Natural Childbirth in Twentieth Century

England:

A History of Alternative Approaches to Birth
From the 1940s to the 1990s

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PhD
DECLARATION

I, the candidate Amanda-Jane Raphael, Department of History, Queen Mary University of London, hereby confirm the following:

1. That the work presented in this thesis is my own.
2. That the work presented in this thesis was undertaken independently of any other party.

Signed: \\
Date: 23.04.10.
ABSTRACT

It is well-established that a medical model of childbirth shaped maternity policy during the second half of the twentieth century. However, alongside this narrative of medicalised childbirth, an idea emerged that was to challenge medical hegemony in maternity care provision. In 1933 British doctor Grantly Dick-Read published his first book, *Natural Childbirth*, detailing his theories on pain during childbirth and its remedy. Natural childbirth was a controversial idea and was not well-received by the medical profession. Nevertheless, some women were enthusiastic about the non-medical approach suggested by Dick-Read and by the 1950s natural childbirth was recognised as a distinct method of coping with the rigours of labour and birth. The term later became synonymous with a range of alternative ideas about the management of childbirth. Such ideas were disseminated through literature advising women about childbirth, and through antenatal education, which aimed to inform, enlighten and empower childbearing women.

Childbirth alternatives were consistently regarded with scepticism and the medical establishment remained critical of them. Midwifery was surprisingly ambivalent, given that it shared some of its core values with the principles of natural childbirth. Nevertheless, a vocal minority continued to enthuse about childbirth alternatives, and a handful of consumer organisations committed to promoting them emerged. By the 1970s and 1980s, a backlash against medicalised childbirth in contemporary Britain provided a platform for such organisations to push their agenda even further.

Natural childbirth discourse provided the means to express dissatisfaction with the medical system of childbirth; it also helped to give form to disillusionment with
contemporary maternity services by shaping expectations. By the late 1980s, policy makers attempted to address the groundswell of discontent amongst childbearing women by alluding to childbirth alternatives and offering a choice of services. Still, as their shared history suggests, the relationship between the medical and natural models of childbirth remained complex and littered with paradoxes.
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* * *

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Finally, I would like to thank my friends and family for their patience, my husband Nick for his unwavering support, and my wonderful children Charlie and Harriet for their inspiration.
ABBREVIATIONS

- AIMS: Association for Improvements in Maternity Services
- AO: Area Organiser (NCT)
- ARM: Association of Radical Midwives OR Artificial Rupture of Membranes
- BMA: British Medical Association
- BTA: Birth Trauma Association
- CHC: Community Health Council
- CMB: Central Midwives Board
- DHSS: Department of Health and Social Security
- MA: Maternity Alliance
- MSLC: Maternity Service Liaison Committee
- MIDIRS: Midwives Information and Resource Service
- NBT: National Birthday Trust
- NCT: National Childbirth Trust
- NHS: National Health Service
- PIC: Population Investigation Committee
- RCM: Royal College of Midwives
- RCOG: Royal College of Obstetricians and Gynaecologists
- RSM: Royal Society of Medicine
- RSPCA: Royal Society for the Prevention of Cruelty to Animals
- SSHC: Society to Support Home Confinements
- WHO: World Health Organisation
GLOSSARY OF TERMS

- **Active Management of Labour**: A systematic approach to labour and birth pioneered by O'Driscoll in the 1980s. The idea behind Active Management of Labour was that no labour should last more than 12 hours if properly managed. The aim was to avoid the trauma supposedly cause by painful protracted labour through intervention to limit the length of labour.

- **Anaesthesia**: Anaesthetic agents are those that allow for the blocking or removal of sensation, including pain, during surgical or other procedures.

- **Analgesia**: Refers to a diverse group of drugs, which act on the peripheral or central nervous systems in various ways to reduce and relieve the sensation of pain. Unlike anaesthetics, analgesics do not completely block pain sensations.

- **Cascade of Interventions**: A term created by the natural childbirth lobby describing the idea of how one unnecessary obstetric intervention inevitably leads to another, and so on.

- **Domiciliary Confinement**: Describes when labour and birth take place in the home environment.

- **Domiciliary/District Midwifery**: Midwifery services provided in the woman’s own home.

- **Dorsal Lithotomy Position**: Refers to the labouring women having being placed on her back, close to the edge of the delivery table, with her legs raised and supported by stirrups. The dorsal lithotomy was once regarded as the optimum position for labour in orthodox obstetric practice because it allowed for swift and easy intervention should it prove necessary.

- **Electronic Foetal Monitoring**: Foetal monitoring is defined as monitoring the baby's heart rate for indicators of stress during labour and birth using ultrasound and electrocardiography. The electronic foetal monitor (EFM) was introduced to labour wards in Britain in the 1970s; they were widely regarded as safer and more efficient method of measuring babies' heart rate than the Pinard stethoscope (a simple wooden funnel). There is, however, controversy concerning the effectiveness of EFM and its role in hastening unnecessary obstetric intervention. Even so, EFM is routine practice in many maternity units in the UK.
• **Epidural**: Form of anaesthesia whereby the nerve routes from the spinal cord are blocked by means of an injection of local anaesthetic into the lower back. Epidural anaesthesia usually causes total loss of sensation from the waist down. It is considered safe if properly administered, although frequently noticed side effects include headaches and a sudden drop in blood pressure.

• **Episiotomy**: A surgical incision to the perineum made during or immediately prior to delivery of a baby. The incision can be midline or at an angle from the posterior end of the vulva, is performed under local anaesthetic and is sutured closed after delivery.

• **First stage of labour**: The period of labour during which the uterus contracts and the cervix opens.

• **Intra-partum Care**: Refers to the management and delivery of care of the woman during labour and childbirth.

• **Maternal Mortality**: The death of a woman during, or within a specified period immediately after childbirth. The term is also applied to death that occurs as a result of termination of pregnancy.

• **Maternal Morbidity**: Physical injury or illness that occurs as a direct result of the state of pregnancy, labour or childbirth.

• **Nitrous Oxide and Air**: A common form of pain relief used by women throughout the 20th century. Also referred to as “gas and air”, a combination of nitrous oxide and air is inhaled through a mask in between contractions. The effects include light-headedness and a feeling of well-being, resulting in a lessening of the pain sensation.

• **Puerperant**: A woman who is in labour or giving birth.

• **Primipara (or ‘primip’)**: A woman who is pregnant for the first time, or who has only one child.

• **Psychoprophylaxis**: A non-medical approach to the pain of parturition which focused on the conditioning of women in the pre-natal period. It was thought women who practiced this method could achieve painless childbirth by learning to divert the mind away from the pain sensations and through the disassociation of childbirth with pain. The method gained notoriety in Britain in the 1950s and 1960s.
• **Puerperium:** The six-week period following birth, during which time the various changes that occurred during pregnancy revert to the non-pregnant state.

• **Second stage of labour:** Sometimes referred to as ‘the pushing’ stage, the second stage of labour commences when the cervix is fully dilated and concludes once the baby has been born.

• **Third stage of Labour:** Describes the delivery of the placenta.

• **Transition:** Refers to the state of mind of the parturient during the period between the first and second stages of labour.

• **Twilight sleep:** A pharmacological method of coping with the pain of parturition developed in the early twentieth century. Twilight sleep combined morphine (an analgesic) with scopolamine, (which cause memory loss). Women who were given twilight sleep responded to the pain at the time, but had no memory of it afterwards. Its use in obstetrics fell out of favour toward the middle of the century.
INTRODUCTION

As is often the case when an amorphous body of ideas gains influence and gets called a ‘movement’, the natural birth movement means different things to different people. Out of the 50, or so, women interviewed for this book, five said they had never heard of a natural birth movement or active birth principles. Others had their own opinions on what they thought the politics were all about, and some felt caught in the middle – let down by both the medical establishment and what they perceived to be the ideology of ‘natural birth’.¹

The concept of natural childbirth emerged during the middle decades of the twentieth century. It was an idea that was to challenge the increasingly medicalised approaches to the management of childbirth that had emerged in the postwar period and effectively transformed western childbirth culture. Seized upon and promoted by a small number of middle-class women living in England in the 1950s who felt somehow ‘let down’ by contemporary maternity care, natural childbirth served as an alternative, promising a fulfilling birth with minimum pain and distress. Natural childbirth, whilst it remained a relatively marginalised interest, nevertheless evolved into what has been regarded as a fully-fledged ‘movement’, spear-headed since 1956 by the National Childbirth Trust (NCT). Set up to promote natural childbirth as well as to educate and provide information to expectant mothers, the NCT has remained at the forefront of the childbirth debate for over five decades.

The improvement, as they saw it, of childbirth for all women was at the core of the NCT’s philosophy. Of course, childbirth in the latter part of the twentieth century was, for most English women, a relatively safe undertaking. Yet, natural childbirth

enthusiasts were vocal in their criticism of what they regarded as an inhuman system, based upon hospital protocol and established routine, with the interests of the medical profession, rather than the individual needs of mothers and babies, at its heart. Natural childbirth discourse existed to point out the failings of this system, and to provide an alternative model of childbirth for those women who wanted it. Even as birth in England became more medicalised and rates of caesarean section increased, even as more and more women were giving birth in hospital and choosing ever more sophisticated methods of anaesthesia and analgesia, the ideology of natural childbirth persisted.

Furthered by the increasingly emphasized role of antenatal education and a growing number of books on the subject, a discourse of natural childbirth emerged. This discourse was initially confined to the pages of specialist books; it was the language of childbirth educators, natural birth campaigners, and a handful of other interested parties. However, by the early 1990s the language of natural childbirth appeared in a Department of Health white paper, Changing Childbirth, published in 1993. This was the first time that official consideration was given to the worth of natural birth principles. Changing Childbirth – the title in itself is significant – represented a distinct departure from earlier policy. Natural childbirth, rather than being seen as a renegade and inherently unsafe approach to childbirth, was reinterpreted as a viable option – an alternative to mainstream medical care that could, according to the evidence, be made available to all women without compromising safety.

This document can be read as evidence of a shift in values amongst childbearing women, policy makers and health professionals toward a more ‘holistic’ approach to
birth. Such an approach embraces childbirth as a 'life experience', which impinges upon the person and society in ways unimaginable to those campaigning for safer childbirth and an end to maternal mortality in the late-nineteenth and early-twentieth centuries. Whilst not everyone working in the maternity services agreed with the recommendations of *Changing Childbirth*, it was clear that the terms of the debate on childbirth had changed, and that alternative approaches to birth were to be worthy of consideration in the future.

Natural childbirth was an idea that was not going to go away – in fact as we entered the twenty first century more and more expectant mothers appeared to be aware of the concept, some even demanding it vociferously. Natural childbirth discourse seemed to have penetrated the consciousness of a growing number of expectant parents as self-help books marketed to pregnant women persuaded them that giving birth in pools of water and eschewing modern pain relieving drugs is both entirely possible, and desirable – perhaps giving the impression that birthing pools etc. were more common than they actually were. An author of a guide to childbirth published in 2002 pointed out that awareness of a natural birth movement or active birth principles was quite common amongst women she interviewed for her research. Worryingly she also indicated that some felt 'caught in the middle – let down by both the medical establishment and what they perceived to be the ideology of natural birth'.

So what is, or was, natural childbirth? The question underpins this thesis: developing a deeper understanding of the discourse of natural childbirth in relation to the complex history of birth in England in the second half of the twentieth century is

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One of the central objectives here. Another objective, and one that will further our understanding of what natural childbirth is (or was), is that of determining where the ideology of natural birth originated and how it developed over time. The question of why the ideology of natural childbirth endured, even as birth became more medicalised, rates of caesarean section increased, and more and more women in England were giving birth in hospital is also fundamental. The relevance of natural childbirth discourse in an era of medicalised childbirth may be questioned, and yet what is fascinating about this idea is that it has continued to generate debate since its inception in the mid-twentieth century. This thesis aims to discover why, and what this tells about the way childbirth has changed during this time.

One way to achieve this is by assessing the impact that concepts of natural childbirth have had on the way birth is managed, via detailed analysis of policy and practice. Another is to evaluate the discourse of natural childbirth itself, analysing both the means of dissemination and the reaction of interest groups in response to it. This thesis takes both approaches in order to build a clear picture of the complex interplay of factors that have shaped the history of the idea of natural childbirth and the response of mainstream maternity care to it. Hence, the research questions tackled here reflect the need to take into consideration the views of the medical profession and midwifery, the changing demands of childbearing women, the development of technology and medical progress, as well as the actions and motives of natural childbirth protagonists. Furthermore, they also allow for a degree of reflection on the wider context against which the childbirth debate has taken place. They are as follows:
• What were the intellectual origins of the idea of natural childbirth?
• How were the principles of natural childbirth disseminated?
• What was actually meant and understood by the term natural childbirth and how have these meanings shifted over the decades?
• What were the views of the obstetric profession and practicing midwives of natural childbirth and did they change over time? If so, in what way?
• How did the medical establishment respond to the challenge of natural childbirth?
• Why did the ideology of natural childbirth endure even as birth in England became more, not less, medicalised?
• What does this tell us about the relationship between mainstream and alternative models of care during childbirth?
• Was natural childbirth a ‘backlash’ against conventional, interventionist obstetrics or was it, rather, an alternative that developed from ‘within’?
• What did natural childbirth mean to women in England and did this change over time? Did women ‘want’ natural childbirth?
• To what extent did natural childbirth discourse inform the development of the notion of ‘choice’ in childbirth that was at the heart of Changing Childbirth?

In order to address these questions, this study takes into consideration a wide variety of sources. Analysis of the body of literature devoted to the subject of natural childbirth plays a significant role in the research; this body of literature is referred to throughout the thesis, in part because it helps expand our understanding of how the discourse developed. It is also helpful in establishing a narrative that allows us to
trace the concept of natural childbirth from its inception in the middle decades of the
twentieth century, through its deployment in the battle to improve the maternity
services in the 1980s. It is suggested here that the many books that were marketed to
pregnant women -- the self-help books, guidebooks or 'childbirth manuals' to which
women who sought advice beyond that offered by the health authorities turned --
served to shape perceptions about childbirth. Thus, it will be shown here that, whilst
texts of this nature can be problematic (it is, for example, very difficult to gauge
exactly who read these books and what they thought of them), as a primary source
they can still tell us something important about contemporary preoccupations and the
development of trends in childbirth.

Nevertheless, such texts alone cannot provide a full picture of how childbirth
alternatives were disseminated, nor can they tell us much about what the response of
the medical profession was to the growing interest in these ideas. For this we need to
look beyond the literature that was in support of childbirth alternatives. Midwifery
and obstetric textbooks, professional journals, position papers, conference material
and other documentary evidence (much of it located in the archives of the Royal
Colleges of Midwifery, and Obstetrics and Gynaecology in London) are employed to
this end. As with other documents consulted in order to assess the views of the
maternity professions, such as those kept by the Ministry of Health, and midwifery's
governing body the Central Midwives Board, this evidence is as valuable for what it
does not say about natural childbirth as for what it does. In other words, as will be
demonstrated here, the lack of material found in the archives pertaining to natural
childbirth is revealing in itself.
Questions regarding dissemination of ideas have been addressed by consulting a range of sources, such as newspapers, magazines, and other printed material, as well as radio and television broadcasts. Mediums such as the printed word, radio and television were a key means of communicating the idea of natural childbirth. The BBC radio broadcast *Woman's Hour* appeared particularly inclined to present the topic to its listeners, particularly in the 1950s and 1960s. The *Woman's Hour* archive at the BBC Written Archives Centre attests to the fact that a healthy dialogue on the subject was taking place at this time between listeners and producers. Similarly, several English newspapers printed articles on natural childbirth, some publishing letters from mothers who had used the methods, others carrying out surveys on readers' views on the subject. Magazines, either those aimed directly at pregnant women, or more general women's magazines, are another source employed here both as a means of demonstrating growing interest in natural childbirth and of illustrating the development of discourse and the dissemination of ideas.

