The regulation of midwives in England, c.1500–1902

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Abstract
Throughout the 19th century, midwives were depicted as incompetent slatterns in both popular imagery and medical literature. We examine how, between 1500 and 1800, midwifery was regulated by a combination of formal licensing by the Church and informal oversight within the community. We argue that episcopal licensing demanded that midwives demonstrate knowledge and competence in midwifery, not only that they were spiritually fit to baptise dying infants. Although episcopal licensing lacked statutory authority, the symbiosis of formal and informal systems of regulation ensured good midwifery practice and midwives were regarded as experts in all matters relating to childbirth. The Midwives Act 1902 introduced statutory regulation of midwives, restoring their ‘professional status’ if in a subordinate role. We show that the history of the regulation of midwives across four centuries casts light on the interplay between formal and informal regulation and matters of gender and professional status.

Keywords
Birth, midwifery, healthcare professions, regulation, history

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Introduction
This article addresses the regulation of female midwives in England from the 16th century to the passing of the Midwives Act 1902. While the 1902 Act initiated statutory regulation of midwives in England, it was not the first measure to provide for the
regulation of midwives. From circa 1500 to the 18th century, midwives required a licence to practise from their diocesan bishop. This system was in many ways akin to provisions for licensing both physicians and surgeons outside London and surgeons in the capital.¹ We argue that the Church oversaw a system of external regulation of midwives that, while not perfect, validated midwifery as a skilled and expert undertaking and conferred status upon all midwives, not just licensees. A number of cavils beset the suggestion that episcopal licensing of midwives can be viewed alongside the regulation of their ‘medical’ counterparts. It might be said to have been ineffective, because many midwives practised without a licence. Such evidence alone does not undermine the significance of episcopal regulation of midwifery. Episcopal licensing of physicians and surgeons in the provinces was far from uniformly applied. The interplay between the formal role of the Bishop as regulator and the role of the local community in which midwives practised is crucial in analysing the efficacy and importance of ecclesiastical regulation. While the Churches’ interest in midwives was related to concerns about a midwife’s role in baptism, by the 17th century regulation was as much about fitness to practise as liturgical correctness.

Studies of regulation law rely heavily upon medicine as a primary model for thinking about the relationship between state intervention and the development of the professions in the 19th century.² While most historical studies of healthcare regulation cite the Medical Act 1858 as the first instance of a regulatory strategy in England, Moran acknowledges the importance of the Apothecaries Act of 1815 in creating a template for medical regulation that ‘all subsequent professionalising projects in healthcare have had to respond to’.³ The Medical Act established a recognisable form of healthcare regulation – one which had a common entry standard, a single register of practitioners and legislative origins. Yet if we follow Ogus’ definition of regulation as ‘(a) any form of behavioural control and (b) sustained and focused control exercised by public agency over activities valued by a community’, then the licensing of physicians, surgeons, apothecaries and midwives over the centuries preceding 1815 merits examination.⁴ Historians of medicine have acknowledged the importance of regulatory controls over the medical professions in the 16th and 17th centuries, yet midwives have been generally overlooked in historical studies of medical regulation. From the late 19th century, midwives’ competence and technical skill have been conflated with formal obstetric education

1. R.S. Roberts, ‘The Personnel and Practice of Medicine in Tudor and Stuart England: Part 1 The Provinces’, *Medical History* 6 (1962), p. 363; R.S. Roberts, ‘The Personnel and Practice of Medicine in Tudor and Stuart England: Part II, London’, *Medical History* 8 (1964), p. 217.
2. E. Friedson, *Professionalism Reborn: Theory, Prophecy, Policy* (Cambridge: Polity Press, 1994), p. 10.
3. M. Moran, ‘The Health Professions in International Perspective’, in Judith Allsop and Mike Saks, eds., *Regulating the Health Professions* (Thousands Oaks: Sage Publications, 2002), p. 19, 19–30.
4. A. Ogus, *Regulation: Legal Form and Economic Theory* (Oxford: Hart Publishing, 2004), p. 1; Anthony Ogus, ‘Regulatory Law: Some Lessons from the Past’, *Legal Studies* 12 (1992), pp. 1–19, 2.
and training. Midwives’ broader role in the parish and in the legal process as an ‘expert’ in matters of reproduction and women’s bodies, and their status within their local area, has been acknowledged but its importance has been overlooked. Recent scholarship has sought to reinstate the midwife as a skilled provider of obstetric care yet the dominant narrative of her licensing and control has continued to emphasise character and moral fitness over skill and competence.

Examining the regulation of English midwifery across four centuries allows us to explore the relationship between regulation and social status, formal and informal regulation and self versus external regulation. The study of these interactions in modern settings has shown that informal regulatory methods such as gossip networks, shaming and the strategic distribution of work are very efficient moderators of behaviour. These informal methods of regulating behaviour and practice and the interrelated control and management of ‘reputation’ are widely observed across multiple disciplines to form part of a ‘regulatory web’ that captures norms of behaviour, institution and professional culture, and conflicting duties of care.

Formal and informal regulation systems are often presented as being in conflict with each other – external formal regulation in competition with organisational structures and cultures to implement change and improve industry standards. Informal regulations, it has been suggested, are ‘to some extent designed to circumvent the constraints and consequences of

5. R. Porter, Bodies Politic: Disease, death and doctors in Britain 1660-1900 (London: Reaktion, 2001), p. 225; Roy Porter, Disease, Medicine and Society in England 1550-1860 (Cambridge: Cambridge University Press, 1995), p. 13; J. Guy, ‘The Episcopal Licensing of Physicians, Surgeons and Midwives’, Bulletin of the History of Medicine 56 (1982), 528–542; T. Forbes, ‘The Regulation of English Midwives in the Sixteenth and Seventeenth Centuries’, Medical History 8 (1964), pp. 235–244.

6. A. Wilson, ‘Participant or Patient? Seventeenth-century Childbirth from the Mother’s Point of View’, in Roy Porter, ed., Practitioners and Patients: Lay Perceptions of Medicine in Pre-Industrial Society (Cambridge: Cambridge University Press, 1986), pp. 129–144, 136.

7. D. Evenden, The Midwives of Seventeenth-Century London (Cambridge: Cambridge University Press, 1999), p. 26; A. Wilson, The Making of Man-midwifery: Childbirth in England 1660-1770 (London: UCL Press, 1995), p. 32; J. Donnison, Midwives and Medical Men: A History of the Struggle for the Control of Childbirth (New Barnet: Historical Publications, 1988), p. 7.

8. L. Haller, ‘Regulating the Professions’, in The Oxford Handbook of Empirical Research (Oxford University Press: Oxford, 2018), pp. 230–231, 216–234; J. Allsop and L. Mulcahy, Regulating Medical Work: Formal and Informal Controls (Buckingham: Open University Press, 1996), p. 9.

9. M. Bacon, ‘The Informal Regulation of an Illegal Trade: The Hidden Politics of Drug Detective Work’, Etnografia e Ricerca Qualitativa 1 (2013), pp. 61–80, 64; S. Percy, ‘Informal Regulation’, Adelphi Papers 46 (2006), pp. 53–61, 53; C. Heimer, ‘Competing Institutions: law, Medicine, and Family in Neonatal Intensive Care’, Law & Society Review 33 (1999), pp. 17–66, 24.

10. On the importance of culture and informal methods of behaviour regulation, see S. Sackmann, Cultural Complexity in Organisations (California: Sage Publications, 1997); E. Schein, ‘Culture: The Missing Concept in Organisational Studies’, Administrative Science Quarterly 41 (1996), pp. 229–240.
formality, [and so] they proved to be highly resilient and adaptable to regulatory mechanisms. We offer a positive account of formal and informal regulation, arguing that the regulation of English midwifery relied upon cultural and social norms of behaviour until the 19th century. The absence of statutory authority for midwifery regulation in the era of episcopal licensing reflected neither the competence nor the social prominence and legal status of the midwife in that era. For so long as the system endured, a symbiotic relationship between formal licensing practices and informal training, mentorship and communal oversight seems to have worked as is evidenced by its longevity.

We suggest that standards set by episcopal licensing derived from and legitimised midwives’ informal practices, providing a framework for ‘good’ midwifery practice not restricted to midwives who obtained a licence. Similarly, processes and principles developed within the ecclesiastical sphere influenced informal practice. The withdrawal of one party to the relationship in the 18th century (the Church) rendered midwives vulnerable to attack by ‘medical men’ and a consequent if gradual loss of status. Nineteenth-century initiatives to establish a ‘new’ regulatory framework for midwifery took place at a time when medical practitioners were consolidating their power and influence and within a context which simply assumed female midwives’ inadequacy and the need for regulation to protect the public. The background to the 1902 legislation indicates that the Act owed more to the entrenchment of medical hierarchies and gendered perceptions of ‘women’s work’ than patient safety. A study of midwifery regulation between 1500 and 1902 reflects many modern concerns about the licensing and regulation of healthcare professions including the efficacy of licensing and regulatory structures; patient autonomy and access to expert knowledge; professional relations and culture; interactions with the state; and methods of enforcement. Neglect of the earlier history of the regulation of midwives has deprived us of a model of partnership between external and self-regulation. The mutually dependent relationship between the informal supervision of midwives at all stages in their careers by their colleagues and attendants and the formal mechanisms of ecclesiastical licensing exemplify the importance of regulation (even imperfect regulation) and recognition in validating expert status and conferring authority. The midwife, we will show, deserves a more central place in the history of the healthcare professions than she has occupied thus far.

