Maternity Charities, the Edinburgh Maternity Scheme and the Medicalisation of Childbirth, 1900–1925

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Summary. Increased medical involvement in maternal welfare has been linked with the introduction of local authority administered schemes associated with government concern for women’s health that reached a peak during the First World War. Although local studies have noted the work of philanthropic groups, the implication has been that their contribution to the medicalisation of childbirth was small. This article uses analysis of the personal health records of users of Edinburgh’s maternity charities to argue that the process of medicalisation was begun by these charities, and preceded the introduction of the Edinburgh Maternity and Child Welfare Scheme in 1917. However, whilst it is argued that initially the Scheme had limited impact, the article concludes that its funding and stability offered the opportunity for more dynamic management of abnormal pregnancies. Thus this encouraged a gradual shift in attitude to birth from an essentially physiological event to a potentially pathological incident.

Keywords: Edinburgh; medicalisation; maternity charities; local authority maternal and child welfare schemes; personal health records

In 1919, Councillor John A. Young, Convener of the Edinburgh Public Health Sub-Committee, noted with satisfaction that, since 1917, care for poverty-stricken mothers and their children, formerly provided by ‘a plethora of agencies’, had been supplied through the ‘most comprehensive and effective’ council-run Maternity and Child Welfare Scheme (MCWS), with beneficial results to all concerned.¹ The Edinburgh MCWS began in 1917, using powers ‘confer[red] upon Local Authorities … to … carry out Schemes for the preservation of the health and life of the mother during her maternity periods’ through the Notification of Births (Extension) Act 1915, and taking prompt advantage of the national government’s offer to fund half the costs.² It provided supervision for poor mothers through the introduction of antenatal clinics and an extension of the City’s Volunteer Health Visitor scheme. Nonetheless, almost all the maternity services in the Scheme were provided indirectly by voluntary agencies receiving Council

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¹Young n.d. probably 1920, p. 47; Williamson 1916, p. 37.
²Williamson 1916, p. 36.

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grants: only from 1932 did the City have its own maternity hospital. Whilst the Medical Officer of Health’s (MOH) initial proposal had acknowledged the work of the ‘unusual number of voluntary agencies’ in Edinburgh, he deplored any overlapping of services, and suggested that, under the Public Health Department, there would not be ‘the slightest possibility of this occurring’. In so doing, he was reflecting contemporary opinion that the state, acting through local government, would be a more efficient provider of services.3 Despite his reference to their ‘substantial work’, the implication that the charitable provision of maternity care before the MCWS had been comparatively minor and ineffectual has continued to colour accounts of the growth of such care in Edinburgh.4 This article reassesses the role of voluntary maternity care in the city, using data culled from records of maternity patients in 1912 and 1924 to examine the users of maternity charities, to show what had already been achieved before the MCWS, and what contribution its additional funding and regulation made to the medicalisation of childbirth.

The role of government has dominated historical analysis of the introduction of maternity care in Great Britain. Initial interest was in the health reforms of the pre-First World War Liberal government, and their adaptation to a post-war society.5 However, increasingly detailed studies of the maternal welfare policy of the interwar era have focused more on the differences in actual provision by local authorities than the intentions of national government, highlighting wide variations in care, the different emphases placed by councils according to their political persuasion, and their vulnerability to central government economies.6 A similar study in Scotland has observed the debilitating effects of high unemployment, poor housing and a disproportionately small middle class, and has suggested that Scotland did not share in the overall improvement in maternal and child health observed in England and Wales as a whole following the First World War.7

The role of government policy has also dominated an alternative approach, examining the effects of increased state interest on childbirth and women’s health.8 This originated in late twentieth-century feminist concerns about the medicalised management of childbirth, seen as becoming the preserve of obstetricians, with a concomitant increase in hospital birth, intervention and a loss of maternal autonomy.9 Two concurrent campaigns for maternity care were identified in the interwar period, the one aiming to improve the health and domestic circumstances of parturient women, and the other to increase access to hospital delivery and medical attendance.10 The medicalisation of childbirth was thus seen initially as a historical process, closely linked to the intervention of the state in maternal and child health, but later interpretations increasingly equated

3See, for example, the comments by the Medical Officer of Health for Aberdeen in Davidson 2000, pp. 60–1.
4Most notably, the official history of Edinburgh’s Public Health Department makes no reference to the contribution of voluntary agencies to maternity care. See Tait 1974.
5See, for example, Gilbert 1970; Gilbert 1973; Thane 1982; Winter 1986; Ross 1993, pp. 219–21; Royle 1997, pp. 200–10.
6See, for example, Peretz in Garcia et al. (eds) 1990; Marks 1996; Aucott 1997.
7Jenkinson 2002, pp. 153–219. Nonetheless, the 1936 Cathcart Committee recorded a long-term trend towards improvement. See McCrae 2003.
8Almost the only areas of municipal medicine to have been investigated. See Welshman 2000, pp. 26–7.
9See, for example, Kitzinger 1978; Tew 1990.
10Jane Lewis argues that the emphasis by the Department of Health on improving obstetric and midwifery provision ignored women’s wider needs. See Lewis 1980. Clare Hanson suggests that women’s demand for medical care rose with their political influence. See Hanson 2004, pp. 129–31.
medicalisation with the control of women and the loss of autonomy, notably in studies of antenatal care and of the place of birth.\(^\text{11}\) However, recent historical studies of the Canadian experience of birth, and of maternity care in Lancashire, have adopted an altogether less pejorative definition of medicalisation in childbirth as a process of increasing certainty and confidence, accepted by both doctors and patients.\(^\text{12}\)