The newspapers, magazines, radio and television broadcasts referred to in the thesis were selected specifically because they were the types of media where mention of natural childbirth methods seemed to appear, at times frequently. It was realized quite early on in the research process that natural childbirth protagonists were using some aspects of the media, in addition to publishing books on the subject, to get their message across. Book reviews, or interviews with authors were one way in which this process could be seen at work. Needless to say, such sources require careful consideration: awareness of the social class bias inherent in the both the consumption and production of the types of media that mention natural childbirth necessarily leads

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3 For example, Dick-Read's private papers at the Wellcome trust Library in London contain a substantial file of press cuttings and correspondence with newspaper/magazine editors.
to further questioning of the evidence. It is such questioning that leads, in turn, to the hypothesis that natural childbirth was (or was perceived as) a largely middle class phenomenon, given that it was mainly women of the middle classes who subscribed to the types of media where natural childbirth was discussed.

Of course there were exceptions to this; nevertheless, the fact that the NCT chose *The Times* and *The Daily Telegraph* newspapers as the medium by which to advertise its inaugural meeting in 1956 is revealing of the class of people its ideas were aimed at.\(^4\) The Trust is central to the narrative of natural childbirth in the second half of the twentieth century, and a variety of sources are used here in order to construct this narrative. The archive of the NCT was, at the time of writing, in a disorganized state; consequently, access for the purposes of this research was limited. Nonetheless, a number of key documents were accessible, including minutes of committee meetings dating back to the early 1960s, and monthly ‘newsletters’ documenting activities from the very early days, provide clues as to the early organization and strategies of the NCT. Sources on the NCT are, fortunately, not limited to the archives kept by the Trust. Files on the NCT are kept in the National Archives, and the Royal College of Midwives holds a variety of material pertaining to the NCT.

One very rich source of information on the origins and subsequent development of the concept of natural childbirth were the private papers of Grantly Dick-Read, housed at the Wellcome Trust in London. This collection provided an abundance of fascinating source material on Dick-Read’s early career and his emerging philosophy, his fraught relationship with the medical profession, and efforts in the 1950s to

\(^4\) The NCT’s middle class origins are discussed in detail in Chapter Two.
popularise natural childbirth. Countless press cuttings attest to a growing public interest in natural birth methods, as do numerous files containing letters of support and requests for more information on natural birth methods from mothers. Other particularly helpful sources from this collection were the files relating to the establishment of the National Childbirth Trust (or the Natural Childbirth Association of Great Britain as it was then known) in 1956.

Fascinating though it is, it has been necessary to approach this material with a degree of caution. Whilst it provides perhaps the most comprehensive overview of the development of Dick-Read's method, and of the way in which the discourse of natural childbirth was initially founded and subsequently developed, it fails to shed much light upon the wider context. Nor does it tell us much about the contribution of other 'pioneers' of natural childbirth, particularly those whose work followed on from Dick-Read's. Other sources, such as published works and smaller collections of private papers (for example those of the originator of the Lamaze Method of 'painless' childbirth) have contributed to answering questions relating to the work of others in the area of natural childbirth.

A number of oral history interviews were conducted in the course of the research. Interviews with NCT founder members and others with a special connection to the Trust were, for example, revealing of the origins and early strategies employed by the NCT, as well as assisting in developing a nuanced understanding of the motives and methods of the early NCT teachers. Oral history is used here to fulfill several requirements, but it is particularly useful in establishing how different individuals perceived the concept of natural childbirth. Oral history also serves to compensate for
the relative scarcity of documentary evidence on natural childbirth, especially in the 
more recent period. It goes without saying that such accounts bring a degree of 
animation to the narrative; yet, perhaps more so than with other sources used here, 
oral testimony has its problems and limitations.

Selecting interviewees, for example, was difficult in itself. The NCT founder 
members, amongst them the well-known birth educator and author of several books 
on childbirth, Sheila Kitzinger, were obvious interviewees. Key protagonists (still 
living) in the development of natural childbirth discourse, such as Michel Odent, were 
also easy to identify and contact, and were keen to speak about their work and their 
experiences. Interviews with these figures tended to be free-flowing and 
unstructured; the key was to find out their feelings and thoughts on the subject, rather 
than directing them via a specific line of questioning. This proved an extremely 
fruitful and enjoyable part of the research and helped to construct a narrative of 
natural childbirth as less of a homogenous movement, and more of an evolving set of 
methods and principles.

In order to gather insight into how these methods and ideas were interpreted into 
practice, several midwives were also interviewed for this research. In this case, 
respondents were self-selecting, having answered an advertisement placed in the 
RCM journal for interviewees on the subject of natural childbirth methods in 
midwifery practice past and present. A more structured approach was taken to the 
interviewing process, with midwives answering prepared questions (some responding 
in writing via postal questionnaire), focusing on aspects of training and experiences

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5 A similar advertisement was submitted to the British Journal of Obstetrics and Gynaecology, but no 
responses from obstetricians were received.
working with women during childbirth. Although the midwives’ interviews were enlightening, frustratingly a large proportion of respondents had an existing personal interest in natural childbirth methods. Whilst the questions posed to the midwives were not specifically on the subject of natural childbirth, with hindsight, a more generic description of the research in the initial stages of contact would perhaps have generated more varied responses. Having said that, the midwives’ interviews, when viewed alongside other sources, do contribute a unique and personal viewpoint in relation to the reaction of midwifery to concepts of natural childbirth.

One of the most challenging aspects of using oral history in the course of this research was in speaking to women about their experiences giving birth. Finding out what ordinary women giving birth in England felt about childbirth, and the extent to which natural childbirth was a concern, was one of the main objectives of this thesis. Ironically, it was that one that posed the biggest challenge. Oral history was one way of addressing this question – perhaps the most obvious given the relative deficiency of pre-existing inquiry into women’s views on this subject. However, whilst some “ordinary mothers” were more than happy to share their experiences, finding willing interviewees proved difficult. It became apparent that the best way of gaining insight into women’s experiences was via an informal approach. This meant that some of the conclusions made here were based upon general conversations, rather than structured questioning, on the subject of birth. Some women were happy to commit their memories to tape, although, again, the line of questioning was kept non-specific. Often women would mention the term ‘natural childbirth’ unprompted; some had strong views on the matter, whilst for others the word natural did not imply adherence to a specific set of principles. Fortunately, other sources were available that offered
further insight into the subject of women and natural childbirth. There exists, for example, a small number of contemporary (and historical) surveys of women’s views and experiences, carried out by individuals and institutions. These surveys, which are referred to in detail in Chapter Five, were selected because they did not focus specifically on the subject of natural childbirth; these more generalised surveys provided an unbiased view of contemporary experiences of childbirth.

The sources hitherto employed provide insight into perceptions of natural childbirth amongst both the medical profession and the lay population between the 1950s and the 1990s. The closing chapter of this thesis attempts to assess what the development of a natural childbirth discourse meant in terms of policy. Sources, such as those on childbirth policy in England – surveys and reports of the Parliamentary Health Select Committees, minutes of evidence, position papers produced by the Royal Colleges, and so on – are particularly helpful in discussion of the ways in which the ideology of natural childbirth impinged upon the childbirth debate during this period. Material published by consumer groups, conference papers, surveys, etc., is also revealing, particularly of the politics of childbirth during the period in question. In referencing such a rich variety of material, a clearer understanding of the ways in which natural childbirth discourse functioned at this time, and how this was brought to bear upon the development of policy is developed.

In terms of secondary sources, many of the texts consulted here focus mainly upon the wider context, the socio-economic and cultural, as well as the intellectual and

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6 Although, in terms of structure, a strictly chronological approach is avoided (given the complexity of the subject, a structure combining a thematic with a loose chronological approach was decided upon), it is not until the closing chapter that more recent developments on maternity policy are discussed. This is because it was felt that the existence of an alternative discourse of childbirth needed to be well-established before discussion of the possible impact such a discourse might have could take place.
medical background to the development of the theories and methods of natural childbirth. Although there is some discussion of natural childbirth in the historiography, most books have their focus elsewhere: the medicalisation of childbirth is very well documented, for example. Even so, this aspect of the historiography is central to this study precisely because it establishes medicalisation as the governing theme in the history of childbirth in the second half of the twentieth century. This thesis aims to demonstrate how theories of natural childbirth were inexorably linked to the medicalisation of childbirth. In constructing this narrative, a handful of books and articles are referred to throughout, the most notable being Marjorie Tew's *Safer Childbirth: A Critical History of Maternity Care* (1998); Ann Oakley's *The Captured Womb* (1984); and Garcia, Kilpatrick and Richards' *The Politics of Maternity Care* (1990). But again, as with primary sources, an extremely wide variety of texts were consulted in the course of researching this thesis in order to develop as deep an understanding as possible both of the subject and of the wider context.

Literature on the medicalisation of childbirth over this period describes how the obstetric/medical model of childbirth had, by the 1970s, become mainstream, and obstetricians, now experts in their field, essentially became the gatekeepers of modern maternity care. The natural births experienced by women in the early decades of the century belonged to the distant past; the 'dark history' of childbirth had been eradicated by that which was considered modern, clinical, high-tech and, above all, safe. The problem of pain during childbirth had been 'solved' by the development of

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7 In this sense obstetrics during this period shared the beliefs of Scientism, insofar as the knowledge and expertise of the profession was beyond question, resisting its advance was nothing less than atavistic.
obstetric analgesia and anaesthesia; high maternal and infant mortality was, mercifully, a thing of the past. Even so, the medical model of childbirth is analysed critically by those who identify the significance of 'alternative' approaches and the emergence of dissenting voices.

The implications of the existence of such alternatives are the object of this thesis; the value they have on shaping childbirth culture is one of historical importance, both in terms of contemporary policy development, and the way in which childbirth is presently viewed. The medical model of childbirth, which can be traced back in the literature to at least the late eighteenth century, became particularly intense and aggressive in the twentieth century, and its role in shaping contemporary childbirth culture is undeniable. Yet, it is argued here, in the second half of the twentieth century a conflicting discourse of natural childbirth emerged to challenge the monopoly of the medical model. In exploring how this discourse developed, however, it has been necessary to employ a number of terms and concepts that are themselves the subject of debate in the literature.

Some of the terms used here presented particular challenges. For example, as Ann Oakley discusses in The Captured Womb (1984), it is misleading to speak of 'women' as a homogenous group. 8 This thesis refers to groups of 'women' or 'childbearing women' throughout; nevertheless, it is recognised that to speak of 'women'in generalised terms is misleading. It is hoped rather to convey the impression that, whilst there are ways in which the term 'women'may be employed as a universal category where discussion of childbirth takes place, ultimately the experience of

childbirth is a subjective one. There are fundamental differences between the expectations and experiences of individual women, as well as between women in particular social (or racial and religious) groups. Social class is but one of a number of factors which belie discussion of women as a homogenous group. Sensitivity to class bias is, therefore, essential to discussion of the sorts of issues dealt with here; for example, this thesis considers the ways in which social class shaped both the origins and later development of theories of natural childbirth. Thus, the term 'women' is employed here with both awareness and understanding of the issues and complexities surrounding it.

Use of the term 'alternative' is also contentious in its own right. The word 'alternative' suggests the existence of an opposing category, in this case 'orthodox'. Roger Cooter's work on the history of alternative medicine is helpful in identifying the historical process by which alternative practices were expressive of 'a conceptual framework different to that of “orthodox” medicine'. The word alternative is used throughout this thesis to describe approaches to childbirth that were conceptually different to those of what might be called orthodox medicine. However, it should be noted that the dichotomy between the 'orthodox' and practices labelled 'alternative' is itself a commentary on what Cooter describes as 'the struggle for professional mastery, the means by which the modern church of medicine achieved its power and authority'. The orthodox/alternative dichotomy encourages an orthodox medico-centric outlook, which, as this thesis demonstrates, fails to take into consideration other factors contributing to the development of methods and therapies defined as

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alternative. Factors such as ‘mentalities, lifestyles, private and public politics, traditions of self-help, philosophy, philanthropy, religion and economics…’ underpin the development of natural childbirth as they did other theories labelled as alternative. Such theories, argued Cooter, may have akin to each other insofar as they were conceptually different to orthodoxy, however, this does mean that they ‘existed de facto as a tidy antithesis to positivist medicine’.

‘Natural’ is another problematic and oft-debated term used throughout this thesis. The Oxford English Dictionary lists numerous definitions of the word ‘natural’. For the purposes of understanding the term in relation to the idea of natural childbirth, the following may be considered most relevant:

- Existing in or caused by nature; not artificial.
- Uncultivated; wild (existing in its natural state).
- In the course of nature; not exceptional or miraculous (died of natural causes; a natural occurrence).
- (Of human nature, etc.) not surprising; to be expected.
- (Of a person, or person’s behaviour) unaffected, easy, spontaneous.
- (Of qualities, etc.) inherent; innate.

Delving into the extensive literature on the idea of ‘nature’ and the ‘natural’ deepens our understanding of the term natural. Philosophers such as Hobbes, Locke and Rousseau debated the idea of nature, and whilst lengthy discussion of the many theories on the idea of nature is not possible here, it is helpful to appreciate how

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11 Ibid. p.xiii
12 R. Cooter “Alternative Medicine, Alternative Cosmology” (1988) p.70
13 See, for example: D. Inglis, J. Bone & R. Wilkie Nature: Critical Concepts in the Social Sciences Vol. 1 Thinking the Natural (2005)
‘nature’ and ‘the natural’ have been interpreted in the past. Acknowledgement of the wider context (both historical and contemporary) is, furthermore, key to understanding such terms and the ways in which they have been employed. Ludmilla Jordanova’s discussion of the idea of nature in relation to medicine and gender in her book *Sexual Visions* (1989) is particularly helpful in this respect. Jordanova explores the dichotomies between nature and culture, arguing that the association between women and nature (and ergo men and culture) ‘has been one of the most pervasive historically’. Jordanova’s work provides insight into the process by which two opposing terms mutually define each other: nature/culture, male/female, town/country, mind/body, public/private, and so on. Each polarity, she suggests, has its own history, at the same time as it develops related meanings to other pairs. Moreover, each pairing was an ideological construct, rather than an historical reality.

According to Jordanova’s analysis, human history – the growth of culture through the domination of nature – was represented as the increasing assertion of masculine ways over irrational, backward looking women by eighteenth and nineteenth century thinkers. The idea of culture was, especially in the nineteenth century, strongly associated with that of civilisation, and the related notion of progress, manifested in the achievements of science and technology. The dichotomy between nature and culture can be interpreted therefore as a dichotomy between nature and science. As will demonstrated in Chapter One, which explores

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15 Ibid. p.20
16 Ibid. pp.20-21
17 Ibid. p.37
18 Ibid. p.37
the wider context in which the idea of natural childbirth first emerged, the feminine qualities associated with nature were once again taken up in the twentieth century, particularly by those who idealised such qualities and regarded them as a powerful civilising influence that stressed emotional and moral rather than scientific or technological progress.¹⁹

Natural childbirth was always inherently idealistic. It looked back nostalgically to the traditional and to primitive societies, recalling a time when birth was a social, rather than a medical event, when mothers were confident of their own ability to give birth, when pain was something to be dealt with positively, rather than being obliterated by drugs, the effect of which on the unborn foetus was little known. As cracks began to appear in the medical model – too few midwives, shortages of maternity beds, spiralling rates of intervention and caesarean section, countless new mothers suffering with postnatal depression – natural childbirth was presented as the 'natural' solution to the problem. Thus, if development of the medical/obstetric approach was a knee-jerk reaction to high maternal and infant mortality at the beginning of the century, natural childbirth was the response to its failings.

This should not be taken to mean that the development of concepts of natural childbirth was in any way straightforward or linear. Indeed, the term 'natural childbirth' itself was (and still is) employed generically to refer to a diverse group of ideas, which as this thesis will demonstrate, have evolved over time and in response to various external factors. This is perhaps why, hitherto, historians have not subjected these ideas to rigorous inquiry. For example, it is difficult to speak in terms of a

¹⁹ Ibid. p.35
distinct natural childbirth 'movement' in twentieth century Britain – even though there are references to this in the literature. Natural childbirth was, and is, a contested term; as Moscucci observes, it is not, and has never been, 'a universal, value-free category'. It is, rather, an extremely complex group of theories and methods, ideas and techniques, principles and practices, which can only be understood fully by taking into consideration the context in which they emerged and the subsequent response of interest groups (midwives, doctors, women) to them. Moreover, because the concept of natural childbirth, both as a theory and a set of principles, continued to evolve over the decades following its inception in the 1930s and 1940s, such an undertaking must go further than merely contemplating origins of the idea.