**Pre-reformation midwifery**

**Formal regulation: Episcopal licensing**

From early in the 16th century, episcopal licensing required that midwives be in possession of a licence from their diocesan Bishop. A midwife aspiring to a licence must have

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11. Bacon, Informal Regulation, p. 15.
12. On the market-driven and competitive nature of regulation, see Ogus, Regulation, p. 1; Friedson, Professionalism Reborn, p. 10; Allsop and Saks, Regulating the Health Professions, p. 19.
13. For a more detailed discussion of these markers of ‘good’ midwifery practice, please see S. Fox and M. Brazier, ‘Midwives Oaths: Ethical Promises in Early Modern Midwifery’, Paper Delivered to York Law School Seminar, publication forthcoming.
undergone a period as Deputy to a licensed midwife (akin to the apprenticeship of surgeons and apothecaries).\textsuperscript{14} When she applied for her licence, the midwife had to pay a significant fee, be examined (either by the Bishop or by someone with obstetric experience) and present testimonials from local medical men, clergymen and women whom she had delivered.\textsuperscript{15} In necessitating testimonials from clients, the requirements of evidence of ‘fitness to practise’ imposed on midwives were more onerous than those imposed on physicians and surgeons seeking a diocesan licence. The applicant had finally to appear before the Bishop or his Chancellor accompanied by the women who had testified in her favour. Should everything be to the Bishop’s or his nominee’s satisfaction, the midwife then swore an Oath to ensure her good practice and her loyalties to the parish. Her licence authorised her to practise and designated the parochial or geographical scope of that practice. The midwife was obliged to retain the licence for display at parish visitations.

It is unclear when the episcopal regulation of midwifery began in England, but it appears to date from around the beginning of the 16th century. Forbes suggests that midwifery licences were a natural extension of the 1511 \textit{Act concerning Physicians and Surgeons} which ordered (1) that:

\begin{quote}
no person within the City of London nor within vii myles of the same take upon hym to excise and occupie as a Phisicion [or Surgion] except he be first examined approved and admitted by the Bisshopp of London or by the Dean of Poules
\end{quote}

and (2) that outside London no person should practise ‘as a physician or surgeon, in any diocese within this realm but if first he be examined and approved by the bishop of the same diocese’.\textsuperscript{16} From 1518 and the grant of a Royal Charter to the London College of Physicians (confirmed in an Act of Parliament in 1522), the licensing and regulation of physicians in London and its environs was entrusted to the College. Episcopal licensing in theory continued to apply to surgeons in London and both surgeons and physicians outside the capital.\textsuperscript{17} Nowhere in the Act are midwives expressly mentioned. Bloom and Rutson James’ lists of medical practitioners in 16th-century London, however, show that three midwives were licensed by the Bishop of London in the immediate aftermath of the Act, indicating perhaps that the Act acted as a trigger to highlight ecclesiastical concern about midwifery.\textsuperscript{18}

\begin{itemize}
\item \textsuperscript{14} Evenden, \textit{Midwives}, pp. 34–42.
\item \textsuperscript{15} A. Wilson, \textit{Ritual and Conflict: The Social Relations of Childbirth in Early Modern England} (Hampshire: Ashgate, 2017), pp. 162–163; D. Harley, ‘Provincial Midwives in England: Lancashire and Cheshire’, in H. Marland, ed., \textit{The Art of Midwifery: Early Modern Midwives in Europe} (London: Routledge, 1993); Donnison, \textit{Midwives and Medical Men}, p. 6; Forbes, ‘Sixteenth and Seventeenth Centuries’, p. 235.
\item \textsuperscript{16} 3 Hen.VIII.c.i An Act concerning Phisicions and Surgeons.
\item \textsuperscript{17} Guy, The Episcopal Licensing of Physicians, p. 528.
\item \textsuperscript{18} J. Harvey Bloom and R. Rutson James, \textit{Medical Practitioners in the Diocese of London, Licensed under the Act of 3 Henry CII, C.11} (Cambridge: Cambridge University Press, 1935), p. 84.
\end{itemize}
It is unlikely that the 1511 Act gave rise to the first interest of the pre-Reformation Catholic Church in the regulation of midwifery, particularly given midwives’ role in baptising frail infants unlikely to survive until a Priest could attend. Baptism had particular importance in Catholic doctrine as infants who died unbaptised were consigned to Limbo. Thomas Forbes argues that the baptismal elements of episcopal licensing were not indicative of a sudden interest in midwifery by the Church, but rather the consolidation of existing practices. He cites a text by an English canon John Myrc published in 1450: ‘And though the child be but half bore, head and neck and no more, Budde hyre spare neuer the later, to cristene hyt and caste on water’. The text emphasises that this authority is only to be enacted in an emergency, and continues; ‘And ef the wommon thenne dye, Teche the mydwyf that schohye, For to vndo hyre wyth a knyf, And for to save the chylde lyf, And hye that hyt crystened be, For that ys a dede of charyte’. The Church’s concern was to ensure the salvation of the child and check that midwives used the proper liturgy to avoid a risk that the baptism had been incorrectly performed. To make an error was to risk losing the soul of the infant to the devil.

The regulation of midwives could therefore be regarded as a matter of religious practice within the usual authority of the Church to dictate; a view perhaps supported by the fact that the penalty for unlicensed practice was a period of excommunication.

If the ecclesiastical regulation of midwives was prompted by the 1511 Act, the Church’s interest went beyond a midwife’s spiritual and moral fitness to practise. The Act had specifically set out its objective to prevent ‘the grievous hurte damage and distruccion of many of the Kings liege people’ caused by ‘a grete multitude of ignoraunt psones of whom the grete partie have no man of insight in the same nor in any other kynde of lernyng’. If the commencement of licensing midwives was a response to this

19. Forbes, ‘Sixteenth and Seventeenth Centuries’, p. 236; Guy, The Episcopal Licensing of Physicians, p. 538; M. Green, Making Women’s Medicine Masculine: The Rise of Male Authority in Pre-Modern Gynaecology (Oxford: Oxford University Press, 2008), p. 148; T. van Sprecher and R. Karras, ‘The Midwife and the Church: Ecclesiastical Regulation of Midwives in Brie 1499-1504’, Bulletin of the History of Medicine 85 (2011), pp. 171–179; R. Petrelli, ‘The Regulation of French Midwifery during the Ancien Regime’, Journal of Medical History 26 (1971), pp. 276–277.
20. Forbes, Op. cit., p. 237.
21. ‘And though the child be but half bore, head and neck and no more, But here spare never the later, to christen it and cast on water’, Forbes, Op. cit., p. 237.
22. Forbes, Op. cit., p. 237.
23. ‘And if the woman [mother] then die, Teach the midwife that so hastens, For to undo her with a knife, And for to save the child’s life, And see that it christened be, For that is a deed of charity; Forbes, Op. cit., p. 237.
24. Forbes, Op. cit., p. 237.
25. Evenden, Midwives, p. 46.
26. Guy, The Episcopal Licensing of Physicians, p. 538.
27. ‘A great multitude of ignorant persons of whom the great majority have no manner of insight in the same nor in any other kind of learning.'
legislation, a midwife’s knowledge and technical ability to deliver infants were relevant factors for the regulator. The Church’s remit went far beyond religion in this period. The parish was the main unit of social administration in England until the poor law reforms of the early 19th century. It was logical that midwives should be regulated by the parish alongside the administration of the poor law, and the maintenance of social order, especially in the light of the key role midwives played in the local community. As such, episcopal licensing of midwives made practical sense.

**Informal regulation: A social birth**

The invisibility of midwives in legislation regulating the medical occupations did not result in an absence of midwifery oversight. Nor did the fact that many women worked as midwives without a licence mean their practice was wholly ‘unregulated’. Birth in the 16th century was a social event as much as a medical matter. Birth mothers were cared for by a group of local women and neighbours – later referred to as birth attendants or gossips. They were without exception married, had given birth themselves and most were experienced in assisting other women as they were delivered. Often the birthing woman’s mother was present; other women being drawn from her friends, and neighbours. These women fulfilled multiple roles. They helped with the birth and called for assistance when it was thought necessary. They cared for the infant once born, washing it, checking for injuries and swaddling the baby. They acted as witnesses to the birth, to confirm that the child had been born alive (or not) and that nothing untoward had happened during the confinement. Birth attendants continued to be important after the delivery had taken place during the 4-week recovery period known as ‘lying-in’, ensuring that the new mother was properly rested and was recovering from her ‘travail’. Crucially, the attendants undertook an informal yet important regulatory function in overseeing the actions of any midwife present.

Midwifery training was both undertaken within, and overseen by, this informal regulatory framework, founded in notions of neighbourliness and Christian duty. Substantial evidence of how informal regulation and training operated is understandably scarce in this period. Midwives were generally drawn from women who had acted as birth attendants. The midwife might be the most experienced birth attendant or show a particular aptitude for midwifery. New midwives, even if they did not apply for a licence, undertook an informal training programme that mirrored that of the Deputy within the episcopal licensing system, working with the incumbent midwife as mentor to gain the

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28. Wilson, *Ritual and Conflict*, pp. 218–219.
29. Wilson, *Making of Man Midwifery*, p. 25.
30. ‘Travail, n.1 (1) Bodily or mental labour or toil, especially of a painful or oppressive nature; exertion; trouble’ hardship; suffering, (4) The labour and pain of child-birth*, *Oxford English Dictionary* [accessed online at www.OED.com, 12:28, 13 March 2019].
31. D.L. Chalk, ‘Saviour, Witness, and Comic Relief: The Midwife in English Texts of the Fifteenth and Sixteenth Centuries’, *Studies in Philology* 112 (2015), pp. 93–99; F. Harris-Stoertz, ‘Midwives in the middle Ages: Birth Attendants, 600-1300’, in W. Turner and S.M. Butler, eds., *Medicine and the Law in the Middle Ages*, (Leiden: Brill, 2014), pp. 58–69.
knowledge and experience that would enable her to practise independently. The move from informal apprentice to local midwife was neither guaranteed nor expected. Some midwives inherited their practice from their mentor as age and infirmity made it difficult for them to continue practising. Others would acquire their own practice, first attending a birthing woman when her mentor was unavailable and becoming more popular with local women as word of her competence spread. Becoming a midwife with or without a licence entailed training, self-identification and crucially, approval by the community. The efficacy of community regulation of midwifery practices is evident in its longevity, continuing long into the 19th century, outliving episcopal licensing. Midwives who did not meet the expectations of their clients or her attendants were unlikely to be engaged again in communities where reputation was a key component of good business practice.