The result of the focus on government policy shared by both those who have focused on state provision of maternity care and those who have studied its influence on childbirth, is to see the creation and application of such policies as the beginning of maternity and child welfare. This downplays the earlier work of local philanthropic groups, based in many major towns and rooted in social and religious concerns. These gave support to the destitute parturient, especially if married, often also providing practical educational experience for midwives and medical students as an additional source of income. Local studies of maternity care which have used institutional and local government reports have demonstrated the vigour of such organisations, and the degree to which, by the end of the nineteenth century, and particularly south of the border, they were experiencing a renaissance as a result of a growing concern for the health of the child population and the introduction of midwifery registration.\(^\text{13}\) It has been argued that, in a period of rapid industrialisation, they made a major contribution to maternal health within their limited catchment areas.\(^\text{14}\)

By 1903, in Scotland, there was voluntary provision for maternity care in the major cities—Glasgow, Aberdeen, Dundee and Edinburgh—offering standardised midwifery training (pupils were prepared for the English Central Midwives’ Board examination) in large outdoor departments and smaller in-patient areas.\(^\text{15}\) However, Edinburgh was unusual in that it had at least eight charities—the ‘plethora of agencies’—whose contribution has so far been unexamined. Case notes from four such—the Edinburgh Royal Maternity Hospital in 1912 and 1924, and from the Hospice, the Deaconess Hospital and the Edinburgh Lying-In Institution in 1924–5—are employed here to ask whether the introduction of the Scheme increased the uptake of institution-based maternity care, thus altering the composition of the institutional patient population, and whether it led to discernible changes in treatment.

In the following section, the institutions and sources are introduced. Thereafter, the social circumstances of the patients are analysed for differences between the two years, and for the role of the MCWS in any changes. The treatment they received antenatally and in labour is examined. Finally, the significance of these findings for both the management of social policy in Edinburgh and for the historiography of the medicalisation of childbirth is explored.

The Institutions and Their Sources

The Royal Maternity Hospital was the largest institution studied. Founded as a charity in 1844, since 1879 it had occupied custom-built premises from where, until the introduction of Maternity Benefit, it provided apparently free indoor and outdoor services to women

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\(^{11}\)See, for example, Oakley 1984; Leavitt 1986; Murphy-Lawless 1998.

\(^{12}\)Mitchinson 2002; Beier 2004.

\(^{13}\)See, for example, Marks 1996; McIntosh 1997; Mottram in Marland and Rafferty (eds) 1997; Thomson 1998.

\(^{14}\)See, for example, Seligman 1980; Marks in Fildes et al. (eds) 1992; Stephenson 1993; Marks 1994.

\(^{15}\)Dow 1984, pp. 151–2; Wainwright 2003.
resident in Edinburgh and to those sent from outside. In 1907, it opened an outdoor dispensary in Leith. Although initially care was more social than medical, from approximately 1900 the Hospital increasingly emphasised its medical function. In 1901, the world’s first dedicated antenatal bed was opened under the supervision of J. W. Ballantyne, one of its four senior physicians, and, in 1915, a prototype antenatal clinic.

Like Ballantyne, all the honorary staff at the Hospital taught at either the University or Extra-Mural Medical Schools in Edinburgh, and were increasingly involved in obstetrical research. The Royal Maternity itself had a major educational role, and much of the indoor and outdoor care was given by its medical and midwifery pupils, with support from trained midwives and house surgeons. Initially these were senior students, but from the mid-1870s they were newly qualified doctors. By 1912, they served for six months, taking responsibility for outdoor cases in their junior three months, and acting indoors for their senior 12 weeks. They were responsible for much of the hospital’s routine clinical management, including the maintenance of the casebooks and the Antenatal Register.

The indoor casebooks are the principal source for in-patients. This study has linked casebook data by name and date of delivery with the social records of individuals in the hospital’s Births Register. Similar links were made to the Antenatal Department Register in 1924. This recorded patients admitted for treatment but not usually in labour. Data for outdoor cases in both Edinburgh and Leith have been taken from the Students’ External Casebooks. These were maintained by the pupil midwives who attended individual cases, and record the nursing care given for the first ten postnatal days. Main Dispensary patients have also been linked to their entries in the outdoor casebook. In 1912, every indoor, outdoor and Leith case was collected (1,933 cases). In 1924, alternate entries were recorded, totalling 1,500 cases.

The Royal Maternity Hospital was the largest institutional provider of maternity care in Edinburgh, and grew to dominate lesser dispensaries. In 1889, it hosted a meeting of representatives from the Royal Public, New Town, Cowgate (or Livingstone), Fountainbridge (or Western), and Edinburgh Provident dispensaries to standardise the fees paid by medical students for their practical midwifery experience. In 1908, as a result of further changes in students’ practical midwifery education, the dispensaries’ medical men were included in the Royal Maternity staff as extern assistant physicians. Most dispensaries became maternity centres under the MCWS, but no case records have been traced from any of these institutions.