One of the most intriguing aspects of the history of alternative approaches to birth is the way they have evolved in response to and alongside changes in the mainstream. In terms of the relationship between natural childbirth and the technology of birth within a paradigm of 'safe' childbirth, for instance, one is drawn to the way in which on the surface the two appear mutually antagonistic; yet delve a little deeper and the complexities of the relationship become apparent. Thus, it is interesting that one observes a resurgence of interest in natural approaches to intra-partum care at exactly the time when the risks of giving birth had been significantly reduced by the very technology railed against by natural birth enthusiasts. The knowledge that a sort of medical 'safety net' existed most certainly made a natural birth more attractive to women – and maternity care professionals – in the late twentieth century. It is but one of the many inconsistencies inherent in the history of alternative approaches to childbirth that had childbirth in the west not become so medically focused over the
course of the twentieth century, natural childbirth might have remained an obscure inter-war theory, a quaint ideal belonging to the past. It was only with the march of technology that the relevance of such ideas came to the fore.

Childbirth in England, as in many other western countries, changed dramatically over the fifty-year period studied here. These changes can to a great extent be attributed to the growing acceptance of medical hegemony and notions of scientific progress. However, alternative discourses were woven into the fabric of childbirth culture as it developed over the second half of the twentieth century. Although the concept of safer childbirth underpinned much of what occurred in terms of maternity policy over this period, once safety was established – both theoretically and empirically – the idea of better childbirth gained greater significance. Still, the possibility that mere lip-service was being paid to the ideals of natural childbirth in order to pacify a vocal minority is a pertinent one, even now. It is a debate that threatens to continue for quite sometime, as reports highlighting the inequalities and the insufficiencies of care during childbirth continue to be published. 21

This is one reason why a historical study such as the one presented here is so timely. In order to understand why these ideas are so relevant to the contemporary maternity care debate, we need to understand where they came from, how they evolved, how they were promoted and disseminated, and what the response of both the medical profession and the lay-population was to them. This thesis sets out to achieve this, raising issues of fundamental importance regarding the organisation of maternity services, the experience and attitudes of both childbearing women and medical staff,

21 See, for example: Department of Health Maternity Matters: Choice, Access and Continuity of the Care in a Safe Service (2007)
and the wider social and cultural influences on childbirth in Britain, both now and in the past. By tracing the development of this idea, from its emergence as a reaction to modern medical approaches to pain in the 1930s, through its evolution into a vibrant counter-cultural movement in the second half of the twentieth century, this thesis assesses the extent of the challenge to orthodoxy and medical power that natural childbirth represented. It is history that has been too long been ignored, and one from which we can learn much, which is of particular importance when considering questions about the future of maternity care.
AN “AMORPHOUS BODY OF IDEAS”? ¹

NATURAL CHILDBIRTH: ORIGINS AND THE DEVELOPMENT OF DISCOURSE

Pioneers pass on unheard and unlamented until the trail they blazed is followed by a few who have believed. At the end they are discovered where their life’s work finished, mourned only by the wild flowers of the wilderness they loved.

Grantly Dick-Read (1942).²

Grantly Dick-Read and Natural Childbirth.

The contemporary concept of natural childbirth first emerged in the 1930s, and was popularised by the pioneering work of British obstetrician Grantly Dick-Read and the publication of his first book on the subject, *Natural Childbirth*, in 1933.³ Born in Suffolk, 26th January 1890, Dick-Read was educated at Bishop’s Stortford College and St. John’s College Cambridge, before beginning his medical training at the London Hospital in Whitechapel, where he graduated in 1914. Grantly Dick-Read joined the Royal Army Medical Corps during the First World War and was seriously wounded during the landings at Gallipoli. Later he served with the Indian Cavalry Corps in

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1 Rosalyn Thiro *Baby and You: The real life guide to birth and babies* (2002) p. 34
2 Grantly Dick-Read *Childbirth Without Fear* (1942; 2004)
3 In the 1930s two physicians working at St. Thomas’s Hospital in London were promoting physical training and relaxation during pregnancy to help women have their babies ‘naturally’ and easily – J. S. Fairburn and Kathleen Vaughan. Their ideas, however, failed to impact to quite the same extent. Jane Lewis writes: ‘Vaughan published several articles on the value of exercises for pregnant women and the best position for natural labour, but her application for a Medical Research Council grant was refused and the Ministry of Health could not see any relevance in her work’. Jane Lewis *The Politics of Motherhood: Child and Maternal Welfare in England, 1900-1939* (1980) p.125
France, and it was here that his Subahdar Major first introduced the young medic to the principles of relaxation.

A young man, Dick-Read was deeply affected by his experiences at this time. Whilst serving as a medic in Gallipoli he became interested not only in the effect fear and anxiety could have upon the perception of pain, but also how companionship and support were integral to the process of alleviating the feelings of dread and promoting a more relaxed state of mind. One particular night in August 1915, was etched upon his memory and recalled in Childbirth Without Fear some thirty years later. In the aftermath of battle and after tending to the wounded and dying, Dick-Read kept solitary watch over the beach at Suvla Bay. The silence was broken by gun-fire and, Dick-Read remembered, ‘a sound of war that still rings in memory, more terrifying than the bombs that were bursting within my grounds as I wrote these words, near enough to shake the lamp upon my table: it was the sound of the bayonet charge’. The fear Dick-Read experienced was compounded by the utter loneliness and isolation he felt as he kept watch over the desolate beach. ‘I would have given anything within my power to have had a trusted companion with me, even if only to ask him who he thought had won. But I was alone and that sickening doubt wore down my vitality...my mind ran riot and I suffered agonies of apprehension and fear’. ‘That night’ he continued ‘I died a hundred deaths. Later I was on the Somme, at Ypres, Arras, Amiens, and Cambrai; Bourlon wood Farbus,

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4 Childbirth Without Fear (1942; 2004) p.198
Flecquiere wood, Fampoux and a dozen other battles where there was ample food for fear, but never suffered so acutely as when I learned what loneliness could mean’. 5

Returning to England, the young and impressionable Dick-Read began work on his first thesis, examining the pain experienced by labouring women. His extensive notes attest to his deep fascination with this phenomenon, as well as to his conviction that the roots of pain were not in fact physical at all, but could be located elsewhere, within the realms of the psychological, the cultural. Nevertheless, upon completion, the thesis revealed little of this interest in the origins of pain and instead contained ‘a great deal of orthodoxy’, detailing how one might best conduct labour ‘in a manner likely to minimize woman’s pain’. 6 His chiefs at the London – Russell Andrews, Bertie Lee and Drummond Maxwell – awarded Dick-Read his MD, yet gave little encouragement in pursuing his thesis on pain further, advising him to ‘learn something about obstetrics before you start writing on the subject’. 7 He remained, nevertheless, undeterred and continued to make observations on the pain of parturition in his private notebooks, becoming ever more convinced of his hypothesis on the cultural and psychological origins of pain.

Such observations were largely based upon practical experience, rather than the medical textbooks – something that set Dick-Read apart from many of his colleagues in the medical profession. As resident accoucheur* at the London [Hospital] from 1912, he regularly attended labouring women, most often in their homes, the great majority of

5 Ibid.
6 A. Noyes Thomas Doctor Courageous (1957) p.64
7 Ibid. p.64
* accoucheur French n. a male midwife (Oxford English Dictionary)
whom appeared to suffer greatly in the 'terror and agony of childbirth'. Yet he was struck by the few for whom childbirth appeared a relatively peaceful and painless experience, calm women 'who neither wished for anaesthetic nor appeared to have any unbearable discomfort'. Dick-Read's early ponderings on obstetrics were coloured by his experiences with these poor, East End mothers. In particular the labour and birth in especially squalid conditions of a Whitechapel woman, was to influence him enormously:

In due course, the baby was born. There was no fuss or noise. Everything seems to have been carried out according to an ordered plan. There was only one slight dissention: I tried to persuade my patient to let me put the mask over her face and give her some chloroform when the head appeared and the dilation of the passages was obvious. She, however, resented the suggestion and firmly but kindly refused to take this help. It was the first time in my short experience that I had ever been refused when offering chloroform. As I was about to leave some time later I asked her why she would not use the mask. She did not answer at once, but looked from the old woman who had been assisting to the window through which was bursting the first light of dawn; and then shyly she turned to me and said: 'It didn’t hurt. It wasn’t meant to, was it, doctor?'

For Dick-Read this was an epiphany. As inexperienced as he was – he and his fellows at the London who went to out 'on the district', to look after women having babies, were students who knew very little; many of them, until then had not even seen a baby being born – the young medic felt an affinity for obstetrics. However, as his biographer points out, whilst 'the Jewesses, the Poles and some of the Irish [whom he attended]

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8 Childbirth Without Fear (1942; 2004) p.19
9 Ibid.
10 Ibid.
11 A. Noyes Dr. Courageous (1957) p.30
made a treacherous, screeching fuss' he 'was quite convinced from the start that all this
was not entirely due to the “agonies” as they were called’. His private papers, in
particular his notes on pain, which date back to the 1920s, reveal the extent to which
Dick-Read struggled with this conviction. He states, for example, his belief that “these
women who yell and lose control actually do suffer very severe physical pain”.
However, he became convinced that the pain they experienced was causally related to
their perception of it and that — contrary to obstetric orthodoxy — the loss of control, the
yelling itself produced the pain, rather than *vice versa*. Thus, he observed the case of a
patient whose labour was disturbed by the woman in the next room (of the maternity unit)
making ‘a frightful noise’:

I pointed out to the girl that it was very unusual and that she must not accept the cries and
moans as synonymous with pain, but in this case [as indicative of] the hysterical state of a
woman who was not entirely in control of her own emotions.

He was entirely convinced he had discovered, no less, the cause of the “agonies”: for
Dick-Read, ‘culture’ was responsible for the pain and distress experienced by women in
childbirth; without it he claimed, ‘parturition is relatively painless’. ‘Pregnancy’, he
wrote, ‘is a retreat from many cultural acquisitions to the more peaceful habits of
Nature’s law’; in pregnancy the emotions are heightened, and ‘a girl’s mind must be

12 Ibid.
14 W.T.L: PP/GDR/B.15 Notes on Pain: The Emotions
15 See: W.T.L: PP/GDR/D.150 Grantly Dick-Read to Sir Eardley Holland, 22nd June 1951 Dick-Read
laments that the Royal College of Obstetricians ‘honour the man who invented gas apparatus, but one who
changes, in a few years, the whole approach to childbirth, discovers the cause of pain in labour, and devises
a means of minimising it without danger to mother and child, is told by your successor as President [of the
RCOG] “there is no place for you in this country”’. Dick-Read was never in any doubt as to the
significance of his ‘discovery’, as his unwavering dedication to his theory demonstrates.
16 Grantly Dick-Read *Natural Childbirth* (1933) p.19
protected 'of harmful ideas'. Education 'in the true facts of Nature's design' was considered crucial during pregnancy; the influence of unenlightened religious dogma* and the 'silence' surrounding childbirth - itself a product of the shame that accompanied discussion of sexual or bodily functions within civilised society - generated fear of the unknown, fear that was further compounded by gossipy stories about the horrors of childbirth. Fear, claimed Dick-Read, 'is acquired either by suggestion or association'. Moreover, fear produces tension and anxiety - the 'physical manifestations of the emotion and fear' - which, in turn, affect the way pain is perceived. Eliminate the fear, by means of education, enlightenment, discussion, and, ran the argument, you eliminate the pain.

This was the essence of Grantly Dick-Read's 'Fear-Tension-Pain Syndrome'. When fear was eliminated, he claimed, 'pain becomes almost negligible in over 95 percent of normal deliveries'. Elaborating upon Robert Barnes' observations in *Clinical History of the Clinical and Surgical Diseases of Women* (1874), which noted 'anxiety and dread' as 'marked symptoms' of 'unpropitious, difficult and complicated labours', Dick-Read

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17 W.T.L: PP/GDR/B.15 Notes on Pain: The Emotions
18 Childbirth Without Fear (1942, 2004) p.57
19 Ibid.
20 Ibid. p.154
recognised that ‘some phenomena of labour may not have been clearly understood and therefore mistaken for pain’. Moreover, he considered that women who were not noticeably distressed, or presented no difficulty were of no special interest, therefore such cases have not be recorded. It is, he suggested, the preternatural, the obstetrically exciting that demand attention:

Difficult cases are recorded and they have tainted and flavoured the science of obstetrics, just as a bad egg in a cake will make the cake bad; the other eggs, however good, serve no purpose, for they cannot make the cake good.

Traditionally, however, childbirth was associated with suffering. Indeed, the notion had a long and prestigious pedigree: the Bible itself states, in Genesis 3.16, ‘Unto the woman he said, I will greatly multiply thy sorrow and thy conception; in sorrow thou shalt bring forth children...’ Since the middle-ages pain and suffering were synonymous with childbearing and, through the centuries, attempts to relieve women’s distress had been frowned upon by the Church, which taught that childbirth was the best way to rid a woman of the original sin, inherited from Eve. By the twentieth century, attitudes had changed enormously. Tina Cassidy notes in Birth: A History that doctors rejected religious and cultural inhibitions concerning the relief of pain, as well as the superstition and folk-law that accompanied them, focusing instead upon trying to eradicate pain by clinical means.

21 Ibid. p.154
22 Ibid. p.155
The example of James Young Simpson, a doctor from Edinburgh, who was the first to administer the anaesthetic ether to alleviate the pain of labour in 1847 arguably set the standard for the development of obstetric anaesthesia. Although ether was an effective anaesthetic, its use on maternity patients was compounded by the fact that it was particularly odorous and was required in large quantities to keep the woman relieved throughout the long hours of labour. Searching for a better alternative Simpson began experimenting with chloroform, administering it for the first time to the wife of a doctor in her second pregnancy. The woman was astonished and delighted with the results – so delighted in fact she gave her baby girl the middle name of Anaesthesia!25 Despite continued resistance to its use, Queen Victoria, to whom obstetrician John Snow administered the drug during the delivery of Prince Leopold in 1853, eventually vindicated the benefits to women of chloroform in labour.

Henceforth, the relief of pain during childbirth became a benchmark of obstetric success, with improvements to anaesthesia consistently strove for. Medicine appeared to have taken personal responsibility for the eradication of suffering in childbirth, in the face of bitter opposition from clerics. To many it seemed rational that childbirth, in being considered a ‘shame – a religious rite’ had necessitated a ‘call for the ingenuity of medical men’.26 However, if, as Dick-Read suggested, birth was in fact considered a normal event, a moment of joy to be celebrated, it followed that such ingenuity was in fact misplaced. Thus, Dick-Read’s thesis at once condemned the development of childbirth culture among the ‘civilised races’ and the trajectory of obstetrics in its

25 Ibid. p.84
26 Ibid. p.57
response. Whilst obstetrics concerned itself with progress and the increased use of technology, Dick-Read's essentially post-modern philosophy harked back to a primitive age, when women gave birth naturally, unfettered by the trappings of religion and civilisation. Whereas organisations such as the National Birthday Trust (est. 1928) were busy devoting their energies to scientific research and the alleviation of suffering by medical means, Grantly Dick-Read dared to suggest that the suffering itself was unnecessary, a product of centuries of Western civilisation, ingrained into the psyche of women since time immemorial. He wrote in 1942: 'It is not without interest, that the more civilised the people, the more the pain of labour appears to be intensified'.