Public office

While English midwives did not hold any formal public office by virtue of their midwifery skills in the 15th and 16th centuries, they have often been associated with juries of matrons. The jury of matrons was a special jury under English common law. Summoned by a writ *de ventre inspiciendo*, the matrons were required to give evidence in cases involving women’s bodies and reproductive knowledge; such as where illegitimate pregnancy was suspected, in rape cases, or where a convicted felon sought to delay her death sentence by ‘pleading the belly’ (claiming to be pregnant). Participation in the jury of matrons was the only way in which women could participate in the justice system other than as witnesses or defendants. Butler concludes that juries of matrons were accorded similar status to non-specialist juries in the late medieval period. Her work shows that there was no differentiation in the language used to describe juries of matrons and all-male juries. She found no evidence that decisions made by juries of matrons were challenged by the courts, suggesting that they wielded considerable authority in matters of reproductive knowledge. Moreover, Butler points out that jury service in the early modern period was a social privilege – it conferred status and offered an

32. S.S. Thomas, ‘Midwifery and Society in Restoration York’, *Journal for the Society of the Social History of Medicine* 16 (2003), pp. 1–3.
33. S. Thomas, ‘Early Modern Midwifery: Splitting the Profession, Connecting the History’, *Journal of Social History* 43 (2009), p. 117.
34. C. Muldrew, *The Economy of Obligation: The Culture of Credit and Social Relations in Early Modern England* (Basingstoke: Macmillan, 1998). On the regulatory role of reputation see Percy, *Informal Regulation*, p. 53.
35. J. Baker, *An Introduction to English Legal History*. 5th ed. (Oxford: Oxford University Press, 2019), p. 559.
36. D.M. Dwyer, ‘Expert Evidence in the English Civil Courts, 1550-1800’, *The Journal of Legal History* 28 (2007), pp. 93–101.
37. T. Forbes, ‘A Jury of Matrons’, *Medical History* 32 (1988), pp. 23–24.
38. S.M. Butler, ‘More than Mothers: Juries of Matrons and Pleas of the Belly in Medieval England’, *Law and History Review* 37 (2019), pp. 1–35.
opportunity to become a local notable. If, as she argues, juries of matrons were seen in the same light as male juries, to be selected bestowed influence and social authority on each matron.

The qualifications necessary to sit on a jury of matrons were vague. Archival references to matrons describe them as ‘upright’, ‘discreet’ or ‘honest’ women. They were married and had given birth to at least one child. Cornett highlighted the many overlaps between descriptions of matrons and those of midwives. The process by which matrons were chosen altered over time. Before the 18th century, there is no conclusive evidence that midwives automatically assumed such a judicial function solely because they were midwives. Being midwives meant that they already possessed a social authority that reinforced and maintained the role of the jury of matrons. As juries of matrons were convened to handle cases which required knowledge of reproduction and sexual conduct, midwives would be obvious choices as jurors. Identifying midwives in the pre-Reformation period is not easy. The informality of training mechanisms and an official tendency to assume that midwifery was part of the neighbourly duty of any married woman has meant that it is difficult to know what qualities (if any) separated the midwife from her fellow matrons. By 1792, however, a jury of matrons would be required to be a jury of midwives.

**Post-reformation midwifery**

The religious upheavals in 16th- and 17th-century England had a significant impact on the episcopal licensing of midwives. In the midst of these upheavals, the mode of baptism became a litmus test for religious conformity and therefore for obedience to the State. Politically, the form of baptism became crucial to enforcing adherence to the Church of England and the rejection of papistry. Coster has shown the lengths to which the clergy went to ensure that they complied with an ever-evolving religious doctrine and the (sometimes competing) demands of their congregations. With

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39. H. Kumper, ‘Learned Men and Skilful Matrons: Medical Expertise and the Forensics of Rape in the Middle Ages’, in Wendy J. Turner and Sara Butler, eds. *Medicine and the Law in the Middle Ages* (Leiden: Brill, 2014), pp. 88–108; B. Capp, *When Gossips Meet: Women, Family and Neighbourhood in Early Modern England* (Oxford: Oxford University Press, 2003), p. 300.
40. J.M. Cornett, ‘Hoodwink’d by Custom: The Exclusion of Women from Juries in Eighteenth-Century Law and Literature’, *William and Mary Journal of Women and the Law* 4 (1997), pp. 1–21.
41. Dwyer, *Expert Evidence in the English*, p. 101.
42. Butler, *More than Mothers*, p. 35; Thomas, ‘Early Modern Midwifery’, p. 119.
43. Kumper, *Learned Men and Skilful Matrons*, p. 105.
44. Butler, *More than Mothers*, p. 17; Harris-Stoertz, *Midwives in the Middle Ages*, p. 59; Green, *Making Women’s Medicine Masculine*, pp. 134–140.
45. *In the Matter of Martha Brown ex p Newton Wallop* (1792) 29 ER 793; Dwyer, *Expert Evidence in the English*, p. 101.
46. W. Coster, *Baptism and Spiritual Kinship in Early Modern England* (Aldershot: Ashgate, 2002), p. 57.
the break from Rome and the shift to the Church of England came a rejection of the doctrine of Limbo.\textsuperscript{47} In this turbulent religious landscape, it might be expected that the practice of midwives baptising infants would become obsolete and episcopal oversight would be no longer necessary, yet this was not the case. Midwives’ Oaths continued to include promises relating to baptism though these now focused on ensuring that the ritual of baptism was performed strictly in accordance with the rites of the Anglican Church and that no Papist practices were covertly performed. Nonetheless, as Walsham has shown, Catholic practices remained embedded in the social and religious observances of early modern England, and many families privately feared the prospect of Limbo for an unbaptised infant.\textsuperscript{48} The liturgy for baptism remained important in the Church of England, as it banished the devil from the child and welcomed them in to the Anglican community. Not everyone supported the role of midwives carrying out ‘emergency baptisms’, however. In 1604, James I, at a conference addressing reforms of the Church of England, declared that he would ‘rather his child was baptised by an ape as by a woman’ and expressed his fear that the custom of midwives baptising dying infants was a cover for witches to steal the bodies of dead infants for satanic rituals.\textsuperscript{49}

\textbf{Formal regulation: Episcopal licensing}

Examples of midwives’ Oaths survive from the middle of the 16th century. Baptism was a prominent concern of the licensing authorities. In 1567, Eleanor Pead swore that:

\begin{quote}
[I]n the ministration of the sacrament of baptism in the time of necessity I will use apt and the accustomed words of the same sacrament, that is to say, these words following, or the like in effect; ‘I christen thee in the name of the Father, the Son, and the Holy Ghost; and none other profane words. And that in such time of necessity, in baptizing any infant born, and pouring water upon the head of the infant, I will use pure and clean water, and not any rose or damask water, or water made of any confection or mixture: and that I will certify the curate of the parish church of every such baptizing.\textsuperscript{50}
\end{quote}

Veiled references to ‘profane words’ and scented waters refer to Catholic baptismal practices, and the requirement to inform the curate of any emergency baptisms seeks to ensure religious conformity throughout the parish. As such, the Oath represented the midwife’s role as what Fissel has called the ‘shock troops of religious reform’, an agent

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\textsuperscript{47} Op. cit., p. 50.
\textsuperscript{48} A. Walsham, ‘History, Memory, and the English Reformation’, \textit{The Historical Journal} 55 (2012), p. 899.
\textsuperscript{49} James 1st Hampton Court conference January 1604 as cited in Jean-Louis Quantin, \textit{The Church of England and Antiquity The Construction of a Confessional Identity in the 17th Century} (Oxford: Oxford University Press, 2009), p. 108, note 121 (Declaration of Conference, 342); and see M. Kishlanksy, \textit{A Monarchy Transformed: Britain 1603-1714}, (London: Penguin, 1996), pp. 72–73.
\textsuperscript{50} Evenden, \textit{Midwives}, Appendix A; T. Forbes, \textit{The Midwife and the Witch} (New Haven: Yale University Press, 1966), p. 145; J. Strype, \textit{Annals of the Reign of Queen Mary} (Oxford: Clarendon Press, 1824), p. 242.
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of the Church rooting out Catholic practices in the birth chamber and enforcing religious
conformity.\textsuperscript{51}

Eleanor Pead’s Oath did not stop at the spiritual welfare of the infant. She also swore
to ‘faithfully and diligently exercise the said office according to such cunning [wisdom]
and knowledge as God hath given me’. And later specified:

\ldots I will not destroy the child born of any woman, nor cut, nor pull off the head thereof, or
otherwise dismember or hurt the same, or suffer it to be so hurt or dismembered, by any
manner of ways or means \ldots

Provisions in Eleanor’s Oath offer evidence that episcopal licensing sought to reg-
ulate the care of the physical health of mother and infant and the competence of the
midwife. Additional provisions in 17th-century oaths support the contention that mid-
wives were regulated as health workers. One version of the Midwives Oath is contained
in the 1649 edition of \textit{The Book of Oaths}.\textsuperscript{52} This book was an early attempt to standardise
elements of public office, claiming to be ‘very useful for all persons whatsoever, espe-
cially those that undertake any Office of Magistracie or publique Implyment in the
Commonwealth’.

11. Item, if you shall know of any Midwife using or doing anything contrary to any of these
premises, or in any other wise than shall be seemely or convenient, you shall forthwith
detect open to shew the same to me[the bishop] or my chancellor for the time being.

14. Item, you shall not make or assigne any Deputie ot Deputies to exercise or occupie
under you the office or roome of a Midwife but such as you shall perfectly know to be of
right honest and discreet behaviour, as also apt, able & having sufficient knowledge and
experience to exercise the said roome and office.