The other establishments studied here were provident institutions which made a small charge for attendance. The oldest was the Lying-In Institution, founded in 1816 and under the supervision of four generations of Drs Thatcher until its closure in 1933. Initially it

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16Nuttall 2007.
17Lothian Health Services Archive (hereafter LHSA), Medical Board Minutes (hereafter MBMERMH), LHB 3/1/4, 5 June 1889.
18The emphasis on practical education did not apparently benefit maternity patients, the maternal mortality rate in Edinburgh of 3.5 to 6.4 deaths per thousand live births throughout the second half of the nineteenth century resembling closely the national figure of 3.8 to 6.6. Registrar-General for Scotland, 1876, 1890; Loudon 1992, pp. 546–7.
19Although it had delivered 446 patients in 1824–5, it was not represented at the 1889 meeting. The failure to record any cases between 1839 and 1902 in its single casebook also suggests that it was a very small enterprise. However, the 1899 Burdett Report enumerates 114 cases in that year. First Annual Report 1825, p. 9; H. C. Burdett, Hospitals and Charities, quoted in Checkland 1980, p. 201.
offered domiciliary attendance only but, by 1924, also provided four in-patient beds. Routine care was given by pupil midwives supervised by a matron, whilst any medical intervention was made by Dr C. Thatcher. It was not involved in the MCWS. All the 198 deliveries attended by its staff in 1924 were collected: the place of birth was unclear and this was checked in the city Notifications of Birth Registers.20

Both the Deaconess Hospital and the Hospice used Central Midwives’ Board-approved record-books. However, the two institutions were very different. The Deaconess Hospital was founded by the Church of Scotland in 1894 with the twin aims of training missionary deaconesses and providing care for the poor of the Pleasance only, a self-imposed geographical restriction which led to the loss of its MCWS grant in the mid-1920s. The hospital provided maternity beds solely for emergencies, and most of its mothers delivered at home, pupils being supervised by midwives (who were not necessarily deaconesses). There were close links between it and the Royal Maternity Hospital: both its current honorary Obstetric Physician and his predecessor had been physicians there. Few of the hospital’s casebooks are extant and therefore details of all the deliveries in the 12 months from February 1925 were collected, totalling 130.

Founded in 1904 in the High Street by Dr Elsie Inglis and the Medical Women’s Club, the Hospice was an all-female establishment which specialised in the care of women and children. It provided in- and out-patient care from the main building, ran satellite clinics in Gorgie and Dalry, and enjoyed particularly good relations with the MCWS.21 Pupil midwives and medical students gave daily care, supported in the first instance by trained midwives and a junior doctor. As at the Deaconess, both indoor and outdoor cases were recorded in the same book. Data from the 475 cases in 1924 were recorded.

The collected data provide an overview of users of institution-based maternity care before and after the introduction of the MCWS, although they do not represent all parturient women in Edinburgh in either year, since births attended by other dispensaries, or privately, are excluded. However, as births associated with voluntary institutions, they are likely to illustrate the characteristics of intended beneficiaries of the MCWS. Further, they give evidence of the treatment of a striking proportion of city births, and of the influence of maternity charities before the introduction of the MCWS. In 1912, the MOH reported that a third of city births were delivered by charities, of which the Royal Maternity Hospital attended two-thirds.22 In 1924 there were 8,766 births in Edinburgh and Leith, of which the collected cases provide evidence of roughly 40 per cent (3,803 cases).23 This material therefore gives the opportunity to study together the social circumstances and medical treatment of women using maternity institutions before and after the introduction of the MCWS. In the following sections it will be used to ask whether the arrival of the

20LHSA, Notifications of Birth Registers, 1924, Accession no. 04/20.
21The … magnificent work … [of] Centres … which are supervised and worked by Lady Doctors’ was specially praised in the description of the proposed Scheme: ‘their inclusion is … a necessity, [which] will strengthen it very materially’. Williamson 1916, p. 39.
22Williamson 1912, p. 17. In 1912, there were 6,700 live births in Edinburgh (not including Leith), of which 2,200 were attended by charities, 1,442 by the Royal Maternity Hospital.
23Robertson 1924: no figures were given for institutional births. More detailed data in 1926 suggest that they delivered approximately 54 per cent of births. Leith was incorporated into Edinburgh in 1920.
Scheme increased the uptake of institution-based care, changed the social profile of patients, or altered the care they received.

Increasing Uptake, Changing Patients?

In 1917, A. M. Williamson introduced his Scheme, contracting to pay annual grants of £200 and £250, respectively, to the Royal Maternity Hospital and Hospice for maternity care. Although the Royal Maternity had, since the mid-1860s, treated all women in labour who sought admission, his initial targets for the MCWS were those women not covered by national insurance, whom he considered most vulnerable. This section asks whether the MCWS contributed to the medicalisation of childbirth in Edinburgh by widening the uptake of institution-based maternity care.

Undoubtedly, there was increased take-up of institution-based care, whether the birth took place at home or in hospital. In 1912, the MOH had claimed a third of live births were delivered by charities but, in the period 1926–30, it was approximately half. In 1912, 1,933 patients were delivered by Royal Maternity staff in both Edinburgh and Leith. By 1924 this had increased by half to 3,027, 34.5 per cent of city births. The number of patients attending the Hospice doubled, from 230 in 1912 to 475 in 1924. However, the increase in Royal Maternity births was part of a longer-term trend. In 1870, the hospital delivered approximately 8 per cent of city births. In 1890 this had risen to 13 per cent, and, by 1912, to 29 per cent. Use of institution-based care was rising steadily before the introduction of the MCWS.

Further, if the rise in institution-based care between 1912 and 1925 was linked to the MCWS and antenatal care, one would expect to see a corresponding increase in clinic use. This was not the case. The clinic at the Royal Maternity Hospital did show a steady increase in new patients from 104 in 1915, to 1,265 in 1924, but the numbers of new patients attending the Leith clinic fluctuated at about 200. If all its clinic attendees had been delivered by Maternity staff in 1924, they would have comprised less than half of all its patients. Similarly, the number of new users of the Hospice’s satellite clinics fluctuated, but only exceeded 100 once: in 1924 there were 48. However, as a result of the Hospice’s provident status, its main clinic was exceptional. In 1924, when Hospice staff treated 475 cases, 431 new patients attended its ‘High Street’ clinic, and 372 patients (78 per cent) booked attendance in advance.