Such ideas reflected Dick-Read's life-long interest in anthropological research into childbirth in 'primitive' societies. Within the obstetric community however, they were, on the whole, belittled and ridiculed [see Chapter Three, below]. Nevertheless, both at home and abroad – for example in South Africa and the United States – natural childbirth was gaining a significant minority following. Dick-Read worked tirelessly to promote his theories, embarking upon numerous tours, lecturing the world over on natural childbirth, delivering his message to midwives, medics and lay-audiences alike. Yet, whilst he claimed his work was not 'for the gynaecologists, but for the women of the world', he was never to resolve the conflict between his unorthodox approach and his

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27 Childbirth Without Fear (1942, 2004) p.3-4
28 In the mid-1950s Dick-Read embarked upon field research observing non-Westernised African women giving birth in their natural environment. Upon completion of his studies he was further convinced of his belief that Western civilisation was responsible for the destruction of normal, natural childbirth.
29 The papers of Grantly Dick-Read, located at The Wellcome Trust Library, London, contain various documents relating to Dick-Read's work both in the United States and South Africa, including boxes full of letters of appreciation from mothers. He was often invited to speak in both countries and in fact lived and worked successfully in South Africa for a number of years and a film portraying his method of natural childbirth, entitled Childbirth Without Fear was produced there.
status as an obstetrician. His theories were undoubtedly underpinned by his obstetric training and his approach was essentially paternalistic: he ultimately regarded it as the duty of the male medical practitioner to ‘deliver’ women into what he described as ‘maternal bliss’. It has been suggested, therefore, that the issue at the heart of his method was women’s ability to maintain control over their own bodies, rather than empowering them to exercise control over what other people were doing to it. Ultimately, for Dick-Read, women had a responsibility to educate and prepare themselves in order to lessen the fear and anxiety – and hence the pain – of labour and childbirth, whilst obstetrics had a responsibility to uphold the traditional values of the profession. Thus, his work failed to question the basic premise of the relationship between doctor and patient.

What Dick-Read did take issue with, however, was the indiscriminate use of potentially harmful technology to alleviate the ‘suffering’ associated with childbearing. Since first being administered by Simpson in 1847, chloroform had become the obstetrician’s weapon of choice in the battle to liberate women from the pains of childbirth. By the 1900s, the adverse effects on both mother and baby of this once fashionable method of pain relief were becoming increasingly evident (if administered in the wrong dose, chloroform was fatal) and a safer alternative sought. Nevertheless, there is evidence that some doctors were still using chloroform in the 1930s – sometimes against the wishes of their female patients.

Dick-Read argued that the indiscriminate use of anaesthesia and instrumental delivery robbed women of one of the most profound and fulfilling events she was likely to

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31 S. Kitzinger The Politics of Childbirth (2005)
experience in her lifetime. He was deeply concerned that women were being encouraged to 'listen to whispers of the easy way' and that this was 'readily interpreted as a godsend to humanity, and the boon of modern science'. His method represented an alternative to obstetric orthodoxy for the childbearing woman, a woman for whom, in his words, 'childbirth is a monument of joy within her memory'. It was prejudice, he maintained, which:

Denies women their wishes to be calm and courageously composed. The consciousness of the purposeful physical sensations, and the emotional reactions to those sensations is denied the modern wife. She is deprived of the full reward of childbirth, which is the realisation of her achievement in the birth of her child...If there is one thing I have envied woman, it is that perfect peace and alienated happiness she demonstrates in her movement, breathing and facial expression when her baby lies contentedly and semi-conscious at her breast.

When obstetrics intervenes with impunity, according to Dick-Read, this deprives women of the opportunity of working with their bodies to achieve this exalted state of maternal bliss – which he believed was the birthright of every woman. But is the 'naturalness' of birth (and motherhood) implied by this image flawed when one considers that the cornerstone of Dick-Read's philosophy was education and preparation?

33 In Childbirth Without Fear (1942, 2004 p. 15) he laments the colleague who proudly boasted that '75 per cent of his women were delivered with instruments' whilst the 'labours of 85-95 per cent of his patients were surgically or medically induced to have their babies at a time convenient to all concerned'. Nevertheless, instrumental deliveries were not common in the 1950s – the rate in 1958 was just 4.4 per cent, whilst caesarean sections accounted for 2 per cent of all live births. The main issue of the day was still pain relief.

35 Ibid. p.25
36 Ibid. p.28
Listening to a recording of a natural childbirth conducted by Dick-Read in 1956, one is struck by the level of concentration and effort demonstrated by the birthing woman on practicing her breathing and relaxation, and the concern she expresses between contractions that she is 'doing it right'. It is perhaps unfortunate, therefore, that Dick-Read chose the term natural childbirth to describe this process considering that—by his own admission—achieving it relies very much not upon doing what comes naturally, but by performing a predetermined routine involving high levels of concentration, will-power and self-control.

We must remember that Dick-Read's work was first and foremost didactic, but is this incongruous with its basic tenet—that the ability to give birth with the minimum of distress and suffering is innate? Perhaps not: Dick-Read never once denied that birth was hard physical work requiring the fullest concentration and emotional engagement. Such effort was necessary because civilised women needed to re-educate themselves about childbirth, to un-learn, so to speak, everything they had been culturally conditioned into accepting, in order to re-engage with their own instinctive ability to give birth naturally, without pharmacological assistance. Dick-Read described natural childbirth as:

childbirth in which no physical, chemical or psychological condition is likely to disturb the normal sequence of events or disrupt the natural phenomena of parturition. A necessary corollary to this perfect condition of a woman is that she should be educated to understand what labour entails and how to assist herself in its varying phases.38

37 Natural Childbirth: A documentary record of the birth of a baby delivered by Dr. Grantly Dick-Read (Recorded 1956)
38 Childbirth Without Fear (1942; 2004) p.156
It is perplexing, and perhaps unfortunate that Dick-Read chose to focus so intently upon education. His aim was undoubtedly to de-mystify childbirth, however, this appears incongruous within a philosophy espousing the innateness of childbearing: surely women should know how to give birth? As Dick-Read saw it, Western women had indeed forgotten how to give birth, or at the very least had lost confidence in their ability to do so; but he was confident that, through hard work and education, they could re-learn this once-instinctive behaviour.

Judging from the many letters he received 'from women who have read, practiced and understood their duty to themselves and their child during labour', the benefits of the method were most definitely worth the effort entailed in its application. Indeed, if his theories met with disdain within the ranks of obstetrics, those childbearing women who experienced it were enthusiastic about this alternative way of birth. Dick-Read's philosophy that birth could be a joyous and fulfilling event in a women's life held particular appeal in the middle decades of the twentieth century, which can in part be explained by the fall in the birth rate associated with increased contraceptive use from the end of the nineteenth century and the development of the concept of "family planning" after the Second World War. As Martin Pugh suggests, women's attitudes toward childbearing in the 1940s were profoundly changing so that by '1945 a young woman on the verge of marriage could reasonably anticipate that only a few years of life would be occupied by the pregnancies and childbirth that had loomed so large in the lives of her

39 Ibid. p.157
mother and grandmother. For a growing number of women, childbirth was something they wanted to experience, rather than endure.

For Dick-Read, experiencing childbirth positively was within the reach of every woman, should she desire it. Nevertheless, as he himself acknowledged:

No two labours are alike; no two women are alike and there is something new to be learned from every case of childbirth. No rule of thumb for the conduct of parturition exists and I know of no rule that governs the conduct of women.

There were women who resolutely practiced his method yet found that they experienced pain nonetheless. Hence, Dick-Read advocated that when women were in labour, anaesthetic or analgesic apparatus should always be at hand and women should have received instruction in its use. However, he noted with interest that, in his experience, women rarely desired analgesia: their 'ambition to persevere and be conscious so that they may be aware of the result of their efforts' rendering recourse to it unnecessary.

Another problem with natural childbirth (as Kitzinger asserts) was that it placed too much emphasis upon the woman maintaining self-control and did not go far enough to challenge the medical establishment. Nevertheless, Dick-Read's philosophy was founded upon principles of traditional midwifery and obstetrics – emphasising support and minimising unnecessary intervention, and valuing kindliness and understanding over

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42 Childbirth Without Fear (1942; 2004) p.194
43 Ibid. p.157
44 See: S. Kitzinger The Politics of Birth (2005) p.47
'the stem regimentation and routine of institutional efficiency'. Whilst insistent women take responsibility for their own labour and childbirth, he recognised that the continuous support of a skilled birth attendant throughout labour was absolutely fundamental to the attainment of natural childbirth. This conviction formed the core of his philosophy, a product not only of his observations of labouring women, but also of his personal experiences as a medic serving in the Great War. Thus, he states:

No greater curse can fall upon a young woman whose first labour has commenced, than the crime of enforced loneliness. Why cannot every obstetrician realise the enormity of this medieval inquisition? Yet, each day and every night, partially or totally uninstructed women are left alone to 'get on with it'. They cannot understand the mechanism of these recurrent contractions from which there is no escape and each contraction, more hateful than the one before, slowly drags the great crescendo of its irresistible might to the very edge of unendurable agony. The agony may not come, but it is so imminent, so terrifying and so real in its proximity that the groan of apprehension is raised to an exasperated wail. Loneliness increases our terrors; under its hideous emptiness we wilt beneath the chastisement of our wild imaginations; we visualise, in its silence, the ultimate horrors of possibility and draw tight the protective cloak of mental and physical tension in readiness for either fight or flight. To be afraid at any time is bad enough, but to be conscious of the presence of a real and justifiable cause for fear, ever advancing to destroy or torture it victim, is an experience that can freeze the bravest heart and scar for all time the strongest mind.

45 *Childbirth Without Fear* (1942; 2004) p.15
46 See Chapter Three, below
47 *Childbirth Without Fear* (1942; 2004) pp.196-197
Educating and instructing women could only achieve so much; without the acquiescence of the professions, even those who had fully prepared themselves for childbirth would feel let down, unable to realise their full potential through no fault of their own. The experience of Prunella Briance, who would go on to establish the Natural Childbirth Association in honour of Grantly Dick-Read and to promote his teachings, is emblematic of this very scenario. Briance felt deeply that mishandling by staff untrained and inexperienced in the Dick-Read method at a ‘famous London teaching hospital’ in the 1950s was to blame for the stillbirth of her first baby. Other women who wrote to Dick-Read complained bitterly at the cruelty and inhumanity they experienced at the hands of unsympathetic maternity ward staff; still others bemoaned their thwarted attempts at securing a doctor who was willing to assist them in accomplishing natural childbirth by Dick-Read’s method. The state of obstetrics in the mid-twentieth century clearly exasperated him and whilst he functioned within its boundaries, he was always critical of those aspects of the obstetric profession he considered detrimental to childbearing women and their infants, both physically and emotionally. As he saw it, obstetrics was letting women down and betraying its original purpose; he always on the watch, he proposed: concentrated observation need not be obtrusive, but it must be accurate and keen.

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48 See Chapter Two [below].
49 The National Archives: MH134/139: Midwifery, Natural Childbirth & Dr. Dick-Read’s Method Prunella Briance to the Minister of Health 24 March 1956.
50 W.T.L: PP/GDR/D.10-D.72 Natural Childbirth Correspondence: Mother’s Letters
* The word ‘obstetrics’ derives from the Latin obstare, meaning ‘to stand by’.
51 Childbirth Without Fear (1942; 2004) p.203
Birth in traditional cultures informed Dick-Read's philosophy and it was to traditional midwifery, with the emphasis on support and unobtrusive observation, he turned when redefining the role of obstetrics. However, his recourse to idealised versions of the past—overlooking the historically chequered safety record of midwifery, not to mention the inherent and very real perils of birth within primitive societies—created problems for the practical application of his methods in mid-twentieth century England.  

Although certain interested factions celebrated them, his theories remained well outside of the mainstream. Indeed, Dick-Read's approach was a difficult pill to swallow for many, the poetical grandiosity of his Philosophy of Childbirth perhaps overshadowing the simple pedagogical message at its core. His approach was, furthermore, contradictory, at once demanding an entirely new and practical way of considering childbirth whilst steeping it in mysticism, romanticism and the primeval. Not only was this approach inaccessible, it was unattainable without major changes within childbirth culture. The obstacles to implementing these changes were manifold; not least among them were changes in the practices of attendants around the time of birth. Reflecting professional developments, human resource shortages and the concomitant 'dehumanisation' of the birth process (reflected in the de-emphasis of moral support during labour and increased reliance upon technology) the historic function of the midwife to provide not only

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52 Critics of natural childbirth seized upon the negative connotations of 'natural' birth in the developing world (where maternal mortality remains a serious issue, even today). Alluding to birth in primitive cultures in this way is problematic, as is illustrated by the following passage taken from Myles' Textbook For Midwives, 9th edition (1981): 'Pregnant women are inadvisably exhorted by certain groups to demand 'natural childbirth' and to refuse any interference. But left to nature, labour can be long, painful, exhausting to the mother and lethal to both mother and child. Women today are not aware of the disastrous results of 'natural childbirth' at the beginning of the century and in some undeveloped countries today. Childbirth has been made safer, shorter and easier by the very scientific procedures some misinformed women object to. Reverting to primitive methods is a retrograde step, which has no justification and should not be condoned'.

53 See below, Chapters Two and Three.
physical assistance, but also continuous companionship and support, was thus transformed. 54

Under these circumstances, what seems to have happened is that aspects of Dick-Read's natural childbirth were taken and distilled from their original form, with the focus being on physical preparation and 'methodology' rather than the more philosophical elements of the concept. Thus, it was the work of others, such as physiotherapist Helen Heardman that rendered Dick-Read's methods more accessible and, to a degree, more acceptable. Heardman's output is of particular interest, as it so clearly borrows from Dick-Read in its definition of natural childbirth:

Natural Childbirth is attained when on the physical plane labour is physiological and unobstructed, and on the mental plane the mother is unafraid, reaching the climax of the actual birth fully conscious, confident and joyous. 55

Heardman's method, however, is a simplification of Dick-Read's, proposing 'health education during childhood and adolescence' and 'preparation during pregnancy' involving physical exercise and familiarisation with the events of labour and the puerperium. The titles chosen by Heardman for her two publications - *A Way to Natural Childbirth* and *Relaxation and Exercise for Natural Childbirth* - are themselves indicative of her no-nonsense, easily accessible approach to Dick-Read's principles. 56 Method very clearly supersedes philosophy in this case, although its influence is felt to a

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54 See Tew Safer Childbirth: A Critical History of Maternity Care Chapter Four “The practices of attendants around the time of birth” pp.142-194
55 H. Heardman *A Way to Natural Childbirth* (1955) p.2
56 See also H. Heardman *Physiotherapy in Obstetrics and Gynaecology* (1951)
degree in the introduction to *A Way to Natural Childbirth*, which states somewhat prosaically:

The most important biological function of Woman is the reproduction of the race. Nature leads her to this crown of womanhood by the pleasant and lovely ways of courtship and marriage. Surely the ultimate plan cannot be the delivery of a child, although longed for, in pain and anguish.\(^57\)

Heardman’s approach placed preparation for natural childbirth within the realm of physiotherapy, which was progressively being promoted as a beneficial way to prepare for childbirth.\(^58\) In 1912 J. S Fairburn, consultant obstetrician at St. Thomas’s Hospital developed, alongside midwife and physiotherapist Minnie Randall an antenatal regime to ‘promote physical health during pregnancy and labour’.\(^59\) Along similar lines, women in preparation for birth during the 1920s practiced Kathleen Vaughan’s ‘exercises for relaxation and the promotion of flexibility of the joints and the pelvis and postures for labour to facilitate the descent of the baby’.\(^60\) Heardman’s method adhered to the principles established by these precedents, as well as to those of Dick-Read; indeed they may have more in common with them. Nevertheless, Dick-Read considered her input ‘a manipulation of his work’, even going so far as to accuse her of ‘plagiarism’. He was deeply concerned about the impact of her work, calling for it not ‘to be disseminated ...
as the genius of a physiotherapist, for not only is the work tarnished by that, but a gross misunderstanding of the true situation is propagated'.