Item 11 in its injunction to detect and report concerns about another midwife’s
practice presages 20th-century controversy on whistle-blowing and duties of candour.
Item 14 expressly focuses on the need to ensure any Deputy had the necessary knowl-
dge and experience. In this version of the oath, the requirement that midwives comply
with the practice and liturgy of the Church of England had dropped to item 15 in the list
of ‘promises’ demanded of a licensed midwife.

The midwife seeking a licence undertook obligations directly related to having the
knowledge and skill to provide good care to the women she attended and to ensure that
her colleagues did the same. Oaths set standards of fitness to practise. Effective regula-
tion, however, requires provisions for enforcement. Within episcopal licensing, it
appears that enforcement was patchy. Midwives were ‘expected to attend’ parochial

\textsuperscript{51} Chalk, ‘Saviour, Witness, and Comic Relief’, p. 100; M. Fissel, \textit{Vernacular Bodies: The
Politics of Reproduction in Early Modern England} (Oxford: Oxford University Press, 2004),
p. 28.

\textsuperscript{52} \textit{The Book of Oaths and The Severall forms thereof, both Antient and Modern. Faithfully
Collected out of sundry Authentick Books and Records, not hereuntofore extant, compiled in
one Volume} (London: W Lee, M Walbancke, D Pakeman, and G Bedle, 1649), pp. 284–290.
visitations by the Bishop or his representative and at each visitation should display their licence. The diligence with which the ecclesiastical authorities enforced the licensing of midwives varied across parishes and incumbents. Women practising midwifery without a licence could be (and were) brought to trial in the ecclesiastical courts and excommunicated, fined or otherwise punished, despite the Church having no express authority in secular or canon law legislation to enforce licensing. Equally, there were parishes with no extant records of midwives being presented for practising without a licence. Thomas’s examination of the Consistory Court records for Northern England across the 16th and 17th centuries shows a correlation in some parishes between the appointment of a new vicar and a rise (or fall) in presentments for unlicensed midwifery practice.

Without effective measures to enforce licensing on unwilling or impecunious local midwives applied consistently across England, might a licence be seen as a certificate of competence rather than an exclusive means of entry to the occupation? Thomas found no evidence that licensed midwives were necessarily considered more competent than unlicensed midwives by their clients. The full picture of the regulatory framework governing midwifery and determining the status of the midwife in the 17th century again requires that account is taken of the informal extralegal oversight of local midwives and midwives’ developing public role in the community.

Informal regulation in the community

Episcopal licensing drew on the model of informal/community regulation in particular in requiring that the applicant provides several testimonials from women whose children they had delivered as well as from parish clergy, and local medical men. Surviving testimonials provide rare evidence of the social regulation of midwifery practice in this period, confirming that women seeking a licence had often already been practising for a period of time and practising successfully. These testimonials demonstrate an awareness of the episcopal framework for formal licensing making reference to the obligations imposed by the Oaths and indicating the extent to which (in the view of the person providing the testimonial) the midwife did, or did not, comply with those obligations. Just as episcopal licensing drew on informal regulation, so too was informal oversight of midwifery influenced by the evolving regulatory principles within episcopal licensing. The two frameworks for regulating midwifery practice were symbiotic and, to an extent, complementary.

Within the community, births continued to be overseen by birth attendants or gossips. This informal group of women may be regarded as overseeing the fitness to

53. Evenden, Midwives, p. 42.
54. Forbes, ‘Sixteenth and Seventeenth Centuries’, p. 239.
55. Thomas, ‘Early Modern Midwifery’, p. 117.
56. Op. cit., p. 117.
57. Evenden, Midwives, p. 50; Thomas, Op. cit.
58. The language of testimonials often mirrored that of midwives’ Oaths, indicating that women were aware of both the content and requirements of the Oaths. See for example testimonials in Chester Archives, EDC 5/1691/30; EDC 5/1688/12; EDC 5/1688/11; EDC 5/1691/31.
59. Wilson, Making of Man-Midwifery, p. 25.
The practice of any midwife, not just those licensed by the Church. They undertook functions performed in relation to ‘medical men’ by regional medical corporations, the Colleges of Physicians and Surgeons and the Society of Apothecaries. Episcopal licensing may therefore be seen as ratifying informal regulation with the latter providing additional means to enforce the objectives of licensing. Evidence of the efficacy of informal midwifery regulation is evident in Julia Allison’s prosopographical study of early modern midwives in rural East Anglia. Allison uses parish records and quarter sessions records to identify fifty named midwives, and eight unnamed, spanning a 200 year period between 1400 and 1600. Despite there being no evidence of any formal training and apprenticeship among these midwives, their accuracy in predicting infants with little hope of survival (and baptising them at home) suggests an impressive level of skill and knowledge. Some of the midwives studied by Allison travelled beyond their parish boundaries to attend to birthing women – eight miles in one instance – suggesting that they had been requested for their midwifery skills rather than simply attending to the women that were in their immediate neighbourhood. She identifies numerous incidents of occupational cooperation and networking, with midwives calling upon each other for assistance in difficult births and accompanying each other regularly. Allison’s account demonstrates a pattern of informal regulation which was collegiate, requiring a level of self-observation and the reporting of concerns to colleagues.

A key component of informal midwifery regulation was based on reputation. The importance of reputation is illustrated by the case of Anne Knutsford, midwife of Nantwich in Cheshire in the mid-17th century. Anne’s midwifery skills were greatly in demand among local women. In a case brought against her by the parish constable for continuing to practise following the revocation of her midwifery licence, one witness deposed that a birthing woman ‘might have been delivered two hours sooner if she had had the said Anne’s helpe when they desired it’. Despite Anne’s reputation for skill, she did not meet the moral and social expectations of a midwife. Deponents praised her practical abilities but noted that she used ‘very uncivill and base scandalous language’ and was ‘given to vaine cursing and swearing’. Despite receiving a prohibition from the Church, Anne continued to practise midwifery. Her reputation for skill meant that she continued to be sent for by the women in her parish.

**Public office in the community**

Parishes remained the principal instrument of local government in this period, having several important administrative functions. The midwife’s role in policing the legitimacy

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60. J. Allison, ‘Midwives of Sixteenth-Century Rural East Anglia’, *Rural History* 27 (2016), pp. 1–2.
61. Op. cit., p. 9.
62. Op. cit., p. 11.
63. Op. cit., p. 13.
64. EDC 5/1663/16
65. Op. cit.
66. Thomas, ‘Early Modern Midwifery’, p. 121.
of children, protecting rights of inheritance and exposing immoral conduct was well
established by the 17th-century. Their role in controlling sexual behaviour and childbirth
in the interests of the State and the parish was formalised in 1624 in what came to be
known as the Infanticide Act, *An Acte to pvent the murthering of Bastard Children.*

The Infanticide Act reflected the identification of illegitimacy in the Elizabethan Poor
Laws as a burden upon the State. While illegitimacy had previously been a moral and
family issue, usually handled by ecclesiastical courts, the Poor Laws reframed it as a
drain on parish budgets and the moral state of the nation. The 1624 Act targeted the
‘many lewd Women that have been delivered of Bastard Children, [who] to avoyde their
shame and to escape punishment, doe secretlie bury, or conceale the Death, of their
children’. The Act provided that if a woman was delivered of a child who if born alive
would be a bastard and she sought in any way to conceal the death of the child:

So that it may not come to light, whether it is borne alive or not but be concealed, in every
such Case the Mother so offending shall suffer Death as in case of Murther, except such
Mother can make pffe by one Witness at the least, that the Child (whose Death was by her
soe intended to be concealed) was borne dead [our emphasis].

Women accused under the Act had to prove either that the infant had been born dead
or that they had not been pregnant. Midwives played a central role as ‘expert witnesses’
in such matters of proof, assuming an important status in the legal process. Midwives had
unprecedented access to women’s bodies not just during birth but also during pregnancy,
and illness or death. They had the social authority to ‘search’ women who were sus-
pected of illegitimate pregnancy – that is, to inspect their stomachs and squeeze their
breasts for signs of lactation. They would search women suspected of having recently
given birth and, where they believed a delivery had taken place, they would be instru-
mental in the search for the body of the child. Having done so, midwives would be
required to give evidence in Court.

While the Infanticide Act empowered the midwife to act on behalf of the State within
the criminal process, midwives also regularly gave evidence in bastardy hearings. Midwives’
duty to the parish demanded that they interrogate unmarried women while
they were giving birth to ascertain the name of the infant’s father. For a woman to
confess the details of her sexual relationships to her midwife not only cleared her
conscience but also enabled the parish to avoid financial responsibility for the new
mother and her infant. This information could then be provided to the parish

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67. 21 Jac.I, c.27 (1624).
68. M. Jackson, *New-born Child Murder: Women, Illegitimacy and the Courts in Eighteenth-
 century England* (Manchester: Manchester University Press, 1996), p. 65.
69. Jackson, particularly chapter 3 ‘Examining Suspects: conflicting accounts of pregnancy,
birth and death’, pp. 60–78.
70. Capp, *When Gossips Meet*, p. 299.
71. A. Muir, ‘Courtship, Sex and Poverty: Illegitimacy in Eighteenth-century Wales’, *Social
 History* 43 (2018), p. 56; Jackson, *New-born Child Murder*, p. 87.
72. Jackson, Op. cit., p. 37.
authorities, who could impose a bastardy order against the father making him financially responsible for the infant in the future and charging him for any payments that the parish had made in providing proper care for the birthing woman and her infant.

Midwives’ increasingly public role in local government and the legal process is reflected in the Oaths that they were required to swear. In 1686, Ellen Perkins of St Martins in the Fields swore not only to attend all women regardless of status and to ensure that no infant be baptised ‘then such as are appointed by the Lawes of the Church of England’, she also promised to:

... neither cause nor suffer any woman to name, or put any other Father to the childe, but onely him which is the very true Father thereof indeed ... you shall not suffer any woman to pretend, faine, or surmise herselfe to be delivered of a Childe, who is not indeed; neither to claim any other woman’s Childe for her own ... you shall not consent, agree, give, or keepe counsel, that any woman be deliverd secretly of that which she goeth with, but in the presence of two or three lights readie...

