSIP about the affairs of the families to which they have been sent."

APPENDIX D.

List of Bodies and Persons who submitted Statements of Evidence to the Committee.

PART I.

Names of Witnesses examined.

Ministry of Health.

Dame Janet M. Campbell M.D., M.S., Senior Medical Officer for Maternity and Child Welfare.
A. B. Maclachlan, Principal Assistant Secretary.
E. Hackforth, C.B., Deputy Controller of Health Insurance.

Central Midwives Board.

H. G. Westley, M.A., LL.D., Secretary.

WELLCOME LIBRARY INSTITUTE

Queen's Institute of District Nursing.

Annie M. Peterkin, General Superintendent of the Queen's Institute of District Nursing,
Margaret F. Chalmers, Superintendent for the East Suffolk Executive Committee of the Suffolk Nursing Federation,
Elizabeth M. Wyatt, Superintendent of the East Sussex County Nursing Federation,
Olive I. Cameron, Queen's Nurse,
Mercy Wilmshurst, Superintendent of the Metropolitan District Nursing Association,
} Trained nurses and certified midwives.

General Medical Council.

Sir Donald MacAlister, Bt., K.C.B., M.D., President.
H. L. Eason, C.B., C.M.G., M.S.

Association of Municipal Corporations.

J. Johnstone Jervis, M.D., D.P.H., Medical Officer of Health, Leeds.

Incorporated Midwives Institute.

Edith Simpson, Secretary,
Florence Mitchell, Hon. Secretary, Affiliated Associations Committee,
Laura Turner, Sister-in-Charge, Post-Certificate School, Camberwell,
Edith M. Doubleday,
} Trained nurses and certified midwives.

Association of Inspectors of Midwives.

Gertrude M. Hardy, President,
May Coleman, Secretary,
Gwendolen Williams,
} Trained nurses, certified midwives and inspectors of midwives.
Lila S. Greig, M.B., D.P.H., Assistant Medical Officer of Health and Inspector of Midwives, Northamptonshire.

Plaistow Maternity Hospital and District Nurses Home.

A. E. Kennedy, M.R.C.S., L.R.C.P., Honorary Surgeon.
Ada Davies, M.B.E., Matron.
C. H. Andrews, Secretary.

Women Sanitary Inspectors' and Health Visitors' Association.

Amy Sayle, M.B.E., M.A., Chairman.
Hilda M. Gray, Secretary.
Jeffie Kent Parsons, Vice-Chairman.
Gladys I. Le Geyt,
Edith M. Davies,
} Members of the Association,
} Trained nurses and certified midwives.

College of Nursing.

Mary S. Rundle, R.R.C., Secretary.

Kathleen V. B. Coni,
Jessie P. Watt,
Ann Warren,
Barbara K. Newill,
} Trained nurses and certified midwives.

Infirmary Medical Superintendents' Society.

W. Brander, M.D., Medical Superintendent, Hackney Poor Law Infirmary.
E. W. G. Masterman, M.D., F.R.C.S., Medical Superintendent, St. Giles' Poor Law Infirmary, Camberwell.

Association of County Medical Officers of Health of England and Wales.

W. A. Bullough, M.B., D.P.H., Medical Officer of Health, Essex.

Liverpool Maternity Hospital.

Ethel M. Cauty, M.B.E., Matron.
Maud Marquis, Secretary of the Ladies' Committee.

General Lying-in Hospital, York Road, Lambeth.

J. P. Hedley, M.B., F.R.C.P., F.R.C.S., Visiting Physician.
Laura Turner, Sister-in-Charge, Post-Certificate School, Camberwell.

Association for Promoting the Training and Supply of Midwives.

Lt.-Colonel F. E. Fremantle, O.B.E., M.A., M.B., F.R.C.S., F.R.C.P., M.P., Vice-President.
Ethel B. Grant, Secretary.

Society of Medical Officers of Health.

R. A. Lyster, M.D., D.P.H.

County Councils' Association.

Sir William Hodgson, Chairman, Cheshire County Council.
J. R. Kaye, M.B., D.P.H., Medical Officer of Health, West Riding of Yorkshire.
J. W. Black, Chairman, Public Health Committee, Leicestershire County Council.

Durham County Council.

T. Eustace Hill, O.B.E., M.B., Medical Officer of Health, County of Durham.

Standing Joint Committee of Industrial Women's Organisations.

Marion Phillips, D.Sc., M.P., Secretary.
Alderman Rose Davies, J.P., Vice-Chairman.

Derbyshire County Nursing Association.

Florence Bourne-Wheeler, M.B.E., Honorary Secretary.
Alice Meldrum, Superintendent.

British Medical Association.

H. B. Brackenbury, LL.D., M.R.C.S., L.R.C.P., Chairman of Council of the Association.
A. Cox, O.B.E., M.B., B.S., Medical Secretary.
C. E. S. Flemming, M.R.C.S., L.R.C.P.,
Christine M. Murrell, M.D., B.S.,
W. Paterson, M.B., Ch.B., } Members of Council.