The only surviving clinic counterfoil book provides additional evidence that the link between clinic attendance and institution care was weak. Some clinic patients planned to deliver privately, whilst others did not intend to deliver at the clinic’s host institution. Brief examination also shows that these clinic-users were not typical parturients. Only 10 per cent were in their first pregnancy, when 29 per cent of all Royal Maternity patients were primigravid; almost none were single. The counterfoils do not provide strong evidence for a direct connection between the increased use of institution care and

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24Edinburgh City Archives (hereafter ECA), Minutes of Public Health Committee, SL26/2/7, p. 73.
25There are difficulties with the data. Whilst both the Registrar-General for Scotland and the MOH counted only live births, the Hospital counted all delivered cases.
26Such low attendance reflected the national experience. See Seventh Annual Report, 1925, p. 121.
27Williamson 1912–24; Robertson 1925–31; LHSA, ERMH Annual Report (ARERMH), 1915, LHB 3/7/71.
28LHSA, ‘Record of Cases’ ‘Aug 1917’–25/4/21, LHB 3/21/5.
the introduction of antenatal clinics, suggesting that MCWS clinics did not play a major part in the expanding use of such care for delivery.

Nonetheless, the nature of institution-based care certainly changed between 1912 and 1924, with the number of in-patient births increasing markedly. In 1912, the Royal Maternity Hospital recorded 631 cases indoors, and 1,302 outdoors. By 1915, its indoor deliveries exceeded those in the individual dispensaries; six years later they exceeded the total number of outdoor cases. By 1924, 1,745 cases delivered indoors, whilst 1,282 gave birth at home.\textsuperscript{29} The Hospice was only slightly behind. In 1912, it reported 48 in-patients, and 182 home confinements.\textsuperscript{30} In 1921, an equal number of in- and out-patients were delivered and, by 1924, 205 were delivered at home and 270 in the Hospice. Contemporaries ascribed the change in the proportions of in- and out-patients to ‘the fact that many of the expectant mothers attending the clinics arrange in advance for admission … so they may take advantage of the facilities and comforts offered by hospital treatment’; that is, as a direct result of the MCWS.\textsuperscript{31} However, the Scheme was not intended to alter the place of birth. A definitive pamphlet from the Local Government Board for Scotland on the role of local authorities in maternity care stressed that indoor care could only be offered under specific circumstances, but included in these irremediable over-crowding.\textsuperscript{32}

Post-war housing in all Scottish cities was notorious.\textsuperscript{33} Contemporaries noted an increase in sub-letting and over-crowding, and that ‘the number of houses being built here is far less than the number needed’.\textsuperscript{34} The pressure on housing is evident in Royal Maternity Hospital records. In 1912, no married in-patients were recorded as living in shared accommodation (that is, their address was ‘c/o’ a third party), whilst approximately 2 per cent of outdoor patients from both the city and Leith did so. By 1924, 8 per cent of women in shared accommodation used the Royal Maternity outdoor services, but indoors a fifth of married patients now lived in shared accommodation, a quarter of these with relations. Over half were having their first baby, but most had unremarkable deliveries, with few admitted at medical request. The evidence would seem to suggest their move into hospital was triggered by social concerns, not obstetric problems: delivering in the Royal Maternity gave them more privacy than in their own home. Shared accommodation was not common at the other institutions examined, and this may indicate that they took patients of slightly higher social status: under a tenth of Hospice patients fell into this category.\textsuperscript{35} Thus, patient choice arising from worsening social conditions, not the MCWS, made a major contribution to the move to hospital admission, a key element in the medicalisation of childbirth.

The rising number of in-patients coincided with a dramatic expansion in the number of married women admitted to the Royal Maternity Hospital, previously considered to be an

\textsuperscript{29}LHSA, ARERMH, LHB 3/7/80, 1924.
\textsuperscript{30}Edinburgh Room, Edinburgh City Library, Annual Report of the Edinburgh Hospital and Dispensary for Women and Children and the Hospice, 1911–12, YRA988E (A3641).
\textsuperscript{31}LHSA, ARERMH, LHB3/7/77, 1921, p. 4.
\textsuperscript{32}ECA, printed pamphlet on the Notification of Births Act 1918, L26/4/1262, sections IX and X, p. 5.
\textsuperscript{33}Report of the Proceedings of the Maternity and Child Welfare Conference, 1917, pp. 90–2; Winter 1986, pp. 272–3; Tait 1974, pp. 185–9.
\textsuperscript{34}Kerr 1926, pp. 20, 25.
\textsuperscript{35}The only Lying-In Institution patient with a shared address delivered on its premises. However, the focus on home deliveries at the Deaconess and the Lying-In Institution would predispose to excluding such women.
indication of increasing medical control of birth. Throughout the nineteenth century, almost all indoor patients had been single, admitted primarily for shelter. This was conceded by the hospital staff, and criticised by its Ladies Committee, who felt their presence deterred married women from seeking admission, and campaigned for a separate Married Women’s Pavilion. Whilst this opened in 1895, uptake was slow, although married women did make good use of outdoor care, to the virtual exclusion of the un-married. Only in 1907 did the number of married patients delivered indoors exceed that of single women for the first time. In 1912, 317 married women were admitted, but only 300 were clearly identified as single girls. By 1924, the Annual Report noted with pleasure that ‘single women were only one-fifth of the whole’. In the indoor case-book of that year, 282 unmarried women appeared, a numeric as well as a percentage decrease from 1912.