Midwives had become agents of the state in the state’s attempt to deter illegitimacy and infanticide or at least to mitigate the impact on the public purse.

**Interregnum**

Episcopal licensing appears to cease from around 1641, prior to the execution of Charles I in 1649 and the abolition of the episcopacy during the Interregnum. Just as there was no legislation granting the Church express authority to license midwives nor was there legislation removing such authority. An Act of the Long Parliament in 1640 sought to prevent clergymen from exercising ‘any Temporall authoritie by Vertue of any Commission’. It is doubtful that Parliament intended in that Act to address licensing of midwives (or medical practitioners in the provinces); instead seeking to prevent Bishops from assuming Parliamentary authority, as they had done previously. This Act was repealed in 1661 – the same year that London parishes resumed the episcopal licensing of midwives.

The cessation of ecclesiastical licensing created an opportunity for midwifery to be incorporated within a secular system of regulation. London midwife Elizabeth Cellier, writing in 1684, suggested that when ecclesiastical licensing of midwives ceased in about 1642:

> [T]he Physicians and Surgeons contending about it, it was adjudged a Chyrurgical [surgical] Operation, and the Midwives were Licensed at Chirurgions-Hall, but not till they had passed

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73. J. Hitchcock, ‘A Sixteenth Century Midwife’s License’, *Bulletin of the History of Medicine* 41 (1967), pp. 75–76.
74. Guy, The Episcopal Licensing of Physicians, p. 541.
75. 16 CAR, c.27, 1640.
76. Forbes, ‘Sixteenth and Seventeenth Centuries’ pp. 235–241.
three Examinations, before six skilful Midwives, and as many Chirurgions expert in the Art of Midwifery.  

Guy doubts that ‘the influence of the Surgeons’ Hall over midwives during the Commonwealth and Protectorate was any more effective outside London than had been that of the College of Physicians after 15 Henry VIII C5 [‘The Privilege and Authority of Physicians in London’ 1522]. It is notable that Cellier’s statement forms part of her campaign to establish a ‘Colledg of Midwives’ under her oversight. Her complaint following the restoration of episcopal licensing that ‘[Midwives] pay their Money (take an Oath which is impossible for them to keep) and return home as skilful as they went thither’ echoed the allegations of man-midwife Peter Chamberlen. Chamberlen had, in the 1630s, proposed a system for the regulation of midwives in which a corporation of midwives under his sole jurisdiction replaced the Church as the licensing authority. His proposals were rejected by (among others) midwives Elizabeth Whipp and Hester Shaw, who argued that deferring to Chamberlen would require them to act contrary to their Oaths. In 1647, Chamberlen had complained of the midwives he had sought to regulate ‘taking this Oath and paying their Money with the testimonie of two or three Gossips, ay may have leave to be as ignorant, if not as cruel as themselves’.

The brief interruption of episcopal licensing during the Interregnum may have opened up debate about how and by whom midwives should be licensed and how midwives might be located within a secular framework for regulating medical occupations. Any practical impact is likely to have been minimal. Episcopal licensing was, both before and after the Interregnum, patchy in its application. Licensing and informal procedures for the training and oversight of midwives continued to exist in symbiosis to provide a framework for good midwifery practice. In the social and political upheaval of this period, there may have been little incentive to interfere with an occupation that functioned effectively.

The 18th century

The resumption of episcopal licensing in 1661 was short-lived and declined over the remainder of the 17th century. The reasons for its gradual decline are, as Forbes says,
‘not entirely clear’. One factor may have been the fragile authority underpinning the episcopal licensing system. The licensing process essentially derived from the Church’s authority over its congregations, enforceable by religious penalties such as excommunication. From the Act of Supremacy until the 17th century, adherence to the Church of England was mandatory. The Toleration Act 1689 allowed freedom of religious worship to individuals, and communities prepared to pledge allegiance to the monarch and reject the Catholic doctrine of transubstantiation. The Church of England remained the established church in England, but the Act allowed non-conformist communities (though not Catholics) to maintain their own places of worship and set up schools. The Church faced difficulty in enforcing its ecclesiastical jurisdiction over every midwife once not all the midwives or the women they attended were members of its congregation, and thus might be unconcerned about religious penalties such as excommunication. In the light of the gradual erosion of clerical involvement in secular government and the nascent developments in ‘scientific’ medicine, the Church may no longer have been seen as an appropriate regulator of midwives or of any other healthcare provider.

**Formal regulation: Decline and decay**

In London, episcopal licensing was obsolete by the 1720s, with the latest surviving licences in other areas dating from only a decade or two later. Forbes notes 30 licences issued to midwives in the Diocese of Norwich between 1770 and 1786, but these are exceptional. The gradual decline in episcopal licensing of midwifery has been attributed to a number of causes. The rise to prominence of the man-midwife cannot be ignored. Forbes suggests that ‘this development [men-midwives] created problems’ in the issuing of ecclesiastical licences, though he is vague on precisely how these problems were manifested. Evenden attributes the decline of both female midwifery skill and ecclesiastical licensing to their proving ‘no match for the claims of the male midwife, waiting in the wings with his shiny instruments and promises of ‘scientific expertise’. The man-midwife alone did not cause the demise of licensing, however. Male medical practitioners had undertaken a role in birthing for many centuries, being called to attend ‘difficult’ births in which a medical intervention was seen as necessary. Over the course of the 18th century, male medical practitioners became more common attendants at a...
birth but did not displace their female counterparts. Female midwives continued to deliver most women particularly among communities of lower social status.

Licensing had never been universal, nor is there evidence that holding a licence was necessarily perceived as an indication of greater competence or better practice than unlicensed women. Evenden has noted that the testimonial requirement of episcopal licensing was frequently and ‘significantly relaxed’.89 Bishops seemed to lose interest in regulating midwifery and without the incursion of secular penalties; aspirant midwives might well not think it worth acquiring a licence.90 The declining role of the Church in all matters not related to the practice of religion resulted in the withdrawal of the Bishops from a role which had been adopted in practice but never formally conferred on them.

**Informal regulation: The advent of the lying-in hospital**

Regulation of midwifery in the early 18th century remained rooted in the local community, in the informal frameworks of good practice which had sustained it in previous centuries. At a practical and local level, the end of episcopal licensing was largely irrelevant; many midwives had practised successfully without ever applying for a licence. In a post-episcopal era, women trained by an experienced midwife would have had to demonstrate the same level of skill to ‘graduate’ to independent practice; the grant of a licence had always been to an extent a consolidation of the status quo. But as episcopal licensing decayed, no alternative system of formal external regulation of midwives replaced the role of the Church. By 1800, pressure was building to introduce effective reforms of the regulation of all the medical occupations. On the national stage, the lack of a soundly based system for formally regulating midwifery left female midwives vulnerable to attack. Evenden comments perspicaciously that licensing may have had little impact on the everyday business of childbirth ‘but it does appear to have been important for the societal respect and credit of the traditional profession’.91

The decay of licensing occurred contemporaneously with a major development in the provision of healthcare. The foundation of medical institutions had a significant impact on the role of female midwives. Institutions were established to provide medical care for the poor, dispense medicines and treat specific complaints and conditions. The move to ‘hospital’ care was to prove instrumental in the process of reforming the medical occupations, medical education and the oversight of medical practice. In response to broader developments in public health, childbirth came to be seen by medical reformers and government as a medical treatment rather than a social event, and attempts were made to align the regulation of midwifery – through certification and examination – with other healthcare occupations, albeit as a lower order.

89. Op. cit., p. 174.
90. Op. cit., p. 175.
91. Op. cit., p. 175.
Lying-in institutions were originally wards within a larger hospital dedicated to the care of parturient women. The first hospital solely dedicated to the care of lying-in women was opened in 1739 and three others were then rapidly established over the next 3 years. Evenden suggests that these institutions represented the end of the ‘self-regulating, cooperative and ecclesiastically based network’ of midwifery practice in the 17th century. She asserts that ‘the establishment of the lying-in hospital was arguably the single most important factor in the demise of the authority and superiority of the female midwife’. Evenden joins Margaret Connor Versluysen and Ann Oakley, in claiming that lying-in hospitals sought to undermine female midwifery practices and assert control over the process of birthing. Lisa Cody’s subsequent research has shown, however, that lying-in institutions generally preserved traditional birthing practices rather than supplanting them. Cody’s exploration of the archives uncovers a system in which midwives continued to oversee births, with surgeons being called only where a surgical intervention was required. Even if inside the hospitals, practice did not immediately change radically, relocation from the community to the public institution was to have a major impact on midwives.

The provision made for training midwives in lying-in hospitals was an important factor in the changing framework for the regulation of midwifery. The finances of lying-in hospitals were fragile, reliant on subscriptions and donations. Hospitals sought to create a revenue stream by training students in midwifery for a fee. The fee of £35 was set high, but not high enough to deter the wives of soldiers and servants from training, suggesting that midwifery continued to be a lucrative occupation. Training of deputies through a form of apprenticeship was nothing new. The crucial difference was that in the lying-in hospitals the form and outcomes of training were no longer determined by midwives within a system of formal or informal self-regulation but by the physicians, surgeons and managers who ran the hospital. Midwifery training was aligned with medical education more generally.