Heardman, who worked with the highly respected obstetrician W.C.W. Nixon at University College Hospital in London, was experienced in the professions of physiotherapy, obstetrics and midwifery and her work was considered helpful to the many woman who ‘found that Grantly Dick-Read did not give enough practical detail about how to relax’ or ‘prepare them to do so under difficult conditions’. Erna Wright, a midwife writing childbirth manuals for women in the 1960s, also lamented the fact that Dick-Read’s practical teaching was ‘not sufficiently advanced to give adequate physical help to the majority of women’. Herbert Thoms, Professor of Obstetrics and Gynaecology at Yale University School of Medicine in the 1950s, was another who tempered his initial enthusiasm for Dick-Read’s method, partly because he was concerned that the term ‘natural childbirth’ was ‘unfortunate’, implying, as it does, that painless labour occurs in primitive tribes and cultures. Dick-Read’s work, he continues:

Leaves a definite impression on the reader that without culture parturition is relatively painless and conversely that with culture it is definitely painful...A matter that should be clarified is the fact that neither Dick-Read nor other writers on the subject of natural

63 E. Wright The New Childbirth (1964) A decade later, well-known obstetrician and author of the Pregnancy series of antenatal advice books, Gordon Bourne expressed similar opinions about the weaknesses of the method, adding that: Unfortunately Grantly Dick-Reed’s [sic] method of natural childbirth was claimed by some as ‘painless childbirth’. Far too much was sometimes claimed of the method and of course when painless childbirth was not achieved the method was castigated by those who did not believe in its principles and it gradually fell into disrepute. Gordon Bourne Pregnancy (1975)
childbirth have ever claimed that childbirth should be conducted without anaesthetic or that it can be devoid of pain.\textsuperscript{64}

It is interesting to note the way in which pain – as opposed to fear – was often the central focus of such publications. It was as if the cycle of fear-tension-pain that was at the centre of Dick-Read’s philosophy had been forgotten, a reflection perhaps of the internalisation of a pharmacological approach to pain in the mid-twentieth century. Consequently, these books furthered a simplistic methodological approach toward the elimination of the pain itself – rather than promoting greater understanding of its cause – making recourse to pharmacological methods acceptable, even within a natural childbirth paradigm.

Dick-Read strongly implied that his method eliminated the need for analgesics or anaesthetics during labour and childbirth. He conceded, nevertheless, that pharmaceutical pain must always be available and offered to those who did need it, but never forced upon those who did not. The choice was seen to lie with the mother at all times, and use of pain relief should not be considered in terms of ‘failure’ in any circumstances. In The ABC of Natural Childbirth (1955), mother and natural childbirth enthusiast Barbara Gelb is keen to emphasise that she used sedatives – as ‘administered in fifty per cent of natural births’ – and alludes to a minority of women ‘cited by opponents of natural childbirth, who are depressed because they had to take a few extra

\textsuperscript{64} H. Thoms Training for Natural Childbirth: A Program for Natural Childbirth with Rooming-in (1950) Pp.1-3
whiffs of gas'. Pain relief remained an issue of crucial importance in the 1950s and 1960s, and one gets the distinct feeling that many natural childbirth enthusiasts felt Dick-Read's method had substantial limitations on this score. The search for 'something better' – to quote Erna Wright – subsequently led them to the work of a Frenchman, Fernand Lamaze, whose method of 'painless childbirth' was being practiced, with apparent success, by women at the clinic he founded in 1947, the Maternite du Metallurgiste in Paris. 

**Influences from the Continent and the Development of Discourse.**

The Lamaze method was in fact based upon the theory of psychoprophylaxis, a Russian school of thought established in the 1920s by the famous physician Pavlov. Ivan Pavlov (1849-1936) received the Nobel Prize (for physiology and medicine) in 1904 following the publication of his theories on the function of 'conditioned reflexes'. Pavlov's main area of research throughout his scientific career was on the digestive process, which brought on a series of experiments exploring the correlation between the nervous system and the autonomic functions of the body. Pavlov experimented with dogs, studying the relationship between salivation and digestion. By applying stimuli to the animals in a variety of ways, using sound, visual, and tactile stimulation, he was able to make the animals salivate whether they were in the presence of food or not; a phenomenon he called the conditioned reflex. 

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65 Thoms *Training for Childbirth* (1950) p.124  
66 E. Wright *The New Childbirth* (1964) p.1. The Maternite du Metallurgiste was a maternity hospital originally established to treat steelworkers' and their families with the aim of providing first class maternity care to working class Parisian women.  
It was whilst working fellow physician Nicolaiev, who in 1927 pioneered the application of hypnosis in obstetrics, that Pavlov demonstrated the cortical nature of pain sensation and the importance of fighting fear in the parturient. \(^{68}\) Where the theory differed from that of Dick-Read was in its psychotherapeutic approach. Thus, Lamaze’s 1958 book, entitled *Painless Childbirth*, comments that Dick-Read’s theories ‘lacked a sound psychological basis, and he was therefore at a loss to work out a correct method that would easily be applied, or would sound convincing to most obstetricians’. \(^{69}\) Psychoprophylaxis was, on the other hand, ‘based upon psychological and physical preparation of the pregnant women’ and worked on the Pavlovian premise that pain could be ‘suppressed through the intervention of other conditioning’. \(^{70}\)

Lamaze’s emphasis upon ‘training’ and ‘conditioning’ was far greater than Dick-Read’s, although both regarded pain as a social/cultural phenomenon that was ‘created by widespread misconceptions and the thoughtless and inhumane organisation of lying-in hospitals’. Nevertheless, Lamaze did not share Dick-Read’s profoundly mystical view of the spirituality of motherhood. His method, rather, replaced this emotional force with a whole series of physical and mental techniques. Consequently, although Lamaze went to great lengths to distance himself from the Pavlovian idea that humans were merely ‘conditionable’ flesh and bones, emphasizing the importance of educated and supportive staff – ‘the essential pillar upon which the success of childbirth without pain rests’ – the

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\(^{69}\) F. Lamaze *Painless Childbirth* (1958) p.29  
\(^{70}\) C. Gutman *The Legacy of Doctor Lamaze* (2001) p.161
criteria demanded by psychoprophylaxis exerted an extraordinary amount of pressure upon women. Accordingly:

A woman must be imbued with the thought that she is essentially responsible for the success or failure of her own childbirth...She must not cease to be the force which directs, regulates and controls her labour. Her mind, carefully educated, steadfast and alert, will know how to abolish pain. The woman will be amply rewarded for her efforts by the inexpressible joy of having contributed enormously to the birth of her child.

Women were encouraged to perform in a specific way in order to achieve their aim. There was a particularly strong emphasis upon education and learning, not only to banish fear, but also to ‘recondition’ the mind: ‘the obstetrician must induce in his patient a healthy frame of mind by remoulding her psyche’. In order to undertake her education, Lamaze stressed that ‘each woman needs only one qualification: she must be willing to work conscientiously toward the birth of her baby’. Lamaze’s practical approach, with its references to hard work and effort, was aimed at not at the ‘pampered’ woman – those who sought the ‘easy way’ (see above) – but rather at those women who wanted a pain-free, conscious delivery and were willing to work to achieve it. ‘Childbirth without pain is not’, argued Lamaze, quoting Andre Bourell, ‘childbirth without effort’.

71 C. Gutman *The Legacy of Doctor Lamaze* (2001) p.167; See also: F. Lamaze *Painless Childbirth* (1958)
72 F. Lamaze *Painless Childbirth* (1958) p.17
73 F. Lamaze (1958) p.27
74 Ibid p.15
75 Ibid p. 16
Succeeding at ‘painless childbirth’ involved intense preparation during pregnancy and concerted effort throughout labour. Furthermore, as with the Dick-Read method, the support of trained attendants was of paramount importance, as this description of Marjorie Karmel’s Lamaze birth demonstrates:

A nurse I hadn’t seen before marched briskly into the room, and, before I could say anything she injected a hypo [sic] of something into me. I remember feeling terribly confused and distressed. How I regretted not being in the Metallurgist’s clinic where all the personnel are trained in the principles of the method. 76

However, with the arrival of her monotrice – the midwife who had instructed her in the method – Karmel’s labour takes a turn for the better:

Mme Cohen told me I could push... Dr. Lamaze called the signals: “Inhale! ... Exhale! ... Inhale! ... Hold! ... Push! – and I performed automatically. 77

Obstetrician Elliot Phillip, who visited Paris in 1959 on behalf of the National Birthday Trust to study the Lamaze method, also observed the significance of the presence of trained attendants. He recommended:

Women should be prepared by the same monitress [sic] during pregnancy as will be by her side during labour. 78

76 M. Karmel Babies Without Tears: A Mother’s Experience of the Lamaze Method of Painless Childbirth (1959) pp.90-91. Marjorie Karmel was a professional actress living in America when she gave birth using Lamaze’s method in the 1950s. She wrote about her experiences with the hope of sharing them with other women interested in the method; her book became a bestseller in the United States. Karmel met fellow enthusiast Elisabeth Bing, an English woman also living in the U.S., and together they established they formed ASPO/Lamaze (now Lamaze International), a not-for-profit organisation composed of parents, childbirth educators, health care providers and other health professionals, to spread the word about Lamaze and to set the standards for Lamaze childbirth educators, in 1960. Karmel tragically died in 1964.
77 Ibid. p.91
78 W.T.L: SA/NBT/II.5/8
Phillip recognised the difficulty of establishing such a system in the UK, especially for ‘non-private’ patients. He did stress, nonetheless, the desirability of sending ‘one or two’ British midwives to learn the method in Paris, or else ‘invite one of the monitresses [sic] from France to teach in a maternity unit over here’.79

No such scheme was to take place; the NBT was of the opinion that it would generate too much friction between ‘hide-bound midwives’ and ‘enthusiastic monitresses’ to be of any practical value.80 Nevertheless, there are indications that a number of mothers in this country used psychoprophylaxis in the 1950s and 1960s, and that they found it helpful.81 By 1960 the NCT was ‘deeply committed’ to the Lamaze method of ‘prepared’ childbirth: ‘it was a method easily learned and taught and more adaptive to the rising rate of hospital delivery than Dick-Read’s philosophy’.82 Indeed, there were those who – like Erna Wright – considered the Lamaze method ‘better’ for a number of reasons. Elliot Phillip wrote in 1959:

79 Ibid.
80 Ibid.
81 The Wellcome Trust Library holds a small archive of press cuttings and material relating to the showing in London of a film produced by Lamaze depicting childbirth by the psychoprophylactic method. These indicate that there was indeed some lay interest in the method in Britain, although the statistics given in the Daily Mail article (3rd July 1954) are for deliveries at the Maternite de Metallurgiste – no comparative statistics for Lamaze births in this country exist. Interestingly, the British press fascination with Lamaze appears to have focused more upon the fact that his method originated in the USSR than upon its merits as a way to easier childbirth. Lamaze’s film and the accompanying lecture he gave was organised by the Society for Cultural Relations with the USSR and the press refer to his method in terms of its Russian origins. The Mail article is particularly keen to draw attention to the fact that this idea was not a new one having been pioneered by the ‘famous British obstetrician, Grantly Dick-Read’!
Some in France are using the Dick-Read method and claiming very good results. I cannot believe that the results can compare with the psychoprophylactic method, nor is the basis, to my mind, nearly as rational as that of psychoprophylaxis.\textsuperscript{83}

It was perhaps its rational 'scientific' approach that made this method more appealing, especially to the authors of manuals preparing women for childbirth, which were a key means of disseminating these ideas to expectant mothers. Thus, Erna Wright describes her antenatal instruction manual \textit{The New Childbirth} (1964) as 'a step-by-step recipe' [emphasis mine] for antenatal preparation according to the principles of psychoprophylaxis.\textsuperscript{84} Midwife Wright claimed that a 'great many workers in the antenatal field expressed enthusiasm and approval for this approach' and 'some hospitals — including one large London teaching hospital — are offering this new approach to their patients under the NHS'.\textsuperscript{85} Indeed, whilst the idea of antenatal preparation originated with Grantly Dick-Read, the methods chosen by midwives and physiotherapists in training expectant mothers who attended antenatal preparation classes — the breathing and relaxation techniques — were closer to the Lamaze method.

Nevertheless, in spite of the growing influence of Lamaze on antenatal education, a significant proportion of the literature aimed at pregnant women to prepare them for childbirth was actually influenced by both Dick-Read and Lamaze. Modified versions of the two methods appeared in books such as \textit{A Way to Fearless Childbirth} (1963) by Betty Parsons, and \textit{At Your Best for Birth and After} (1969) by Eileen Montgomery. The

\textsuperscript{83} WTA: SA/NBT/II.5/8
\textsuperscript{84} E. Wright (1964) p.11
\textsuperscript{85} Ibid pp.14-15
foreword to the former (written by the surgeon and obstetrician, Sir. John Peel whose 1970 report on the maternity services recommended the universal hospitalisation of birth) states:

I like this book because while Mrs. Parsons expresses her great debt to the separate teachings of Drs. Grantly Dick-Read and Fernand Lamaze, she rejects the term ‘natural childbirth’ which has been bandied about so widely laitly [sic], and which has done more to fog the issue and obscure the underlying principles these men tried to teach than anything else. I like it because the author frankly admits that no system of training, of psychoprophylaxis, of relaxation, or whatever name may be used to designate antenatal preparation, will guarantee to any individual woman a painless childbirth. 86

With pragmatism as their shared feature, books of this nature legitimised the use of pain relieving drugs and other obstetric technology whilst ostensibly remaining steadfast to the central principles of Dick-Read and Lamaze. Hence, the notion of preparedness, of confidence building and the elimination of fear were presented as sound principles that were – and this is key – not incompatible with hospitalised birth or obstetric intervention. 87

86 B. Parsons A Way to Natural Childbirth (1963) p.viii
87 Indeed, the somewhat counterintuitive idea that collusion with the medical profession provided women with the best chance of giving birth ‘naturally’ was embodied in the modus operandi of the NCT throughout the 1960s. See Chapter Two, below.
Contextualising Natural Childbirth.

Whilst the theories discussed so far had yet to impact extensively on the mainstream, the discourse of natural childbirth – this ‘amorphous body of ideas’ – gradually evolved into what might be referred to as ‘movement’. Whilst the pioneer figures of this so-called movement differed in their approach, what they did have in common was the profound conviction that birth was, in most cases, a normal physiological process, and that most healthy pregnant women were capable of delivering their offspring without medical intervention. But what sustained this conviction? And what kindled women’s interest in these ideas, hastening the growing market in antenatal instruction literature? To find the answer, we must look beyond the theories themselves, and reflect a little upon the context in which they emerged, developed and were disseminated.

Consideration of the interplay between the broader social and cultural context and natural childbirth discourse is fundamental to our understanding of the shifting meaning of natural childbirth. For example, the term ‘natural childbirth’ does not refer merely to the ideas of Grantly Dick-Read; it was in fact used more generally to refer to a range of approaches to childbirth that might be considered alternative. Moreover, understanding and usage of the term has changed over time, influenced by later alternative birth proponents, such as Michel Odent and Sheila Kitzinger (see Chapter Four, below), as well as by contemporary developments in maternity care. Underpinning everything, of course, was a much wider social, cultural and political framework. Thus, only by contextualising natural childbirth can we begin to engage with its many complexities, beginning with the term itself.
Moscucci argues that natural childbirth in twentieth century Britain 'served as a form of cultural and political critique aimed at various crises of modern Western society, from industrialism, capitalism and materialism, to urbanisation and mass culture'.\textsuperscript{88} For example, it would seem that, far from merely being a series of antenatal instruction manuals, Dick-Read's body of published work, coupled with his campaigning efforts in this country and abroad, can be understood as a reflection of his deep spiritual despair, not only with the state of contemporary childbirth, but with the very heart of Western culture and society. His focus on women and childbirth in some ways served as a metaphor for the real core issues that concerned him.