Where had the single girls gone—were they no longer admitted by the Royal Maternity Hospital? This is not borne out by its records, nor did many single girls attend the other institutions investigated. Only 40 of the 475 Hospice patients had no married title, whilst only two at the Deaconess were called ‘Miss’. All patients at the Lying-In Institution were recorded as ‘Mrs’. It could also be suggested that increasing knowledge of contraception, or wider use of abortion, kept them outside the care of a maternity hospital, although access to the former was limited, even for married women.

A more plausible explanation is that some women continued to conceive whilst single, but that whereas previously the legitimisation of children on their parents’ marriage under Scots law had made delay acceptable, recent social changes now encouraged marriage. For example, marriage certificates developed ‘considerable economic value’ during and after the First World War, when possession ensured payment of separation allowances and National Insurance benefits. The changed distribution of patients’ ages supports this point. Married indoor patients at all institutions in 1924 were noticeably younger than their 1912 equivalents, resembling more the single girls of that year, as shown in Figure 1. The ‘earlier marriage’ theory is further supported by the increase in married indoor first-time mothers at all institutions. In 1912, a quarter of married women at the Royal Maternity Hospital were having their first child, but almost half the deliveries were first births. By 1924, 35 per cent were married primigravidae, while first births were 41 per cent of the whole. The other institutions also recorded an excessive proportion of in-patient married first-time mothers. The rise in married in-patients did not necessarily indicate a widening uptake of maternity care following the introduction of the MCWS.

Further, focus on the apparent change in indoor patients ignores the degree to which married women had previously had contact with the hospital. Even if the building was

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36 Oakley 1984, p. 52.
37 Croom 1881, p. 714; LHSA, DMERMH, LHB 3/1/4, 7 October 1884.
38 LHSA, ARERMH, LHB3/7/80, 1924, p. 4.
39 LHSA, DMERMH, LHB3/1/5, 17 June, 15 July 1924; 44 single girls were admitted from identified local ‘mother and baby’ homes in the 1924 sample.
40 Teitelbaum 1984, pp. 208–10; Lewis 1980, pp. 196–218; Cook 2004, pp. 122–142; Fisher 2006, pp. 26–75.
41 Sinclair 2000, pp. 9, 42–3.
42 Winter 1986, p. 265.
43 37 per cent of married in-patients at the Hospice were primigravid. Half of the 37 in-patients at the Lying-In Institution were first-time mothers.
unfamiliar, Royal Maternity care was not. Over all departments, throughout the nineteenth century, 55–60 per cent of all patients were married, and this had increased to 83 per cent by 1912 (see Figure 2).

By 1924, 90 per cent of all Royal Maternity patients were married, the small rise suggesting that the MCWS and the increasing use of the clinic made a comparatively small difference to the hospital’s client population. The growth in married users of the Royal Maternity Hospital was a longer-term trend, preceding the Council’s initiative.

The period 1900–25 in Edinburgh saw steady growth in the numbers using institutional maternity care, implying increasing medicalisation of childbirth. However, this expansion had its roots in the earlier work of maternity charities, which had already accustomed their patients to medical care, a view supported by the relative lack of such care in Leith and the ensuing slower take-up of antenatal and in-patient care there. It did not result primarily from the MCWS.

Changing Treatment?

This section contrasts the treatment of maternity patients given by the Royal Maternity Hospital in 1912 with that given by all the institutions studied in 1924–5, and asks whether there were differences in management, whether these resulted from the MCWS, and whether they contributed to the medicalisation of childbirth in Edinburgh.

Fig. 1. Comparing ages of married in-patients from three Edinburgh maternity institutions in 1924 with ages of single and married in-patients from ERMH in 1912. Source: Edinburgh Royal Maternity Hospital Indoor Casebooks for 1912, 1924; Edinburgh Lying-In Institution Casebook 1924; the Hospice Casebook, 1924.

44Oakley 1984, p. 52.
45Post Office Directories list no dispensaries in Leith, 1890–1920, although Boyd claims the Dispensary for Diseases of the Eye and Diseases of Women opened in 1892. Good use was made of the outpatient provision at Leith Hospital, but there was no maternity care. See Boyd 1990, p. 44. In addition to their limited clinic attendance, in 1912 only 12 per cent of Leith-resident Royal Maternity Hospital patients were in-patients. By 1924 this had risen, but only to 31 per cent. By contrast, 31 per cent of central Edinburgh-resident Royal Maternity patients were treated indoors in 1912, and 60 per cent in 1924.
For medicalisation to be significant, and not to be explicable as a change in the management of a specific complication, it has also to be apparent in normal cases, and this section first examines the management of spontaneous deliveries, before exploring the increase in antenatal admissions, and the rationale of a widening range of interventions available to obstetricians.

The great majority of patients at the institutions studied gave birth spontaneously. Even indoors at the Royal Maternity, where almost all sick or emergency cases were taken, half of the patients sampled delivered without any recorded medical interference or antenatal ill-health at all. Yet despite their great numbers, there is much less evidence for their routine care. Therefore those themes which can be extracted—pain relief (if any), the use of other drugs, supervision, mobilisation and fear of infection—will be examined, and the management of 1924 contrasted with that of the Royal Maternity Hospital in 1912 and earlier.

In both 1912 and 1924, pain relief was seldom offered to women in normal labour. Its use was not recorded at all at the Lying-In Institution, and seldom in the Royal Maternity Hospital, its dispensaries, at the Deaconess or Hospice. The minimal use of pain relief indicates a continuing physiological approach to birth, and that this aspect was not medicalised.46 However, the recorded use of other drugs had increased since 1912. Patients

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46For corroboration, see Devlin (ed.) 1995, p. 104.
delivered at home by either the Deaconess or the Royal Maternity main dispensary routinely received prophylactic oral ergot after delivery, to promote involution and reduce the risk of haemorrhage.\(^{47}\) This apparently improved outcomes in the third stage of labour. In 1912, in the Royal Maternity main dispensary, 66 patients had third-stage problems: in the 1924 sample there were 11 equivalent cases. In contrast, the Hospice only used such drugs if clinically necessary, with the result that 19 of its patients suffered post-partum haemorrhage. The routine use of ergot illustrates the role of increasing medical certainty in the medicalisation of birth. However, whilst it was a change in treatment, it was not directly associated with the MCWS, except in so far as the Scheme required best-known practice for its mothers.