Relocation from domestic spaces in the local community to public hospitals altered the legal relationship of midwives and the women they attended. Midwives had traditionally been independent experts who provided services to their clients, just as a surgeon sold his services to sick or injured patients. The midwife attending a woman in a private residence and whose fees were paid by the woman or her family entered into a contract for her services with her ‘client’. There is one problem when such contracts are

92. Wilson, *Making of Man Midwifery*, p. 146.
93. Evenden, *Midwives*, p. 186.
94. Op. cit., p. 187.
95. Op. cit., p. 186; Margaret Connor Versluysen, ‘Midwives, Medical Men and Poor Women Labouring of Child: Lying-in hospitals in Eighteenth-Century London’, in Helen Roberts, ed., *Women, Health and Reproduction* (London: Routledge, 1981), pp. 18–49; Ann Oakley, *Women Confined: Towards a Sociology of Childbirth* (Oxford: Martin Robinson, 1980), pp. 10–12.
96. L.F. Cody, ‘Living and Dying in Georgian London’s Lying-in Hospitals’ *Bulletin of the History of Medicine* 78 (2004), pp. 309–315.
97. Op. cit., p. 319.
considered. Prior to the Married Women’s Property Acts 1870 and 1882, married women as *feme coverts* had effectively no legal personality and with a few exceptions lacked capacity to enter into a binding contract.\(^98\) Any contract would have to be made on her behalf by her husband. Midwives were nearly always married women or widows as were most of their private clients. The contract to provide midwifery services was a contract between the women’s husbands.\(^99\) There was one exception to the rule. In the City of London, by custom, though not strict law, a married woman engaging in trade on her own account could trade and make contracts as though she was single, a *feme sole*.\(^100\) In some other urban centres, a similar custom applied.\(^101\) Whatever the niceties of contract law, the contract imposed obligations – and thus accountability – to birthing women and their families.\(^102\) By contrast in lying-in hospitals, a number of the senior midwives would be employed by the hospital, and therefore obliged to comply with reasonable commands of their employers. In her private practice outside the hospital, the midwife remained an independent actor. Within the institution, even visiting midwives who were not employees gradually lost some of their prior independence. Midwives who defied hospital policy would not be engaged again. Midwives’ clients became patients of the hospital.

**Public office: In decline?**

Initially, 18th-century midwives continued to play a significant role in the legal process and their local community.\(^103\) By 1800, this role was beginning to be eroded contributing to the decline in the status of the midwife as highly regarded independent expert. The managers of the lying-in hospitals began to take over much of the midwife’s role in supervising morals and protecting the public purse. Lying-in hospitals occupied a liminal position, as both medical institutions and instruments of social control. Echoing midwives’ duties in past centuries relating to the proper form of baptism, lying-in hospitals sought to impose Anglican beliefs on their patients through elaborate public christenings and demanded social recognition through thanksgivings. This liminality is further evident in a statute of 1773 entitled *An Act for the better Regulation of lying-in hospitals, and other places, appropriated for the charitable reception of pregnant women; and also to provide for the settlement of bastard children, born in such hospitals and places*.\(^104\)

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98. Baker, *English Legal History*, pp. 525–527.
99. C. Crawford, ‘Patients’ Rights and the Law of Contract in Eighteenth-Century England’, *Social History of Medicine* 13 (2012), pp. 381–401, 398.
100. *La Vie v Phillips* (1765) 3 Burr 1766; *Clayton v Adams* (1796) 3 Term Rep 604.
101. M. McIntosh, ‘The Benefits and Drawbacks of *Feme Sole* status in England 1300-1630’, *Journal of British Studies* 44 (2005), pp. 410–438.
102. In those cases where the parish arranged and paid for the care of pauper women, the contract was made with the parish. Poor women were also treated *gratis* by midwives.
103. See M.A. Stein, C.P. Guzelian and K.M. Guzelian, ‘Expert Testimony in Nineteenth Century Malpraxis Actions’, *American Journal of Legal History* 55 (2015), p. 194.
104. *An Act for the better Regulation of lying-in hospitals, and other places, appropriated for the charitable reception of pregnant women; and also to provide for the settlement of bastard children, born in such hospitals and places*, 1773 c.82.
Despite the reference to ‘better regulation’ and the requirement that lying-in hospitals be licensed, the provision of medical services, and the safety of patients is absent from this Act. Lying-in hospitals and other charities providing maternity services were required to apply for a licence from the local justices of the peace at the Quarter Session hearings. The purpose of licensing was to ensure that infants born to single women did not become the financial responsibility of the parish in which the hospital was situated. As such, it echoed many of the social concerns of the Infanticide Act 1624 by absolving the parish authorities from financial responsibility for infants born to single women. The Act of 1773 required all women admitted to the hospital to be examined before the Justice of the Peace to ensure that they were married, formalising the hospital’s role in morally supervising the behaviour of patients and ensuring the cost of an illegitimate child did not fall on the public purse.

The 19th century

In the absence of episcopal licensing, multiple and contradictory proposals were advanced to regulate midwives culminating eventually in the Midwives Act 1902. Even so, there was little alteration in most women’s material experiences of childbirth. Female midwives continued to oversee the majority of deliveries in the home of the birthing woman.  

Personal recommendation and the testimonials of birthing women continued to be the primary consideration in selecting a midwife, either male or female, prioritised above certification and training. Despite having the confidence of birthing women, midwives no longer had any formal status as experts in matters of reproduction and birth. They therefore lacked protection from allegations of poor practice, which proliferated across the century. Demands for the regulation of midwives within a broader framework of medical care overrode the informal regulatory mechanisms that had previously supplemented certification and licensing practices. A hierarchical view of midwifery based around the nature and location of a practitioner’s training emerged. Midwives trained and certified at a lying-in hospital claimed a status not to be shared by uncertified women who became known as “unqualified” or “bona fide” midwives.

Formal regulation: Campaigns for change

For much of the century, medical reformers battled to unify the antiquated tripartite system for the regulation of the ‘medical men’.  

105. F. Badger, ‘Illuminating Nineteenth-Century Urban Midwifery: The Register of a Coventry Midwife’, Women’s History Review 23 (2014), pp. 683–705, 683; Forbes, ‘Eighteenth and Nineteenth Centuries’, p. 355.

106. As evidenced by the case of R v Williamson (1807) [172 ER 579] in which the testimony of numerous patients suggested ‘some degree of skill on the part of the (male) midwife and delivered a not-guilty verdict in a murder trial. Forbes, ‘Eighteenth and Nineteenth Centuries’, p. 357.

107. S.W.F. Holloway, ‘The Apothecaries Act 1815: A Reinterpretation’, Medical History 10 (1966), pp. 107–129.
include midwives in reforms of the medical occupations as a whole. In 1806, the College of Physicians had suggested that no one should be permitted to practise medicine, surgery, midwifery or pharmacy without a licence from the College which would prescribe the conditions and requirements of licensing. In 1808, a group of eminent practitioners styling themselves the ‘Associated Faculty’ proposed a national framework to regulate all the medical professions including midwifery. Men-midwives, they suggested, should have studied anatomy, while female midwives would be required to ‘obtain a certificate of proficiency from an obstetrician’. In 1813, another Bill (subsequently withdrawn) presented to the House of Commons proposed that ‘apothecaries, surgeon-apothecaries and practitioners in midwifery’ should demonstrate ‘a competent professional knowledge by some regular education’. No gendered specifications were made in the Bill though it is likely that it was aimed at male practitioners of midwifery, many of whom also maintained an apothecary practice in this period.

The reformers were to be disappointed when the first outcome of their campaign for radical change resulted only in the enactment of the retrogressive Apothecaries Act 1815. As Holloway comments ‘The Apothecaries Act was a re-assertion of the theory of orders at the very moment that this theory was crumbling in the face of the new social structure’. In the event, the Apothecaries Act contained no reference to midwives. Medical reform continued to be a central parliamentary issue, with 17 medical reform Bills introduced between 1840 and 1858. The resulting legislation – the Medical Act 1858 – established the General Council of Medical Education and Registration in the United Kingdom (GMC) and the Medical Register. Falsely claiming to be a registered medical practitioner became a criminal offence but the Act did not outlaw unqualified medical practice. It granted registered practitioners protection of title. Unregistered persons were not banned from providing healthcare; they were prohibited from claiming the title of ‘doctor’. Again, no mention was made of midwives.

The omission of midwives from the 1858 Act did not signify lack of support for the introduction of midwifery regulation. From 1883 to 1902, six Bills proposing the registration of midwives were debated in the House of Commons. Proposals for regulation focused not so much upon the skill and capability of midwives as concerns about the recognition of female professional status. Before and after 1858, it was argued that the regulation of midwifery should be subject to the supervision of the medical profession, but which of the three medical corporations should undertake the role was much disputed. In 1817, the College of Physicians had decreed that midwifery was ‘a manual art’

108. Op. cit., p. 115.
109. Op. cit., p. 117.
110. Apothecaries Petition, vol.27, col.165, 19 November 1913.
111. I. Waddington, The Medical Profession in the Industrial Revolution (Dublin: Gill and MacMillan, 1984), p. 53.
112. ‘Registration of Midwives in England and Wales’ (1883); ‘A Bill to provide for the Registration of Midwives’ (1890); ‘A Bill For the Compulsory Registration of Midwives’ (1896); ‘A Bill for the Registration of Midwives (1897); ‘A Bill to promote the better training of Women as Midwives and to regulate their practice’ (1899); ‘The Midwives Bill’ (1900).
and therefore the education and regulation of midwives lay within the remit of the College of Surgeons. The College of Surgeons argued that they did not possess the legal authority to render it compulsory for midwives to undertake their examinations. The Society of Apothecaries also stated that they lacked the jurisdiction to conduct compulsory examinations in midwifery. The Apothecaries offered to undertake that responsibility if granted the necessary legal authority.

Inaction by the medical corporations prompted the formation in 1825 of the Obstetric Society. The Society sought to:

address the respective medical corporate bodies, pointing out the evils which they believed to result from the indiscriminate practice of midwifery, and requesting to know how far the said corporate bodies were willing to co-operate in remedying the abuse, and whether they possessed the power and inclination of doing so.

Despite appealing to the surgeons and the Home Secretary, the Society had limited success. It was succeeded in 1858 by the London Obstetrical Society. In 1872, the London Obstetrical Society began issuing certificates of competence to midwives who passed its examination. The certificates were controversial as they only recognised midwives as sufficiently skilled to attend what they deemed to be ‘natural’ labours. Should there be any sign of complications, certified midwives were expected to defer to the expertise of an obstetrician.