Like many of his contemporaries, Dick-Read believed the declining population in the early twentieth century was but further vindication of a process of degeneration and social decline that had been underway since the late nineteenth century. Celebrating motherhood, encouraging women (particularly middle class women) to have babies – babies who would grow into vigorous, healthy adults – was part of a strategy toward improving the quality of the race. According to Dick-Read, nothing less than the future of Western civilisation rested upon this: for example, he spoke of his unshakeable belief that the foundation of World peace must be laid in motherhood, and that the nature of a child will form its own environment. Essentially, his philosophy embraced the middle-class ideal of the family and sets clear gender boundaries within that ideal. In other words, according to Dick-Read, women are maternal by nature and through their role as mothers that they make their supreme contribution to society:

Motherhood offers all women who have the will and the courage to accept the holiest and happiest estate that can be attained by human beings. That we, as obstetricians, can help and guide them, is our greatest privilege, for with each succeeding generation we may establish the foundations of a new race of men with a clear vision of the future, that holds a practical philosophy and a purpose worthy of fulfilment.\textsuperscript{89}

His legacy was thus not only the creation of an ideal birth, but also an ideal woman; a mother figure whom, in his own words, represented a model of 'simplicity, the fundamental charm of womanhood, [which] is so very rarely found today.'\textsuperscript{90} As Moscucci points out, it was no coincidence that 'Nature' had a long association with 'feminine values such as love, cooperation and altruism, in opposition to the destructive qualities traditionally vested in the male'.\textsuperscript{91}

The intellectual origins of natural childbirth rested upon these opposing values, which were themselves symbolic of the disenchantment with modern life and Western civilisation felt by some sections of society during the interwar period. Moscucci presents the ideology of natural childbirth as a series of diametrically opposing categories, encompassing contemporary counter-cultural movements such as vegetarianism and the rediscovery of spiritual aspects of reproduction:

\textsuperscript{89} Dick-Read \textit{Childbirth Without Fear} (1959) p.7
\textsuperscript{90} Dick-Read (1933) p.26
\textsuperscript{91} Ibid. L. Jordanova provides a fascinating and detailed analysis of nature and its meanings in Western intellectual thought in her book \textit{Sexual Visions: Images of Gender Science and Medicine between the Eighteen and Twentieth Centuries} (1989)
What this simplified model demonstrates is how disillusionment with civilisation and modernity was manifested in contrarieties that underscored the paradoxes of Western society. Historians of the twentieth century have observed how the middle decades, a time of remarkable scientific and technological progress were, paradoxically, marked by a period of collective nostalgia and self-reflection. Such influences are clearly evident in the writings of Grantly Dick-Read, most visibly in his articulation of the concept of the 'primitive' woman, whom he constructs as a counterpoint to the 'civilised' woman. The woman to whom Dick-Read is referring is of course a cultural construct, a timeless figure, living in no particular place, yet it is significant that her image became an

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enduring one. Ruth Barcan, writing on the subject of nudity as a cultural construct, writes that:

If non-Western societies were understood as lacking in comparison to the developed civilisations of modernity, they were also sometimes understood as repositories of all those values and freedoms that these same societies were imagined to have squandered or lost – an authentic relation to nature, a simple, untroubled life, a primordial innocence.93

The assumption is made in Dick-Read’s work that Western culture/civilisation does not uphold the values of motherhood in the same way as do the ‘primitive races’. Indeed, he writes of the primitive woman: ‘to have conceived is her joy; the ultimate result of her conception is her highest ambition’.94 Of women in the West, he states:

To me is incredible that there is a tendency amongst modern civilised and even cultured women to discard, for one of many reasons exhibited as justification, the opportunity, given only to them, of implanting in the mind and body of their newborn infants the seeds of the fullest and richest possessions in life.95

Dick-Read’s audience of white middle-class women – those for whom ‘the easy way’ of obstetric analgesia and anaesthesia had obliterated the birth experience – were told that preparation for birth would enable them to sit and wait patiently for their baby and would ‘beautify the maternal consciousness’.96 Natural birth would, moreover, develop in the civilised woman the innate ‘feminine qualities’ of patience, sensitivity and

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94 Grantly Dick-Read Natural Childbirth (1933) p.40
95 Dick-Read Childbirth Without Fear (1959) p.13
96 Cited in S. Kitzinger The Politics of Birth (2005) p.47
understanding. The apparent paradox in Dick-Read's appropriation of the primitive women – that her instinctive wisdom has to be learned from books – is overlooked in the eagerness to communicate the ideal.

The sense of urgency felt by Dick-Read and his like-minded contemporaries was buttressed by deepening anxiety about the fall in the birth rate. The idea that motherhood had fallen out favour, particularly amongst women of the middle classes was a cause for concern. The declining birth rate engendered real anxiety about the possibility of 'national decline' and, subsequently, a barrage of thought on how best such decline might be arrested. Pronatalist, egalitarian, social-democratic, eugenicist and racialist theories abounded 'permeating a myriad of social policy issues during and after the war'. Indeed, as Denise Riley points out:

The welter of proposed improvements in the lot of post-war mother and family seems dazzling ... A huge literature, concentrated in 1945 and 1946, argued for nurseries, after-school play centres, rest homes for tired housewives, family tickets on trains, official neighbourhood babysitters, holidays on the social services for poorer families, access for all to good gynaecological and obstetric help, a revolution in domestic architecture ... and more communal restaurants and laundries.

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98 Ibid. p.264
99 Ibid. p.265
There was also an emphasis on domestic education, hygiene, sex education, household skills and ‘preparation for family life’ from those whose intention it was to promote the desire, amongst women, for children and home making. The principle of ‘positive eugenics’ was, according to Pauline Mazumdar’s study of British eugenics, ‘devoted to encouraging the reproduction of the eugenically valuable or prudential classes, as Malthus had called them’. It was this aspect of eugenics she argues, as opposed to that which emphasised the elimination of the ‘unfit’, that probably attracted many educated women to the Eugenics Society. Whilst there is not room here for a detailed analysis of reform, or ‘positive’, eugenics, it is important to understand how it influenced contemporary debate. The 1940s were a time when discussion about public health and social conditions often took place within eugenicist parameters, something Mazumdar relates to the tradition of Victorian social reform. It was only later, in the years following the end of hostilities in Europe that the term eugenics fell out of common parlance in England, forever to be associated with the atrocities of the Nazi era.

However, in the early to mid-1940s positive eugenics addressed a number of issues of social concern, particularly those related to maternal and child welfare. It was, for example, in the 1940s that the Population Investigation Committee (PIC), in association with the RCOG, carried out a survey of childbearing women in Britain. The PIC was established in 1936 specifically to ‘examine the population problem and the circumstances which have led to it’. The Committee, which included representatives

100 Ibid. pp.265-266
102 British medical Journal (14th November 1936) p. 989
of the RCOG, the Medical Research Council, the Royal Economic Society and the Eugenics Society, was of the opinion that ‘before useful suggestions [could] be made to avert a serious decline in numbers there must be a much fuller investigation of the position than [had] yet been undertaken’. 103 In the mid-1940s, the need for such investigation was addressed with an ambitious survey, which, it was hoped, would draw attention to the dire state of the maternity services and the need for reform. The report of the Committee was eventually published in 1948 with the title *Maternity in Great Britain*. It confirmed the suspicions of member of the PIC: women were unhappy with the maternity services they were offered and the costs – both social and financial – associated with childbearing were considered a ‘serious deterrent to parenthood for all sections of the community, not only the poorest’. The survey concluded: ‘if women are to be encouraged to have more children, much more attention needs to be paid to the material and psychological needs of expectant mothers’. 104

We can draw interesting parallels between the language of reform, or ‘positive’, eugenics – with the emphasis was upon encouraging reproduction between the genetically advantaged – and Dick-Read’s natural childbirth philosophy as it developed in the 1930s and 1940s. 105 Addressing a meeting of the Eugenics Society in 1945, Dick-Read made ‘an eloquent plea for raising the status of motherhood in the post-war world’.

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103 Ibid.
105 Moscucci’s research into the intellectual origins of natural childbirth emphasises the significance of ‘reform eugenics’. She writes: ‘Health reform organisations such as the People’s League of Health (founded in 1917) and the New Health Society (founded in 1927) tried to develop a reformist eugenics, which mixed theories of environmental improvement with theories of selective breeding to produce a better future for human society. The development of natural childbirth owed much to the activities of physicians and health professionals who were in sympathy with the aims of reform eugenics’. O. Moscucci (2003) pp.168-173
He warned those assembled that without this, 'our country will, within a few generations, cease to be a power or even an influence among nations of the world'. 106 Similar means were employed to address issues that had come to the fore in the years since women's enfranchisement. According to Richard Soloway:

Female demands for the vote, expanded education, greater economic, occupational and professional opportunities, as well as control over property, children, and less explicitly, sexuality, called into question the stability of the family, the nature of authority, the fundamental religious, moral and scientific basis of gender and the very future of the race. 107

It is revealing that a large degree of support for Dick-Read's teachings came from the pages of women's magazines - the very medium that helped to sustain what Pugh refers to as a 'cult of domesticity' in the middle decades of the twentieth century. 108 For example, Woman magazine (1937), which boasted a (largely middle-class) readership of 3.5 million by the late 1950s, was unadulterated in its support of Dick-Read. The editors at Woman were quick to recognise how his celebration of motherhood and domesticity appealed to the values of the magazine and those who read it in the 1950s. In 1958 Woman published, in pamphlet form, an Open Letter to all Midwives describing natural childbirth as 'the kind of labour and birth which leaves the mother with a good and wholesome memory of it. A birth which she can look back upon with a sense of

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106 Eugenics Review Vol.37 No.2 July 1945 p.71
fulfilment, thankfulness and satisfaction'.\textsuperscript{109} Pugh argues that \textit{Woman} was but one of a handful of women's magazines that that propagated an ideology of domesticity, where it was acceptable 'for women to work for a living up to their early twenties', as long as they 'remained as anxious as ever for the pleasures of home and family life'.\textsuperscript{110} Other publications aimed at women, such as \textit{Housewife} magazine (1946), contributed to the barrage of domestic propaganda that proliferated during this period; that \textit{Housewife} also printed letters of support from their readers on the subject of natural childbirth is, of course, significant.\textsuperscript{111}

Concerns about the possibilities of the declining population played out in the general press as well as in the pages of women's magazines. Dick-Read's interest and involvement in these matters is clearly evident from the archive of his personal papers, which includes a file from 1943 with numerous clippings under the heading "Population Concerns". Evidently, he contributed to an array of newspaper articles tackling the perceived problem of population decline in the mid-1940s. For example, his warnings about the likelihood of national decline as a result of the under-valuing of the state of maternity were repeated in the \textit{Derby Evening Telegraph} in June 1945:

\begin{quote}
Unless motherhood is raised to the position of supreme importance in post-war reconstruction, this country will, within a few generations, cease to be a power or even an influence among the nations of the world.\textsuperscript{112}
\end{quote}

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\textsuperscript{109} W.T.L: PP/GDR/C.103
\textsuperscript{110} Pugh (2000) p. 210
\textsuperscript{111} W.T.L: PP/GDR/C.103
\textsuperscript{112} W.T.L: PP.GDR/C.103 Press Cuttings: National & Local Press \textit{Derby Evening Telegraph} (7\textsuperscript{th} June 1945)
\end{flushright}
Further, it was reported that Dick-Read had gone as far as to call for the establishment of an officially sanctioned 'ministry of reproduction' during an address to the Royal College of Midwives, such was the imperative nature of the population crisis. These ideas were perhaps not as far-fetched as they now appear; in the atmosphere of post-war reconstruction, the issue of maternity was rightly of some significance. It also featured highly on the agenda in plans for a future welfare state and so was entirely in keeping with contemporary discourse.

The uncertainty engendered by the perceived population crisis, which was only magnified by the social upheavals concurrent with the denouement of the Second World War, undoubtedly shaped discourse about natural childbirth in the mid-1940s. The controversy not only manufactured newspaper column inches on the issues of maternity and reproduction, but also drew influential members of the medical profession into the debate. For instance, Sir Eardley Holland, president of the RCOG in the mid-1940s, added his voice to the chorus of anxiety on population decline in a speech on the future of the midwifery service at a National Conference on Maternity and Child Welfare in 1943. Holland, who was privately sympathetic towards Dick-Read's theories [see Chapter Three, below], made his solution to the problem of population decline plain in the address stating:

Those who are directly interested in the maternity service of this country should be eugenically minded...it will be necessary to eliminate the breeding mental defectives, epileptics and deaf mutes and other undesirable citizens...At present the birth rate

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113 W.T.L: PP/GDR/C.103 Press Cuttings: National & Local Press Derby Evening Telegraph (7th June 1945); Municipal Engineering (26th August 1945)
amongst the least successful and skilful people is relatively high, and [amongst] the successful - e.g. the professions and skilled artisans - is relatively low. I regard eugenics as a component of a national maternity service.  

The Minister of Health, Ernest Brown, made a comparable contribution, speaking on the subject of Britain’s need for ‘More Mothers and Better Babies’. This suggests that the development of natural childbirth rhetoric was inextricably linked to ideas about eugenics, population and, of course, public health.

Needless to say, long before such issues came to the fore, maternity care had been a key issue of public health and the subject of lengthy debate in the press. The concept of public health emerged in the nineteenth century when a whole swath of ambitious reforms aimed at improving the health of the nation were prompted by the realisation of the impact on it of the physical environment. The success of these reforms, manifest in the significant reduction in the number of deaths from hitherto common diseases such as tuberculosis and polio, typhoid and cholera, was, according to Roy Porter, down to the successful and uncontroversial joining of forces of the medical profession and the general public. The triumphant coupling of public health and medical science in the nineteenth century was embodied in the nineteenth century campaigns against disease and illness. By the early twentieth century, there remained little doubt that public interest coincided with the interests of the established medical profession in a number of key areas.

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114 Eugenics Review Vol.35, No.1 (April 1943)
115 Ibid.
Childbirth — a ‘classic arena’ for debate on public health — was one such area. Childbirth remained a dangerous undertaking for both mothers and babies in the early part of the twentieth century; consequently the State intervened with a variety of directives aimed at regulating maternity care. The Midwives Acts of 1902 and 1936, the Maternity and Child Welfare Act of 1918, and the creation of the Ministry of Health in 1919, can all be seen as part of the growing involvement of the State in the health of the nation’s mothers and babies. During the Second World War, the concern for the health of mothers and babies was also evident in the government’s decision to evacuate those living in urban areas to safer, rural locations, and its efforts to provide extra food rations and dietary supplements. The results of these initiatives were ‘unexpectedly favourable’, perhaps an indication of how improvements could be made to maternity care provision in the post-war period.

It was society’s concern about the health of childbearing women (partly related to anxieties over population decline and loss of political power) that led to the preoccupation with safety in childbirth. The passing of the National Health Services Act in 1946 promised to bring the maternity services out of the dark ages by standardising care, giving all women, regardless of social standing, access to high standards of clinical care. Yet it is interesting that at exactly the time that childbirth had been declared safe, that a ‘succession of dissenting voices was raised, protesting against the authorized medical rituals’ embodied by NHS maternity care. Porter makes the suggestion that

118 Ibid. p.198
Dick-Read's *Childbirth Without Fear* was at the centre of this debate for both its 'medical and social message'. Criticism of state medical and health care was not limited to the maternity services however. Other areas of the NHS came under attack from a public unhappy with the inefficiencies of the service, manifest in poorly equipped hospitals, inhuman and brusque treatment at the hands of medical staff, and inequitable distribution of services.

Porter argues in *The Greatest Benefit to Mankind* (1997) that the popularisation of medical science/knowledge had created 'health care consumers', rather than patients willing to accept the Foucault 'medical gaze'. He stresses that even prior to the establishment of the NHS 'a commercial civilisation purchased regular medicine's services, but it also brought other therapeutic brands on offer'. This exercise in consumer choice did not disappear after the NHS began providing free health care. On the contrary, as the growth in the field of alternative medicine over the second half of the twentieth century perhaps suggests, a significant proportion of health care consumers responded to the failings of the NHS — and, by extension, orthodox medicine — by looking elsewhere for remedies to their ills. The 'self-help' approach appealed to expectant mothers in this way, with Dick-Read's natural childbirth, or psychoprophylaxis, providing an alternative to orthodox approaches to care during childbirth.