A period of post-delivery bedrest was advocated for all women from the mid-nineteenth century.\(^{48}\) Although this has since been criticised as an example of medicalisation very much to the patient’s detriment, the need for rest after childbirth was stressed by women in the early twentieth century.\(^{49}\) Scanty Royal Maternity Hospital records suggest that, in 1870, inmates first left their beds three days post-partum, and were discharged after a week, but that by 1890 they stayed for ten days.\(^{50}\) The Students’ External Casebooks show that in both 1912 and 1924 the majority of outdoor patients first got up eight days after delivery, before being discharged on the tenth day. Earlier mobilisation was rarely noted. Mrs Sutherland’s discharge in 1924 provides an example of the hospital’s attempt to enforce conformity. A 32-year-old whose fifth child had been born before Royal Maternity Hospital pupils arrived, she was first described as being out of bed on her fifth postnatal day. The entry for Day 7 reads ‘Patient up on morning of 6th day. Refused to return to bed. Miss Turnbull [Public Health Department Superintendent of Nurses] notified’.\(^{51}\) Mrs Sutherland was summarily discharged. This episode shows not only that increased medical involvement in postnatal care did deprive some patients of self-determination, but also the role of pupil midwives in enforcing this.

Although the MCWS urged closer postnatal supervision, Royal Maternity nurses had attended all outdoor deliveries from the mid-1880s, and by 1914 made an average of 9.6 visits a case. By 1924 this had increased to 13 visits over ten days.\(^{52}\) Other institutions also recorded regular attendance by their pupil midwives. Vital signs were recorded on every visit, and rises in temperature were investigated and treated. This procedure, which by its nature gave birth the trappings of illness, arose from fear of infection and from the training requirements of the Central Midwives’ Boards, and again preceded the MCWS.

A patient’s agreement to treatment can often only be measured by the initial act of choosing that care. However, records of babies born before the arrival of professional staff (BBAs) offer the possibility of extracting the attitudes of a few individuals. At the Royal Maternity Hospital the proportion of BBAs was largely unchanged between 1912 and 1924, being 20 per cent in the main dispensary and 10 per cent at the Leith

\(^{47}\) Moir 1955, p. 731.
\(^{48}\) See, for example, Edinburgh Health Society 1881, pp. 130–1.
\(^{49}\) Tew 1990, p. 118; Llewellyn (ed.) 1915.
\(^{50}\) LHSA, ERERMH Special and Ordinary Casebooks, LHB 3/17/1, /5, 1870, 1890.
\(^{51}\) LHSA, 1924 Students’ External Casebook (SECB) (Leith), LHB 3/18/34, case 383. All patients’ names have been anonymised.
\(^{52}\) LHSA, ARERMH, LHB 3/7/73, /80, 1917, p. 7, 1924, p. 5.
Branch. Whilst, for most, these cases simply indicated a faster-than-expected delivery, some mothers apparently intended to give birth with family rather than hospital staff present. In 1912, Mrs Petrie delivered without hospital assistance, and two days later requested that the nurses’ visits stop, as ‘Patient’s mother a midwife’. In 1924, Baby Exton was described as ‘B.B.A. 1 1/2 hrs before call’, and when Nurse Mackay arrived from the Hospice at Mrs Howard’s home, she found ‘[b]aby & placenta delivered by handywoman before nurse’s arrival’. However, almost all BBA mothers were happy to accept postnatal nursing. If this was a rejection of medicalisation, it was very limited.

With the exception of the use of ergot, the management of normal deliveries in 1924 closely resembled that practised by the Royal Maternity Hospital since at least 1890, and the introduction of the MCWS produced few changes. It was rooted in the institutions’ concern for their reputation and their fear of infection, and sustained by their need to provide standardised training to their pupils. Clearly these were medical imperatives and based on growing medical knowledge, but the care given was predicated on a physiological approach to labour, was administered by pupil midwives, and was widely accepted. The MCWS had little influence upon such well-established treatment, other than to encourage women to use it.

Up to this point it has been argued that the influence of the MCWS on the medicalisation of childbirth in Edinburgh was small, and that it was reliant for its reputation on the work already begun by the city’s maternity charities. However, the Scheme did have an increasing impact in the management of abnormal cases. At its establishment, the MCWS had emphasised the need to treat antenatally maternal conditions which might endanger both lives and, in addition to establishing a further six antenatal clinics by 1920, it increased the provision of antenatal beds at its main centre, the Royal Maternity Hospital. In 1919, the hospital set up a separate Antenatal Department (AND). This had its own labour ward and staff for delivering women with venereal disease, although it was not limited to such patients.

This emphasis on the care of the pregnant sick ultimately shifted the focus of care to seeking out the potentially pathological. It also altered the distribution of antenatal patients at the Royal Maternity Hospital. In 1912, only one-eighth of inmates had been admitted before labour but, by 1924, this had risen to a quarter. As a result of the Hospital’s new role, the nature of their complaints also changed. Figure 3 shows that two-thirds of the pre-war admissions had resulted from serious ante-partum haemorrhage and eclampsia (meaning that a crisis had already occurred, and treatment was typically by prompt delivery). However, by 1924, more than half were suspected of having venereal disease, had raised blood pressure or were to be induced (see Figure 4). Antenatal admissions at the other institutions studied resembled the Royal Maternity’s pre-war intake. Nine of the 14 antenatal cases at the Hospice were admitted with eclampsia or haemorrhage, as were eight of the 14 admissions to the Deaconess.