Bradford Corporation.

J. J. Buchan, M.D., Ch.B., D.P.H., Medical Officer of Health, Bradford.
Alderman David Walker, M.D., Chairman, Public Health Committee, Bradford Town Council.

London County Council.

Florence Barrie Lambert, C.B.E., M.B., B.S., D.P.H., Vice-Chairman, Midwives Acts Committee.
Elizabeth Macrory, M.B., Ch.B., D.P.H., Chief Inspector of Midwives.

Medical Women's Federation.

Catherine Chisholm, B.A., M.D., Ch.B., Hon. Physician Children's Northern Hospital, Manchester, and Manchester Babies' Hospital.

Mary H. Frances Ivens, M.S., M.B., Ch.M., Clinical Lecturer in Obstetrics and Gynaecology, University of Liverpool, Hon. Obstetric Surgeon, Liverpool Maternity Hospital.

Rhoda H. B. Adamson, M.D., B.S., University Lecturer in Midwifery University of Leeds, Hon. Surgeon, Leeds Maternity Hospital.

North Middlesex Poor Law Hospital.

Lt.-Colonel Spencer Mort, M.S., M.D., F.R.S., Medical Superintendent and Surgical Director.

Annie Dowbiggin, R.R.C., M.B.E., Matron.

Independent Witnesses.

Beckwith Whitehouse, M.S., F.R.C.S., Professor of Midwifery and Diseases of Women, University of Birmingham.

Daniel Dougal, M.C., M.D., Professor of Obstetrics and Gynaecology, University of Manchester.

E. L. Holland, M.D., F.R.C.S., Obstetrical and Gynaecological Surgeon, London Hospital.

Aleck W. Bourne, M.B., B.Ch., F.R.C.S., Senior Obstetric Surgeon, Queen Charlotte's Maternity Hospital.

W. H. F. Oxley, M.R.C.S., L.R.C.P., Visiting Physician, East End Maternity Hospital.

Edith Charter, Superintendent, Wolverhampton District Nursing Association,
Christina A. Tait McKay, Secretary and Superintendent, Northumberland County Nursing Association,
} Trained nurses and certified midwives.

May Turner,
Mabel D. Ruddock,
} Certified Midwives.

PART II.

List of Bodies and Persons from whom Written but not Oral Evidence was received.

Association of Poor Law Unions.

Poor Law Medical Officers' Association of England and Wales.

Lady Williams.

(69918) Wt. 9929—4022/785 3000 9/29 P.St. G.71

THE ROYAL SOCIETY

FOR THE PROMOTION

OF HEALTH

Founded 1876

LIBRARY REGULATIONS

(a) Books, periodicals and pamphlets may be borrowed by Fellows, Ordinary Members, Associates and Affiliates personally or by a messenger producing a written order. The person to whom such publications are delivered shall sign a receipt for them in a book provided for that purpose.

(b) Publications may be borrowed through the post upon a written order. An acknowledgement of the receipt of such publications must be made on the form provided and returned to the Society immediately. Failing this, it will be assumed that the borrower has received the books, for which he will accordingly be held responsible. The postage of publications returned to the Society shall be defrayed by the borrower.

(c) A borrower may not have more than three publications in his possession at one time.

(d) A borrower will be considered liable for the value of any publication lost or damaged while on loan to him, and, if it be a single volume or part of a set, for the value of the whole work thereby rendered imperfect. Marking or writing in the publications is not permitted, and borrowers are requested to call attention to damage of this character.

(e) **Books and pamphlets may be retained for twenty-eight days. Periodicals may be retained for fourteen days. Applications for extension of the loan period must be made in writing before its expiry.** This loan period cannot be extended without application being made to the Secretary of the Society whose decision in this matter must be accepted as final and binding.

(f) Books and pamphlets added to the Library will not be lent until after the expiry of one month from the date received. The current number of a periodical may not be borrowed.

(g) Borrowers retaining publications longer than the time specified, and neglecting to return them when demanded, forfeit the right to borrow until they be returned, and for such further time as may be ordered by the Council.

Any borrower failing to comply with a request for the return of a publication shall be considered liable for the cost of replacing it, and the Council, may, after giving due notice to him, order it to be replaced at his expense.

No publication may be reissued to the same borrower until at least seven days have elapsed after its return, neither may it be transferred by one borrower to another.

(h) **Publications may not be taken or sent out of the United Kingdom.**

(i) Publications returned through the post must be securely packed and adequately protected.

(j) Parcels should be addressed: THE LIBRARIAN,

THE ROYAL SOCIETY OF HEALTH

90 BUCKINGHAM PALACE ROAD, LONDON, S.W.1

— June, 1960

O.B., TRURO