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120 Ibid.
121 Ibid. p.396
Letters (such as those sent to the NCT, for example) dating back to the early days of the NHS suggest that there were women who felt let down by the services provided by the state. The principle of free maternity care for all was beyond reproach; still there were many who bemoaned the new system. Dick-Read was deeply concerned about what effect the NHS would have on childbearing women; privately he also worried what impact it would have on his own private practice. As time went on and it became clear that by choosing to give birth under the NHS, women were contributing to the trend of standardised, medically-defined maternity care, Dick-Read increasingly questioned the effects of the NHS on the care women received during childbirth. In a letter to a sympathetic colleague in 1950, he mused 'the NHS has definitely made it extremely difficult for men who wish to be good obstetricians'. His response to what he called 'this abominable medical service' was to write 'another book setting out more clearly the details of my teaching and dealing more firmly with what I believe to be the modern trend of insanity in scientific childbirth'. Hence Dick-Read's work can be regarded as both contributing to and having been part of the increasingly controversial public debate on childbirth in the mid-twentieth century. This debate provided Dick-Read with a forum to speak about his theories, which were part of the wider debate on the superiority of medical science over other approaches to public health, as well as the role of the State in health care provision.

Clare Hanson, in her book *A Cultural History of Pregnancy* (2004) argues that the 'natural childbirth movement derived much of its impetus from a reaction against both

122 W.T.L: PP/GDR/D.148 Dick-Read to Dr. J. Gillies (24th October 1949)
“mass production” and increasing technological intervention in obstetrics’. In employing the term ‘mass production’ Hanson refers to F. J. Browne’s metaphor for the impersonal system of maternity care that had developed in Britain since the 1930s: the first edition of Browne’s *Antenatal and Postnatal Care* (1935) pointed out the inadequacies of antenatal care in Britain, couching them in terms of the ‘lack of good relationship between doctor and patient’. There is plenty of evidence – both anecdotal and empirical – of women’s disappointment with what was considered a ‘conveyor belt’ approach to many aspects of maternity care (particularly antenatal care) in the mid-twentieth century. The establishment of a national maternity service under the NHS in 1948 aimed at eradicating the insufficiencies of the inter-war maternity care facilities. However, many problems persisted and, indeed were exacerbated under the new service. Inadequate resources and lack of coordinated planning meant that the maternity service suffered from serious defects and uneven distribution of service in different areas. Principally, however, it was the impersonal, systematic style of maternity service provision that many took to be its worse aspect.

Hanson argues this system ‘undermined rather than developed [pregnant women’s] self-confidence. She also asserts that many women ‘distrusted the medical profession’s enthusiasm for technological developments’. The natural childbirth movement, claims Hanson, ‘attempted to address the related issues of women’s lack of self-confidence and

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124 Cited in Ibid. p.129
125 Evidence provided by the Report of the PIC/RCOG study into *Maternity in Great Britain* (1948) and other sources, such as letters from mothers to Grantly Dick-Read, written memoirs and oral history provide insight into women’s experiences of and attitudes to maternity care. These are discussed in detail in Chapter Five [below].
the increased medicalisation of pregnancy and childbirth'. Thus, Hanson sees natural childbirth as a reactionary concept. Yet, paradoxically, she also suggests that Dick-Read’s philosophy ‘fitted in with a long-standing tradition of conservatism and cautious intervention in British obstetrics’, arguing that his theories were, in fact, informed by ‘contemporary scientific thought’. This appraisal of Dick-Read’s contribution colludes with biographer Noyes Thomas’s observations that his early theses on the origins of pain ‘contained a great deal of orthodoxy’. Of course Dick-Read practiced obstetrics first and foremost, and that although he struggled to reconcile his views with those of his colleagues, and was concerned about the implications of some of obstetrics’ more excessive aspects, he felt a deep regard for the traditions of the profession. Even so, the fact that the concept emerged from within obstetrics is, of course, one of the more controversial aspects of the history of natural childbirth.

Sheila Kitzinger attempted to resolve this apparent contradiction at a celebration of the centenary of Dick-Read’s birth held by the NCT in 1990. She described him as ‘a very rare doctor who loved and listened to women and whose concern for them shone through his writing’. Kitzinger continued: ‘his attitude to women was paternalistic, as was the style of his time, but he was 100 percent on their side, arousing in other obstetricians a great deal of anxiety because he threatened the established doctor-patient relationship’. She was correct in her summation: some aspects of Dick-Read’s method did appear to

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127 Ibid.
128 Ibid.
129 A. Noyes Thomas (1957) p.64
131 Ibid.
pose threat to established practice, as is discussed in Chapter Three [below]. However, his approach was inexorably bound with obstetric tradition, which he admired in spite of his scepticism about many aspect of contemporary practice. In *Childbirth Without Fear* (1942) for example, he asks rhetorically: ‘can any science bear greater responsibility for the future than obstetrics?’ He nevertheless questioned the way modern obstetrics was developing and asked his contemporaries to be mindful of ‘the limitations of science’. He was emphatic in his condemnation of modern obstetric practice, claiming that ‘as a branch of medical and social science, obstetrics in this country is not worthy of our high tradition’.

French obstetrician and champion of non-medical childbirth, Michel Odent [see Chapter Four, below] calls Dick-Read ‘a brilliant observer’. His observations of contemporary maternity care, particularly after the establishment of the NHS maternity services, doubtless informed his work. It was his concern about the more negative aspects of this care – the enforced isolation of labouring women on busy hospital wards, the increased reliance on pharmacological pain relief, the lack of personal attention and support – that motivated him to develop his philosophy of natural childbirth. Yet Dick-Read must have been aware of the growing demand for obstetric technology, particularly after 1950. He certainly seems to have viewed it as misguided: he took it upon himself to educate women about birth with the express aim of convincing them that recourse to obstetric anaesthesia, for example, was unnecessary and possibly even harmful. As Dick-Read’s

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132 *Childbirth Without Fear* (1942; 2002) p.27
133 Ibid.
134 Michel Odent (Interviewed Dec. 7th 2006)
obituary in the *British Medical Journal* attests: ‘his ideas were a complete reaction to twilight sleep and excessive practice of operative delivery’. 135 Nevertheless, he still regarded obstetrics as being of immense significance to the future of humankind; as we have seen, his concern was that contemporary obstetric practice over-emphasized the ‘physical components of reproduction’. ‘No matter how carefully and apparently successful this may be’, he wrote in *Childbirth Without Fear*, ‘the raising of the standard of the human mind cannot be accomplished unless men and women are guided by the creative and directive spirit’.136

Ideologically, Dick-Read’s philosophy shared common ground with that of his contemporaries C.S. Lewis and J.R.R. Tolkein: his view of the world echoed their work in terms of its veneration of the past and of nature, anti-materialism, the affirmation of individual agency, the importance of community, and the primacy of the spiritual realm. 137 Dick-Read’s theories were thus a reaction to modernity; they also alluded to a wider intellectual struggle to reconcile theories of scientific progress with ideas about nature, and spirituality. Significantly, part of this struggle was related to gender: as Jordanova argues that within discourse on the conflict between nature and science during the eighteenth and nineteenth centuries, femininity was often associated with Nature and masculinity with science and technology. According to Jordanova:

135 WTA: PP/GDR/A90 Scrapbook of Obituaries, etc.
136 *Childbirth Without Fear* (1942; 2004) p.27
Human history, the growth of culture through the domination of nature, was represented as the increasing assertion of masculine ways over irrational, backward looking women. The very concept of progress was freighted with gender.\textsuperscript{138}

She goes on to point out that this was not to say that women could not contribute in other ways to progress. Many considered women to be a powerful civilizing influence, particularly those who valued the ‘feminine form of the civilizing process’, that which stressed ‘emotional and moral rather than scientific, economic, technological or political progress’.\textsuperscript{139}

This was the school of thought to which Dick-Read belonged, and it is in this sense that his work echoes that of the eighteenth century naturalist and writer and ‘prominent disciple of Rousseau’, Bernardin de Saint-Pierre (1737-1814). In an introduction to an 1806 edition of his famous work \textit{Paul et Virgine} (first published in 1788) Saint Pierre wrote of women:

Women lay down the first foundations of natural laws. The first founder of human society was a mother of a family. They are scattered among men to remind them above all that they are men, and to uphold, despite political laws, the fundamental laws of nature... Not only do women bind men together by the bonds of nature, but also by those of society.\textsuperscript{140}

Maternity was always a key issue in nature/science discourse, but the debate continued, indeed was intensified, by the development of chloroform in the mid-nineteenth century; according to Mary Poovey:

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\textsuperscript{138} L. Jordanova \textit{Sexual Visions: Images of Gender in Science and Medicine between the Eighteenth and the Twentieth Centuries} (1989) p.37  \\
\textsuperscript{139} Ibid. p.37  \\
\textsuperscript{140} Cited in Jordanava \textit{Sexual Visions} (1989) p.34
\end{flushright}
The anaesthesia debate constitutes an important episode in the mid-Victorian discussion of the “woman question” because of the crucial role played by medicine in formulating a scientific justification for what was held to be woman's natural reproductive function and circumscribed social place.¹⁴¹

There were still those who questioned, as did Dick-Read, whether the woman in labour belonged ‘to the realm of nature, which is governed by God, or to culture, where nature submits to man’.¹⁴²

Opponents of chloroform in the nineteenth century, when they were not able to make a case for the medical dangers of the method, often drew upon arguments that postulated childbearing (and the pain of such) in terms of religious morality. In his work on the history of public healthcare in the nineteenth and early twentieth centuries, The People's Health (1979), Smith gives the example of a Dr. Robert Lee who was deeply concerned about the safety of chloroform after noting no less than seventeen cases in which administration of the drug had caused a range of injuries, including the death of four patients. Yet in making his case against the use of chloroform, Dr. Lee chose to employ ‘Old Testament’ morality, rather than relying upon the clinical facts at his disposal. Smith documents – with more than a little incredulity – Dr. Lee’s claim that ‘it was a most unnatural practice to destroy the consciousness of woman during labour, the pains

¹⁴² Ibid. p. 139
and sorrows of which exerted a most powerful and salutary influence upon their religious
and moral character, and upon all their future relations in life'.

During the inter-war period, debate over the appropriateness of obstetric anaesthesia
continued. Through the work of Dick-Read we can see how this over-lapped with the
debate over the role of spirituality and religion in a society driven by notions of scientific
progress. By the 1930s and 1940s, the falling out of favour of traditional customs such as
the ‘churching’ of Christian women after childbirth – a special service for new mothers
held as a ‘thanksgiving’ for having survived ‘the great pain and peril of childbirth’ – was
testament to shifting attitudes regarding the pain of parturition. Fewer people than ever
still believed the Old Testament assertion that the pain of childbirth was emblematic of
the ‘curse of Eve’, yet for many intellectuals, medics and clerics, the problem of
reconciling the teachings of the Bible with new discoveries in medicine was far from
resolved.

As were many of his like-minded contemporaries, Dick-Read was disappointed that the
Bible and the teaching of the church provided little in the way of comfort or courage to
expectant mothers. He believed, nonetheless, that it was possible to resolve the
‘teachings of the past’ whilst at the same time ‘moving forward with the advance of
science that has overcome so much of the distress to which our forebears were
subjected’. Dick-Read approached obstetrics with a deep and profound belief in God
and a firmly held conviction of the limits to the human endeavour of scientific

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143 F.B. Smith The People’s Health: 1830-1910 (1979) p.21
investigation. His lifelong search for the 'truth' about childbirth was underpinned by these beliefs, and this goes some way toward explaining the reception of his ideas amongst his peers and amongst those to whom he dedicated his life's work - mothers.

By the 1950s, when his ideas were gaining in popularity, having been seized upon by a group of articulate and assertive women bent upon promoting natural childbirth through a new organisation, the Natural Childbirth Association of Great Britain (later the National Childbirth Trust, est. 1956), science and technology appeared to be encroaching upon everyday life in ways unforeseen even a decade earlier.

Dick-Read proposed an alternative to the march of technology that pervaded not only the experience of birth but was also beginning to infringe upon all aspects of motherhood, for example through the development of the baby formula industry. The technological developments emerging in the post-war consumer boom were intended to make mothers' lives easier. However, it has been suggested that in practice the increased mechanisation of childbirth compounded mothers' sense of isolation - with implications that went beyond the birthing room. Looking back at the institution of motherhood that developed in post-war Britain, Germaine Greer remarked in 1984:

The woman who becomes a mother suffers a crushing loss of status; as a "patient" she was at the bottom end of the health professionals' social hierarchy. At home she is a solitary menial. Fewer and fewer women can exact the support of another family member during their maternal isolation, and fewer still could expect or would welcome the support of neighbours. Modern dwellings are arranged in such a way that housewives
carry out identical tasks in isolation from one another, in suburbs which are deserted by
day except for their lonely selves and their babies.\textsuperscript{145}

Indeed, the commonest complaint of women giving birth in hospital in Britain in 1947
was that they had been left alone during labour.\textsuperscript{146} The price paid by mothers for the
march of technology was, it appeared, greater isolation and a loss of the community that
had once supported them.

Disillusionment with this aspect of the 'modern' mother's life surely encouraged
interest in ideas such as natural childbirth – this and a desire to rekindle the simpler
aspects of mothering, particularly those that emphasised the spiritual over the material.
For example, Mother and Baby a magazine aimed firmly at the modern mother with its
advertisements for formula milk, laundry detergent, stylish maternity clothes and
newfangled prams, and thus an unlikely source for the airing of such sentiments,
published regular 'Meditations on Motherhood' by an Anglican Chaplain during the
1950s. Science and technology, it would appear, had failed to provide the answers to
many mothers' questions.\textsuperscript{147}

As we have seen, the intellectual origins of natural childbirth were inextricably linked to
the wider context of myriad changes to society in England in the middle decades of the
twentieth century. Ideas about science and nature, culture, civilisation, spirituality and
materialism, race, gender and social class underpinned the development of these theories,
which can to a degree be viewed in terms of a reaction against the more negative aspects

\textsuperscript{146} See: \textit{Maternity in Great Britain} (1948)
\textsuperscript{147} \textit{Mother and Baby} (1956-)
of modernity. Whilst those who popularised theories of natural childbirth in the 1950s chose to focus specifically on the rather more temporal issue of maternity care, natural childbirth still served as a metaphor for the expression of dissatisfaction with contemporary notions of progress and with modernity in general. For this reason, natural childbirth endured as a 'post-modern' idea, even when, as we will see in the following chapters, its meaning shifted, again in response to wider contemporary social, cultural and economic changes.
PROMOTING NATURAL BIRTH: 1956-1970

In the 1950s, increasing numbers of women were giving birth in hospital, in an often unfamiliar and frightening environment. They were given very little information and few choices, as the prevailing attitude at the time was that 'doctor knows best'. In hospital, labouring women were given drugs, had their membranes ruptured, an episiotomy, or even a forceps delivery without their consent. As a result, women’s experiences were often traumatic. The fear and pain they experienced were compounded because very few women knew about the processes of labour.

The National Childbirth Trust: The Early Years.

The conference to celebrate the fiftieth anniversary of the National Childbirth Trust in 2006 was an opportunity to reflect upon five decades of change in the maternity services. As a well-known television celebrity gave a moving account of the natural birth – at home – of her first child, there was a general consensus amongst NCT members that whilst much had been achieved, there was still work to be done for an organisation committed to the rights of expectant parents in the UK. The theme of the conference was one of celebration and reflection; this was underpinned by the emphasis upon the facing up to future challenges by learning from the past. Hence the presence of numerous NCT founder members was more than symbolic. On a day inevitably dominated by rhetoric, what these women represented was action, rather than words.

1 G. Werkmeister “Don’t Forget the Breathing: Fifty Years of Antenatal Classes” NCT New Digest July, 2006 pp.7-8
Of course, the spoken and written word was fundamental in creating generating interest in natural childbirth. In the 1940s and 1950s the dissemination of these ideas, mostly through books aimed at pregnant women, led to the development of a natural childbirth discourse. However, although the burgeoning market in antenatal advice and instruction literature in the late 1950s demonstrated growing interest amongst lay readers in the processes of labour and birth, preparation by means of the printed word was, in the words of a former teacher for the National Childbirth Trust (NCT) Deidre Mackay, ‘rather like learning a foreign language from a book without ever having heard it spoken’.\(^2\) Moreover, many who read the books – which, incidentally appears to have very rarely been on their doctor or midwife’s advice, but rather by means of word-of-mouth recommendations from friends, neighbours and family members – often found themselves unable to put the advice they gave into practice once in hospital due to the ignorance of the medical attendants in natural childbirth techniques.