We have addressed only a few of the proposals made in the 19th century to introduce formal regulation of midwives: both attempts to persuade Parliament to legislate and in initiatives taken by the medical professions. The proposals shared a common theme, decrying the dangers posed by unqualified midwives and the need for medical (and male) supervision, education, examination and registration of qualified midwives. The examinations did not necessarily indicate a midwife’s skill; rather they indicated a level of education and wealth that enabled an aspirant midwife to undertake and pay the fee for her education, obtain her certificate and then hold herself out as ‘qualified’. Certification improved midwives’ status among the medical profession. Forbes notes that the certificate issued by the London Obstetrical Society in 1891 (to 918 midwives) ‘although lacking in legal basis, had acquired much respect from male medical practitioners’. The professional status of midwives was also of some concern to the GMC during their 1875 discussions of proposed amendments to the Medical

113. D.I. Williams, ‘The Obstetric Society of 1825’, Medical History 42 (1998), p. 235.
114. ‘Obstetric Society’, The Lancet, 7(185) (1827), pp. 768–769.
115. Forbes, ‘Eighteenth and Nineteenth Centuries’, p. 358.
116. Proposed topics for the examinations included the symptoms, course and management of Natural Labour, and when a midwife should send for assistance, in addition to the demonstration of a possession of a moderate elementary education. General Medical Council, Minutes of the General Council of Medical Education and Registration of the United Kingdom; of the Executive Committee; and of the Branch Council Volume XIV for the year 1877 (London, 1877), p. 53.
117. Forbes, ‘Eighteenth and Nineteenth Centuries’, p. 359.
Act 1858. At the General Council meeting on the 26 June 1875, the Council dismissed suggestions that women should be able to pursue medical practice on the same footing as men using old arguments about their lack of the ‘peculiar moral and physical qualities’ required in a practitioner. The GMC noted that:

for the safe and efficient practice of Midwifery as a branch of Medical Science, a full and complete Education in Medicine and Surgery is necessary, [however] the Council believe that a much more limited and less expensive Education might be afforded to Women who after due Examination might, as Midwives, render valuable service to the community . . .

As such, the certified midwife from a good family and social class sought to gain professional status and a place in the medical hierarchy, albeit a subordinate place.

**Informal regulation in the community: A fact of life?**

Given that demands for the regulation of midwives claimed to be based on evidence of the dangers ‘unqualified’ midwives posed to mothers and children, it might have been expected that any remnants of traditional community/informal regulation that still persisted would and should rapidly disappear. In fact, ‘old’ customs continued to apply in practice and were to inform the deliberations of the Select Committee on Midwives Registration in 1893. Moreover, accusations against ‘ignorant midwives’ were often anecdotal, with names and sometimes locations not given. Prosopographical studies of 19th-century midwifery practice illustrate the persistence and success of informal regulation. Badger’s examination of Coventry midwife Mary Eaves’s register of births between 1847 and 1875 not only shows a thriving practice of over 200 deliveries per year, it also records a mortality rate far below the national average despite practising in a slum area. Eaves was not certified, nor is there any evidence of her undertaking any formal training suggesting that her competence in practice was the result of an informal apprenticeship, potentially to a neighbour that was listed in the census as a midwife. Badger also noted changes to the entries in Eaves’ register books in response to the Births and Deaths Registration (Amendment) Act 1874, indicating that Eaves was not only skilful in her craft but also informed and competent in relation to the legal requirements of practice. As Tania

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118. Minutes of the General Council of Medical Education and Registration of the United Kingdom; of the Executive Committee; and of the Branch Councils, Vol.XII, General Council Meeting, 26 June 1875, p. 131.

119. To date, we have not identified any claims for negligence against female midwives. Nor were any prosecutions for mala praxis brought by the College of Physicians against female midwives in the pre-revolutionary period. Evenden, *Midwives*, p. 178.

120. Badger, Illuminating Nineteenth-Century Urban Midwifery, p. 685. This is not an anomaly. Irvine Loudon has shown that maternal mortality was lower in poor urban areas where midwives continued to deliver the majority of infants; I. Loudon, *Death in Childbirth: An International Study of Maternal Care and Maternal Mortality* (Oxford: Oxford University Press, 1992), p. 244.

121. Badger, Illuminating Nineteenth-Century Urban Midwifery, p. 687.
McIntosh’s study of Sheffield midwives between 1880 and 1936 demonstrates, the majority of deliveries continued to be handled by ‘bona fide’ (uncertified and informally trained) midwives for several years following the 1902 Act.122 ‘Bona fide’ midwives were those that could prove to the Central Midwives Board that they had been practising as a midwife for at least one year before the passing of the Act and that ‘she bears a good character’.123 This provision for ‘bona fide’ midwives essentially supported the traditional framework of informal apprenticeship and community regulation that had been so vital to good midwifery practice in preceding centuries albeit for a finite period of time.

In the absence of evidence that ‘bona fide’ midwives achieved poorer outcomes than their certified colleagues, it would seem that good standards of practice were maintained. Women continued to request their services. While witnesses testifying before the Select Committee on Midwives Registration in 1893 repeatedly emphasised the competence of certified midwives, little if any actual evidence of harm caused by uncertified midwives was presented to the Committee. Consider the evidence given by physician and surgeon, Henry Bott, who noted that in Brentford in 1892 there had been 492 births, 181 of which had been attended by a certified midwife. Of the remainder, between 40 and 50 had been attended by an uncertified midwife, while the town’s five or six medical men had overseen the rest.124 Bott attacked the uncertified midwives stating that while he had ‘many cases of suspicion’ that poor practice from an uncertified midwife had led to the death of an infant, ‘I have never been able to fix one’. Evidence from Mr Emmerson emphasised the importance of capability in the selection of a midwife, particularly from a patient’s perspective. Emmerson confirmed that there were uncertified midwives practising in his district – in Langford, he noted, there were three midwives in a population of 1200; in Biggleswade, there were ‘three or four’ unqualified midwives. He confirmed to the Committee that he had had no recent cases of ‘improper treatment’ by these midwives.125

There was little consensus among medical reformers about the nature of midwifery regulation. Proposals for reform sought to impose similar restrictions on the practice of unqualified midwives as the Medical Act had upon unqualified medical practitioners including enforcing fines and prison sentences upon those that were convicted.126 In line with the 1875 proposals of the GMC, reformers envisaged a centralised system to regulate midwifery. A national system was opposed by the London Obstetrical Society.

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122. T. McIntosh, ‘Profession, Skill or Domestic Duty? Midwifery in Sheffield, 1880-1936’, Social History of Medicine 11 (1998), pp. 403–420, 411.
123. Midwives Act 1902 section 3.
124. Select Committee on Midwives Registration, Report from the Select Committee on Midwives’ Registration with the Proceedings of the Committee and Minutes of Evidence (London: Eyre and Spottiswoode, 1893), p. 5.
125. Op. cit., p. 10.
126. ‘Registration of Midwives in England and Wales’ (1883); ‘A Bill to provide for the Registration of Midwives’ (1890); ‘A Bill For the Compulsory Registration of Midwives’ (1896); ‘A Bill for the Registration of Midwives (1897); ‘A Bill to promote the better training of Women as Midwives and to regulate their practice’ (1899); ‘The Midwives Bill’ (1900).
The Society’s objections to the GMC’s proposed amendments to the Medical Act demonstrate how firmly midwifery practice remained embedded in local communities. The obstetricians disputed the necessity of a central administrative body for the regulation of midwives, arguing that:

[P]ractically a woman [midwife] would value more highly the certificate of the chief doctors in her county town, whom she knows by repute, than that of, to her, unknown people in London. In Norfolk, e.g. Dr Copeman; in Lancashire, Dr Grimsdale or Dr Whitehead; in Warwickshire, Dr Berry would carry more weight than Dr Fane, or Dr Barnes, or Dr Hicks, or Dr Priestly, among the classes who would be their clients.\textsuperscript{127}

The suggestion that the examination and regulation of midwives should be administered locally was supported by the Royal College of Surgeons. Objecting to clause 24 of the proposed Medical Act (Amendment) 1876, the surgeons had contended that:

Clause 24 proposes, as a new national institution, that the General Medical Council, subject to approvals of the Privy Council, shall provide for the examination, licensing, registration and disregistration of Midwives throughout the United Kingdom, with apparently some censorship over the registered midwives, and that the designation (title) of “registered midwife” should be protected from unauthorised use.\textsuperscript{128}

The College pointed out that the GMC ‘has not expressed any disposition to accept the very large administrative responsibility that clause 24 would evidently impose upon it’. The College identified what it saw as the discrepancy:

that a minor skilled industry, which in general must be mainly local both in its ambitions and its credentials should have to bear comparatively heavy costs for registration by a central office, and for dependence on the elaborate acts of an expensive central Council.\textsuperscript{129}

Implicit in the stance taken by the London Obstetrical Society and the surgeons is recognition by at least some medical practitioners that midwifery practices remained grounded in the local community.

In proposals for legislation in 1893, the Select Committee recognised the role played by unqualified midwives in their local community. The Committee concluded that, while formal qualification would guarantee a level of competence (in the eyes of medical practitioners), it did not follow that unqualified midwives were incompetent. The Committee addressed the price of midwifery attendance, and the services that different practitioners offered noting that unqualified midwives often remained in their patient’s home as nurses following the delivery. It was clear that medical practitioners did not wish to reduce the number of midwives in practice, as this would increase their role in the delivery of what they called ‘natural’ births. The Committee suggested a

\textsuperscript{127} Minutes of the GMC, General Council Meeting, 12 April 1878, p. 40.
\textsuperscript{128} Op. cit., 11 April 1878, p. 22.
\textsuperscript{129} Op. cit., 17 April 1878, p. 22.
tiered system, whereby certified midwives were permitted to call themselves ‘Registered Midwives’ and uncertified practitioners, only ‘Midwives’. The first reading of the Bill in the House of Lords raised a number of issues, not least the problems of defining a ‘natural birth’ to which a midwife could be called, and the fate of the many hundreds of ‘that necessary class of midwives’ that would be unable to afford the proposed qualification. Lord Playfair suggested the proposals contained in the Bill would be ‘so costly in their administration that it would be exceedingly difficult to make the Bill work’. A second reading of the Bill was postponed for further amendment and it was eventually dropped.