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53LHSA, 1912 SEC (Leith), LHB 3/18/30, case 105. 54LHSA, 1924 SEC (Leith), LHB 3/18/34, case 473; LHSA, 1924 Hospice Casebook, LHB 8A/13/2, case 468. 55See also Devlin (ed.) 1995, p. 92. 56LHSA, DMERMH, LHB3/1/5, 30 June, 7 July 1919; Davidson 2000, pp. 61–5.
The most common complaint, affecting more than a quarter of Royal Maternity ante-natal patients, was suspected venereal disease: that is, patients presented with a copious, coloured vaginal discharge, although most had negative Wassermann test results before and after delivery. In contrast, in 1912 only four patients were considered ‘specific’ (syphilitic), generally based on the appearance of the baby.\textsuperscript{57} By 1924, most were diagnosed and treated before the birth, typically as a result of clinic attendance.\textsuperscript{58} Only two venereal patients were identified after delivery. Treatment was apparently successful: 49 babies were delivered at term and discharged well. However, these successes, and the high number of negative Wassermann results among AND patients, together suggest over-diagnosis.\textsuperscript{59} This is to fail to appreciate either the difficulties of interpreting Wassermann results (and therefore the degree to which doctors continued to rely on their clinical judgement), or the large number of chronic vaginal infections afflicting women which complicated the diagnostic picture.\textsuperscript{60}

Admissions also resulted from the triad of raised blood pressure, albuminuria and oedema (any two of which signify a pre-eclamptic state and therefore forewarn of

\textsuperscript{57}For example, Bridget Lee’s son was described as ‘[p]remature, specific’ (LHSA, 1912 ERMH Indoor Casebook (ICB), LHB3/16/3, case 26 (Dr Barbour’s quarter)).

\textsuperscript{58}Twenty-six women out of the 73 who attended the VD unit were admitted through the antenatal clinic; three were sent in by their doctor.

\textsuperscript{59}Fifteen patients had positive Wassermann results; three had gonorrhoeal symptoms; 41 returned negative results for venereal disease.

\textsuperscript{60}See Davis 2008, pp. 130–2; Shorter 1982, pp. 255–67. Nonetheless, the appointment of F. J. Browne to be responsible for all Wassermann testing at the Royal Maternity Hospital should have increased the reliability of the test (LHSA, DMERMH, LHB3/1/5, 30 June 1919). The authorities failed to quantify the incidence of VD in Scotland, and remained convinced of the existence of a pool of previously-identikit cases, like these patients. See Davidson 1993.
eclamptic fits), patients in this group being evenly divided between those admitted through the clinic or at their GP’s request. Outcomes improved as a result of earlier detection. In 1912, the Royal Maternity Hospital admitted 30 antenatal eclamptics, 26 of whom fitted. Seven mothers and 18 babies died. By 1924, only four expectant mothers fitted, and only three died out of the 31 pre-eclamptic cases in the Royal Maternity Hospital sample. Sixteen babies were discharged well. Again, it could be argued that the recovery of five undelivered mothers with rest alone indicates an excessive medical desire to intervene made possible by access to mothers antenatally. There are other indicators of more dynamic management. Extremely sick pre-eclamptics were induced soon after admission, whilst Mrs Yeats, sent by Dr Howison at three months’ gestation with a history of the loss of two previous pregnancies due to ‘fits and toxaemia’, was summarily delivered ‘on account of … high blood pressure (260/140)’.61 However, the similar number of cases in the two years suggests that antenatal care was ensuring that sufferers received treatment earlier, rather than increasing their overall number. In contrast, at the Hospice, Mrs Yelland, a 19-year-old primigravida, had not attended the clinic and was admitted as an emergency with ‘[n]ephretic toxaemia. Eclampsia! [sic]’, two months premature. Her baby died.62 Failure to diagnose pre-eclamptic cases and subsequent poor management was one of the criticisms levelled at interwar antenatal clinics, although it was one area of maternal mortality where preventive medical treatment could be effective.63

Access to in-patient care seems to have made a difference in Edinburgh.

Whereas both venereal disease and pre-eclampsia were clearly defined problems with a known treatment, the increase in admissions for induction of labour indicates more dynamic obstetric management of a range of problems, again associated with antenatal access to patients through MCWS clinics. Any intervention in the course of pregnancy suggests a high level of medicalisation. Induction was effectively a new strategy first

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61LHSA, 1924 ERMH ICB, LHB3/16/5, Case 1055.  
62LHSA, 1924 Hospice Casebook, LHB 8A/13/2, Case 278.  
63Loudon 1992, p. 90.
used widely in the interwar period. Throughout the nineteenth century, it had been viewed as a treatment of last resort, to be undertaken only after consultation to avoid any suspicion of procuring an abortion. By the 1930s, the technique was widely employed to manage post-maturity and suspected pelvic disproportion, and many senior obstetricians felt it was over-used. In 1890, only one woman, severely afflicted with rickets, had been admitted to the Royal Maternity for induction. In 1912, nine were admitted, most commonly for previously diagnosed inter-uterine death. By 1924, the labours of 42 women in the Royal Maternity Hospital sample, 5 per cent, were induced.