Public office in the community: Disappearing midwives

Midwives’ role in the legal process and local government diminished significantly in the 19th century. From the last two decades of the 18th century, surgeons and men-midwives became more commonplace as expert witnesses in court cases. The impact of male medical practitioners on the discourse surrounding childbirth had undermined the significance of physical experience in the acquisition of reproductive knowledge, undermining midwives’ authority. This was part of a broader trend that valued scientific knowledge and clinical observation, particularly among medical practitioners.

The jury of matrons was rarely called and it was no longer seen as an honour to serve. The Poor Law Amendment Act 1834 (the new Poor Law) reduced the role of midwives in local government, repealing:

[A]ny Acts of Parliament as enables any single Woman to charge any Person with having gotten her with any of Child of which she shall be pregnant . . . or as enables the Mother of any Bastard Child or Children to charge of affiliate any such Child or Children on any Person as the reputed or putative Father thereof . . .

130. Midwives Registration Bill, vol. 33, col.1141, 14 May 1895.
131. J. Allotey, ‘English Midwives’ Responses to the Medicalisation of Childbirth, 1671–1795’, Midwifery 27 (2011), pp. 532–538.
132. Forbes, ‘Jury of Matrons’, p. 29, 31; When Anne Wycherley was sentenced to death in 1838 for the murder of her daughter, she told the courtroom that she was pregnant. The Legal Observer reported that the judge then ordered ‘Let the sheriff impanel a jury of matrons forthwith. Let all the doors be shut, and no one be suffered to leave the Court’. This was, apparently, to prevent an exodus of married women from the public gallery, keen to avoid jury service: see R v Wycherley, 8 C&P 262; Reported in The Legal Observer, or, Journal of Jurisprudence, vol.16 (1838) p. 306; K. Crosby, ‘Abolishing Juries of Matrons’, Oxford Journal of Legal Studies 39(2) (2018), 259–284.
133. The Act abolished parishes as the main unit of social administration, replacing them instead with larger ‘Unions’ and finalising the gradual separation of Church and State that started in the 18th century. Outdoor relief was largely abolished to discourage all but the destitute from seeking relief, those in need of assistance were required to go to the union workhouse.
134. Poor Law Amendment Act 1834 c.76 s.lxix.
The Act removed the need for midwives to ascertain details of an infant’s father, reducing the midwife’s importance as an agent of local government.135 Midwives’ engagement with the state was tenuously maintained through the requirements of Births and Deaths Registration (Amendment) Act 1874. The original Act of 1836 had required the Registrar to ‘inform himself carefully of every Birth and every Death which shall happen in his District’ and enter the information into the Register ‘as soon after the event as conveniently as may be done’.136 The Amendment Act redirected this duty primarily to the parents of the infant, but also included ‘[T]he occupier of the house in which to his knowledge the child is born, and of each person present at the birth, and of the person having charge of the child’.137 The Act does not mention midwives as such. The midwife was simply a ‘person present’.

The Midwives Act 1902

The Midwives Act was finally enacted in 1902. Between 1893 and 1902, six Bills had been presented to Parliament often with only minor alterations to the substance of the Registration of Midwives Bill 1893.138 Objections to the proposals were hotly debated in both Houses. Of principal concern among legislators was the lack of clarity from the medical profession about the benefits of regulating midwives. In the Commons on 9 March 1900, T.P. Connor complained:

I have a letter in my hand from the editor of the Lancet... in which he states that a circular letter was issued to the medical profession in England with a view to ascertaining the opinion of the profession on the Bill. He received 7,250 replies and an analysis of the answers shows that 1,547 medical men are in favour of the Bill, 640 are indifferent, whilst the remaining 5,000 odd are opposed to the measure.139

The Lancet had proclaimed:

[W]omen who have acquired a superficial training of a few months will be licensed as proficient in the practice of midwifery as independent practitioners. This, we hold, would be opposed to the spirit and would be a reversal of the Medical Acts which were instituted for the guidance and safety of the public.140

Mr Boscowan (MP for Tunbridge, Kent) contended that

The whole tendency of legislation had been in favour of greater medical and scientific methods, and substituting the medical practitioner for the quack. The present Bill was for

135. Chalk, Saviour, Witness, and Comic Relief, p. 113.
136. 37 & 38 Vict Cap.88 s.xiii.
137. Op. cit., i.
138. This Bill was introduced following the 1893 Select Committee on Midwives’ Registration.
139. Midwives Bill, House of Commons, Second Reading, 9 March 1900, Vol. 80, Column 538.
140. The Lancet, Editor’s note, 21 April 1900 Vol. 155, Issue 3339, pp. 1166–1167.
the purpose of setting up a class of people as being people partially qualified to act in these matters, and he ventured to think that fatal results would follow if it were passed into law.\textsuperscript{141}

These concerns – about giving what the medical establishment considered to be ill-qualified women a formal recognition of status – were compounded by difficulties in agreeing definitions. While most medical men agreed that midwives were suitable attendants in ‘natural’ labours, a midwife should immediately call for qualified medical assistance should it become clear that the delivery was going to be ‘abnormal’. Definitions of ‘natural’ labour were far from agreed upon. In a House of Lords debate on the Midwives Bill 1902, Lord Thring scoffed ‘To show how stupid the Bill is I would call attention to the Clause which provides that a midwife is not to attend abnormal cases. How is an unfortunate woman to know whether a case is abnormal or not?’\textsuperscript{142} The issue of professional status and capacity remained central to the concerns of medical practitioners. The formal education and registration of midwives would, they feared, give midwives a medical status which would make them, to some extent, competitors.\textsuperscript{143} As such, it was professional hierarchy that the 1902 Act sought to consolidate, not patient outcomes.

The 1902 Act granted the certificated midwife protection of title following the model of the Medical Act 1858 in relation to registered medical practitioners. Section 11 of the Medical Act made it a criminal offence for a person to ‘wilfully and falsely’ pretend to be registered under the Act or use any name or title implying that he was so registered. Section 1(2) made it a crime for a woman ‘habitually and for gain’ to attend women in childbirth save under the supervision of a registered medical practitioner unless she be a certificated midwife.\textsuperscript{144} The Act in its reference to habitual attendance and gain left some leeway for friends and family to attend a birth without the presence of a qualified person, though this was removed by later legislation.\textsuperscript{145}

\textbf{Conclusions}

Examination of the regulation of midwives in the 400 years before Parliament introduced statutory regulation in 1902 reveals two different eras in the broader history of midwifery and its place in the regulation of healthcare. In the first, a symbiotic relationship between episcopal licensing and informal regulation within the local community created a regulatory framework which assessed and monitored midwives’ fitness to practise as independent health workers. Midwives’ Oaths demonstrate that licensing addressed skill and competence, not just religious probity, and included remarkably forward-looking requirements such as the duty to seek aid from fellow midwives in cases of difficulty.

\textsuperscript{141} Midwives Bill, vol.84, col.1258, 27 June 1900.
\textsuperscript{142} Op. cit., col.1238, 20 June 1902.
\textsuperscript{143} Op. cit., col.1241, 20 June 1902.
\textsuperscript{144} The 1902 Act assumed that only women would act as certified midwives. This exclusion was eventually abolished by the Sex Discrimination Act (Amendment of section 20) Order 1983 SI 1202 which allowed men to practice as midwives under certain conditions.
\textsuperscript{145} See section 1 Midwives and Maternity Homes Act 1926 and Midwives Act 1951.
and a duty to whistle-blow if another midwife was not fit to practise. Within the community reputation was a crucial regulatory tool. The requirement to submit testimonials from women whom she had delivered illustrates the link between formal and informal regulation of midwifery. Informal practices of training and mentoring were reflected in the need for applicants for a licence to have served a long period as a Deputy. Formal licensing drew on informal regulation; the community reflected and enforced principles of good practice, standards for practice sanctioned by the Church. It did not matter that not all midwives acquired a licence. Midwifery practice was still subject to the standards derived from the interplay of community and episcopal oversight. The suspension of licensing in the Interregnum had little effect; midwifery practice continued to be monitored in the community.

The decay of episcopal licensing proved more damaging and ushered in a second era of ‘medicalisation’. The absence of formal oversight of midwives by the 19th century led many early historians of midwifery, to equate lack of formal regulation to incompetence. Demographic assessments of 18th- and 19th-century birth rooms show that this was not the case. What was lost by the end of external regulation was the respectability conferred by the ecclesiastical ‘seal of approval’, rendering midwives vulnerable to accusations of ‘quackery’ by the medical men seeking to dominate provision of obstetric care. Two other developments diminished the status of independent midwives. The midwife’s role as ‘expert’ in matters of pregnancy and reproduction passed to the nascent male experts, the obstetricians. The gradual relocation of births from private homes to public hospitals signalled a change from client to patient for the woman and limited the independence of midwives employed in institutions led by medical practitioners. Initiatives to establish statutory regulation were grounded in a false image of midwives and driven by the determination of the medical profession to control female midwives.

The 1902 Act restored the standing of midwives as recognised health workers but in a subordinate role. The study of English midwives and their regulatory practices offers insight into the interaction between formal and informal regulation, a model in which the two work together to have an impact on an occupational group. Just as these systems of behaviour modification can work in tension, they can also be symbiotic – relying upon each other for authority and compliance. Moreover, as can be seen in the parliamentary debates of the 19th century, regulatory structures are heavily dependent upon the cooperation of clients/patients through the exercise of choice, particularly in healthcare where individual relationships between healthcare provider and patient are so important. Finally, this study shows that even informal methods of regulation rely upon some engagement with the state for legitimacy. Without some form of state endorsement, be it through recognition of ‘expert’ status or more formal channels of registration and regulation, an occupation is unable to maintain its authority and reputation.

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