However, half of the women were already in the hospital as AND patients, admitted in equal numbers from the clinic or by their doctor. Five, for example, were pre-eclamptic, whilst Mrs Bertram, a 38-year-old mother of seven, was seriously ill with Hyperemesis Gravidarum. Their ill-health justified their treatment: induction was the final phase of their antenatal care, which had already resulted in admission, whilst the Hospital’s new role as a main centre for antenatal care under the MCWS ensured their concentration there.

Well-founded concern for pelvic capacity led to the termination of a further seven pregnancies in the final three weeks before term, the women having contracted pelves based on antenatal vaginal measurement and, usually, previous experience. Following induction, all delivered vaginally. Yet 42 of the 52 patients of doubtful pelvic capacity were still admitted in prolonged or obstructed labour. Twenty-nine were primiparous; most were sent in, typically by their GP. Deliveries and outcomes in this group resemble those of 1912, when 12 of the 16 cases of pelvic disproportion were first seen as emergencies, and three mothers and nine children died. In 1924, four mothers died and there were 20 perinatal deaths. For the majority of those identified as having cephalo-pelvic disproportion, there was little difference in outcome between 1912 and 1924, apparently the result of failure to use antenatal care. Only a few benefited from the increase in induction.

However, the induced deliveries of 14 women do illustrate increasing medical domination of pregnancy and the role of the antenatal clinic in this. All were at term or post-mature, with maturity the only reason for intervention. All had received antenatal supervision. Unlike the low-level medicalisation evident in the hygiene-focused nursing care, where childbirth was seen as essentially physiological, these interventions in the course of pregnancy suggest a new attitude to birth, that it was a potentially pathological event, for which medical management was necessary. For these cases, medicine does appear to be taking over nature’s prerogative, only limited by the reduced numbers who attended the antenatal clinics.

64 Loudon 1992, pp. 133–4.
65 See, for example, Browne 1932, p. 3; Wrigley 1934, p. 893.
66 LHSA, 1890 ERMH ICB, LHB3/16/2, case 38 (Dr Berry Hart’s quarter).
67 LHSA, 1924 ERMH ICB, LHB3/16/5, case 427.
68 Similar results can be seen at the Hospice. One of the two disproportion cases recorded did not book; the other did. However, both underwent difficult forceps deliveries; both had stillborn children (LHSA, 1924 Hospice Casebook, LHB 8A/13/2, cases 38a and 14).
69 By the fifth edition of his textbook, R. W. Johnstone, Assistant Physician at the Royal Maternity Hospital, and Professor of Midwifery in Edinburgh from 1926, advocated induction at term, as ‘[t]he rapid increase in the size, and … hardness, of the foetal head … makes postmaturity [his italics] a definite danger to the child, and to a less extent to the mother’. Johnstone 1926, p. 476.
The MCWS intended to increase access to antenatal care and thereby ensure that predictable problems were not first met during delivery. Although this was the area in which it was most innovative, and in which it made its greatest contribution to the medicalisation of childbirth in Edinburgh, initial success was mixed. Examination of the most common reasons for antenatal admission has found that, whilst there was an increase in treatment for vaginal discharge and pre-eclampsia, with a gratifying improvement in outcome, there was less impact in induction, and that the majority of patients with contracted pelves continued to be diagnosed when problems occurred during delivery. Obvious symptoms of ill-health encouraged women to seek medical help, but without such prompts they were unlikely to attend for antenatal care. Although the MCWS offered the possibility of more effective management of abnormal cases, in its early years the scope for routine medicalisation of the problems of pregnancy and labour was limited by lack of clinic attendance.

Conclusion
This article has used personal health records to look at the relative contributions of both voluntary institutions and the MCWS to the medicalisation of childbirth in Edinburgh, asking whether, during the period 1917–25, the Scheme changed either the populations of the institutions studied or the treatment offered to their patients. The use of such records has given a more detailed and ‘ground-level’ view than the annual reports and summaries previously used. It has shown that there was less real change in the population served than first appears, and that antenatal supervision produced only limited changes in treatment in its first seven years, although in its care of the pregnant and sick it showed the potential for further intervention. The histonography of maternity welfare provision in Edinburgh has previously implied that a sudden change in client behaviour coincided with the introduction of new state-sponsored services. This article has recognised that the MCWS provided a stability of income which became a major influence on existing providers of maternity care in the city, and that it presided over changes in treatment associated with the introduction of antenatal clinics, culminating in a change in attitudes to birth. Nonetheless, it has questioned whether it began the process of medicalisation in Edinburgh.

The detailed examination of the medicalisation of childbirth in the city undertaken in this article has shown that it can be traced back to the mid-1880s, that it resulted from the long-term medical and educational concerns of the charities involved, and that it largely preceded government maternity and child welfare policy. The crucial role of midwives in its implementation has also been demonstrated. Such care was widely accepted, indicating that medicalisation and the loss of autonomy were neither synonymous with, nor an imposition on, poor women. The same sources have also highlighted the association between increasing medical confidence and diminishing negotiation over treatment.

As a result, this article has emphasised the long-term work of voluntary maternity care institutions both in increasing the numbers of women in their care, and in the provision of supervised pupil midwives as primary carers, and thus the long slow advance of medicalisation. Equally, it has drawn out the formerly unacknowledged degree of co-operation between voluntary institutions and nascent local government provision, at least within Edinburgh. That the MCWS could be called ‘comprehensive and effective’ in 1919 was

70See also Jenkinson 2002, p. 190.
largely the result of the work of the ‘plethora of agencies’ that it sought to replace. The implications of their charitable origins have led to a down-playing of their considerable contribution to maternity care, both by contemporaries and later historians, which this article begins to redress. The MCWS might more reasonably be considered a half-way stage in the medicalisation of childbirth in Edinburgh.

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