In the mid-1950s Prunella Briance, a young mother living in London, took it upon herself to rectify this situation, beginning with an impassioned plea to the Minister of Health that ‘something positive’ be done about ‘Dr. Dick-Read’s remarkable system of childbirth’.\(^3\) Still reeling from her own experience of stillbirth,\(^4\) Briance was outraged at

\(^2\) Deidre Mackay *Mid-Cheshire NCT: How it All Began* (Unpublished memoir, 1991) p.1

\(^3\) T.N.A: MH 134/139 Midwifery / Natural Childbirth / Dr. Dick-Read’s Method Prunella Briance to the Health Minister, 24th March 1959

\(^4\) The baby was her second child. Briance already had a son, born in Cyprus by caesarean section. In her book to commemorate the fortieth anniversary of the NCT, Joanna Moorhead writes of Briance: ‘This time around she was determined to have a natural delivery, she wrote to Dick-Read for information, and read his book *Childbirth Without Fear*. The book inspired her, but during the delivery disaster struck. The baby was born dead – a consequence, Briance was convinced, of mishandling by medical staff during labour’. (Moorhead *New Generations: Forty Years of Birth in Britain* (1996) p.2) In a postcard to fellow NCT founder member, Gwen Rankin, dated September 2005, Briance expressed regret that she had never herself been a patient of Dick-Read. (By kind permission of Gwen Rankin)
the lack of 'proper training in the method for midwives and doctors'.

5 Her enthusiasm for the Dick-Read method inspired Briance to take steps toward establishing an organisation dedicated to promoting understanding of its benefits. The initiative was unique in that it came not from the maternity professions or the NHS, but from the private sector – from mothers without formal training in either obstetrics or midwifery. It all started, recalls Gwen Rankin, with an advert in the personal column of the Times in 1956, placed by Briance, calling for anyone interested in finding out more about the 'Dick-Read method' to attend a meeting at Westminster's Caxton Hall.6 The response was overwhelming, mail 'simply poured through the door' and Briance was astonished by the number of women who wanted to get in touch and lend their support'.7 The meeting, which Briance herself organised, promoted and funded, was held on 29th January 1957. Grantly Dick-Read was invited to be one of the speakers, and the meeting generated attendance from well over one hundred people, including television, radio and newspaper journalists.8

The Natural Childbirth Association of Great Britain was duly founded by a group of 'about a dozen' women from the audience at the Caxton Hall who felt, as Briance did,

5 National Archives MH 134/139 Ministry of Health Midwifery / Natural Childbirth / Dr. Dick-Read’s Method
6 Gwen Rankin Twenty-Five Years On: A History of the National Childbirth Trust (Unpublished memoir, 1981) p.1 In fact Briance placed two adverts announcing her intentions to establish a Natural Childbirth Association 'for the promotion and better understanding of the Dick-Read system': one in the Times, one in the Daily Telegraph, on Friday 4th May, 1956, inferring that the notices were intended to reach a particular demographic – educated, middle-class women.
8 Briance recalls: 'The Caxton Hall excitement was at the inaugural meeting in January 1957 when all the TV and radio came...' (September, 2005) (By kind permission of Gwen Rankin)
that something needed to be done 'in response to the demonstrated need'. \(^9\) Briance recalls how an 'instant and profuse response' kept her busy from the very beginning. The period following the inaugural meeting of the Association, which was held at the private home of Nancy Greaves (the sister of founder member Gwen Rankin) in Kensington, London, she remembered as being particularly demanding, for various reasons. \(^10\) Finding suitable premises was a problem from the start; the NCA instead taught classes to expectant women from the drawing rooms of private homes, charging a nominal fee for attendance. In the early years, Briance remembered there was a great deal of moving about. In private correspondence with Rankin she writes of her indebtedness to those kindly (and obviously wealthy) individuals in whose homes the first NCT classes took place:

> After your lovely sister lent her house for the very early meetings we then had Jean South's house in Phillimore Gardens – also the de Lazlo house was very kindly allowed near Marble Arch and we had those very first under the marvellous de Lazlo portraits – (I still know the family). Then to make the film of Jess [Dick-Read's] class we had June Monat's flat near Regents Park... \(^11\)

Reliance on the kindness of individuals, as well as their conviction in the principles upheld by the NCA, shaped the fortunes of the organisation in its early stages. As well as providing premises, for the five or so years prior to the NCA gaining charitable trust status, the commitment and generosity of the handful of comfortably-off volunteers who were able to work considerable hours for no financial reward was essential. Such

\(^9\) G. Rankin (1981) p.1  
\(^10\) P. Briance "The Birth of the NCT" *New Generation* (September, 1990) p.5  
\(^11\) Prunella Briance to Gwen Rankin (c.2006, by kind permission of Gwen Rankin)
beginnings established the NCT as a firmly middle-class organisation, representing the values of those who funded it. Dedicated individuals involved in the day-to-day running of the organisation expended a great deal of time and effort in making sure the NCA functioned properly from the outset as a respectable organisation, committed to both the teaching and promotion of natural childbirth principles. Briance herself attended classes taught by Dick-Read's wife, Jessica, in order to really absorb 'the simplicity of birth, and how to teach and get results'. 12 Education was key, and one of Briance's initial aims was the establishment of a College of Natural Childbirth to promote understanding of Dick-Read's work. Sadly, in spite of the diligent work done in lobbying the health authorities, this aim was never achieved; hopes of opening a small clinic 'to welcome mothers who wished to give birth naturally' were also dashed. 13 Indeed, private funding could only take the NCT so far and little in the way of support from the government – financial or otherwise – was forthcoming. Nevertheless, disregarding the difficulties and set-backs, Rankin remembers:

We who had learned from those books, and listened to Grantly Dick-Read, wanted to make it more widely known so that all women could benefit from all that we had found so helpful. We were motivated by a simple missionary spirit! We had no funds, no starting grant, no lottery money or sponsorship by big companies or governments, just a desire to share knowledge and skills with pregnant women everywhere. 14

12 Ibid. Jessica Dick-Read worked alongside her husband in the promotion of natural childbirth and was involved with promoting and developing the concept of antenatal instruction. She even wrote her own book on the subject What Every Woman Should Know About Childbirth (1965) which was co-authored by Prunella Briance.
13 Ibid.
Many of the founder members displayed similar qualities of enthusiasm, tenacity, and boundless energy, not to mention an unwavering commitment to the ideals of natural childbirth. Responding to expectant mothers' needs specifically by exposing them to Dick-Read's teaching was undoubtedly the cornerstone of the fledgling Association's philosophy: the first 'antenatal classes' were based on his teachings and run strictly along lines dictated by his wife and dedicated disciple, Jessica. In 1957 a notice to all NCT Area Organizers on the Conduct of Antenatal Classes was circulated, stating:

For those running “authentic Dick-Read classes” the following instructions are issued by Mrs. Dick-Read who is running the model class for our association. They must be carried out if mention of this method is made.\(^{15}\)

However, even in the early days, when the NCA was still heavily influenced by the values held by Briance and Jessica Dick-Read, promoting Dick-Read's method in particular and exposing expectant mothers to his teachings specifically represented but one facet of the association's activity. The NCA's broader aim was to improve childbirth for women, to address their concerns, which were voiced in their many letters, and to convey them to the authorities in the hope that the maternity service would change in response to women's perceived needs. Thus, from the very beginning, the NCA existed to bridge the communication gap that seemingly existed between doctors and midwives on the one hand, and childbearing women on the other.

\(^{15}\) See: Appendix I
The original, published aims of the Association voiced a clear message to the maternity professions that here was an organisation whose raison d'etre was to speak out to them on behalf of mothers. They were as follows:

1. That women should be humanely treated during pregnancy and in labour, never harried bullied or ridiculed.
2. That husbands should be present during labour if mutually desired.
3. That analgesia should not be forced on women during childbirth (and) nor should labour be induced merely to save time.
4. That more emphasis should be given to self-regulated breast feeding and rooming-in allowed if the mother wants it, and that future maternity units should be designing with this in mind.
5. That a mother trained for natural childbirth should be allowed and encouraged to carry out her training fully during labour.
6. That all mothers should be encouraged to use natural childbirth for the benefit of themselves and their babies and that posters to this effect should be displayed at all antenatal clinics.
7. That the idea fostered by many medical people today that childbirth includes routine internal examinations, routine administration of analgesia, routine episiotomy should be dispelled.
8. As childbirth is not a disease it should take place in the home wherever possible. If impossible the maternity units should be homely and unfrightening and in no way connected with "hospital".16

16 National Childbirth Trust The Aims of the Natural Childbirth Association of Great Britain (1956)
In publishing its aims, the NCA hoped to establish a dialogue with the medical profession highlighting that women’s concerns went beyond the nebulous concept of safety and wellbeing perpetuated through the medical model of childbirth. As such, the aims did not merely express that women should be able to practice natural childbirth if they so desired, but also argued for the humane treatment of all women during their confinement, consideration of their wishes and, above all, respect for their capacity as mothers to act in the best interests of their offspring. In this sense, the NCA focused attention and placed import upon what might be considered the social aspects of childbirth, effectively defining them (and natural childbirth) in opposition to the medical. Stating unequivocally that childbirth was not a disease and ought not to be associated with hospital in anyway was bound to alienate those who worked on the maternity wards – midwives as well as doctors. Nonetheless, stirring up antagonism between the two sides was not the intention of the NCA. In one sense, notwithstanding Briance’s dedication to the teachings of Dick-Read, advocacy of natural childbirth was employed as a framework, which it was hoped would enable childbearing women more say in the treatment they received. Thus, the language of natural childbirth – expressed so eloquently in the aims of the NCA – provided childbearing women with the means to articulate their needs. Moreover, because the published aims of the NCA were based on mothers’ own experiences, a dialogue was being established that had the potential to change the maternity services and benefit future generations of mothers.

*Experience* formed a key part of the NCA’s teaching philosophy. Briance and the other founder members certainly felt that listening to women’s experiences – and, more
importantly, learning from them - was of enormous value to the development of maternity policy. Alongside the establishment of a lay-teaching network, some of the more radical (for the era) proposals made by Briance and NCA for the fostering of wider understanding and appreciation of Dick-Read’s methods included enrolling mothers who had experienced natural childbirth as teachers in NHS antenatal clinics and the publication of a list of doctors and midwives practiced in the method.\(^{17}\) It is not difficult to imagine that there were more than a few feathers ruffled in the maternity medical professions at this suggestion [see chapter Three, below]. Nonetheless, an article in the *Times* in the spring of 1959 announcing the organisation’s recently acquired charitable status (and a change in name, to the Natural Childbirth Trust), stressed the importance of ‘liaison with the medical profession’ and the need for ‘somewhere we can sit down across a table and put across that we are not a bunch of cranks’.\(^{18}\) It goes on to state:

> At the top of the agenda will be the question of seeking a closer understanding between those who prepare mothers and those who attend them in labour. Such teamwork is a vital key to a natural birth, for although a few women have enough will power, courage and self-control to practice what they have learned with minimum help for midwife or obstetrician, most rely upon the sympathetic and practical guidance of attendants to help them through.\(^{19}\)

It was this notion of cooperation with the medical profession that steered the direction of the NCT in its early years, as Jenny Kitzinger has shown. Kitzinger’s paper describes

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\(^{17}\) T.N.A: MH134/139 Ministry of Health Memorandum: ‘Press reports on the establishment of the Natural Childbirth Association’

* The professional response to the ideas promulgated by the NCA will be discussed in chapter 3, below.

\(^{18}\) *The Times* 13\(^{th}\) April 1959

\(^{19}\) Ibid.
how the NCT’s strategy to deflect criticism from medical professionals was initially to align itself with them. This meant emphasizing that NCT classes were merely ‘filling a gap’ in the NHS, rather than competing with it, playing down the role of teachers by referring to them as ‘just mothers’ and rejecting old wives tales in favour of the ‘forces of “truth”, “education” and “science”’.20 It is interesting that the NCT assumed the role of mediator in this way, rather than exerting greater pressure for change upon the maternity services, something they may have been in a position to do. Maternity care was long established as an issue of public health and, as the nation reflected on a decade of the NHS, there was a degree of currency in exactly the type of issues the NCT were addressing, especially given the growing emphasis upon the psychological aspects, initially raised by Maternity in Great Britain (1948). Nevertheless, the NCT’s reluctance to involve itself overtly in the politics of maternity care at this early stage can be explained by further analysis of their modus operandi in the late 1950s and early 1960s, which takes into consideration the development of the lay-teaching network and the way it responded to women’s perceived needs.

Fitting in and finding a role.

In an article featured in the July 2006 edition of New Digest (the NCT’s quarterly journal for workers in the field of maternity care) Gail Werkmeister, NCT President, in alluded to the trauma experienced by women giving birth in hospital in the 1950s. She writes:

The NCA rebellion against this ‘torture’ meant that our founder members were on a mission. They began to educate women about birth and ways of coping so it would not

20 J. Kitzinger (1990) p.102
be frightening and overwhelming. From the start, the desire for better treatment of women was also very much on the agenda. The founders wanted doctors and midwives to ‘humanise’ the process of having a baby.21 Werkmeister goes on to talk about the letters the NCT answered in response to women’s concerns and inquiries into Dick-Read’s techniques. The letters are described in the article – quoting Jeanne Langford – as ‘the first incarnation of childbirth education performed in the name of the NCA’.22 The founder members of the NCT undoubtedly felt they were on a mission to remove the veil of mystery that surrounded childbirth – many imply such sentiment was present in their work as antenatal teachers.23 As letters from women ‘poured in’ – increasing, it was claimed in the first edition of the NCT journal New Generation in 1967 from thirty to over five hundred every week – such missionary zeal was perhaps justifiable.24 The form it took, however, reflected something far more than a pragmatic reaction to the needs of childbearing women. It was, rather, bound with growing awareness in post-war society of the injustice of gender inequality, class-biased notions of betterment and the transformative power of education.

Reflecting on fifty years of the NCT, Gwen Rankin writes:

Emancipated by the Second World War, when the country could not have survived without women taking over the work that men (then fighting in Africa and Europe) usually do, we were quite reluctant to go back to obscurity and being ‘just housewives’.

We had a new strength and a new voice with confidence. Times had changed forever.

21 G. Werkmeister “Don’t forget the breathing! 50 years of NCT antenatal classes” NCT New Digest - July, 2006 pp.7-8
23 Based upon personal, unpublished accounts and interviews with former NCT founder members. Many, for example, expressed enthusiasm in doing something they felt was both worthwhile and groundbreaking. 24 Paula Davies “From Small Beginnings...” New Generation Vol. 1 No. 1 (October 1967)
The advent of reliable contraception made us free to control our fertility – and our attitude towards children changed as a result.25

The other NCT founders, she implies, shared such sentiments, successfully combining family life with teaching, campaigning and other administration duties for the NCT. Most, for example, conducted antenatal classes directly from their own homes, often in the evenings, hastily clearing away supper dishes, putting small children and babies to bed, and ushering husbands ‘out of the way’ into studies so that sitting rooms might be transformed into private, comfortable spaces for five or six expectant mothers to relax in. Several commented on the way in which antenatal teaching had provided them with new opportunities, hastening friendships that would last lifetimes, and allowing them to pursue what Deirdre Mackay described as ‘an absorbing and fulfilling occupation that is home-based and flexible hours so that it fits in with being a wife and mother’.26

Early NCT volunteers were also drawn to the voluntary aspect of antenatal teaching, and in this respect their actions fit into the wider context of voluntarism in post-war Britain. A study of women’s voluntary organisations in England and Wales by Caitriona Beaumont (2009) sheds light upon the significance of women’s voluntarism during this period. Through organisations such as the Women’s Institute (est. 1915), the Mothers Union (est. 1885) and the Towns Women’s Guilds (est. 1929), women were given the opportunity to make an important contribution to politics and public debate, campaigning specifically on the issues that affected them.27 Like the NCT, membership of

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25 By kind permission of Gwen Rankin (2006, unpublished)
26 By kind permission of Deidre Mackay (1997, unpublished)
27 C. Beaumont “Housewives, Worker and Citizens: Voluntary Women’s Organisations and the Campaign for Women’s Rights in England and Wales during the Post-War Period” in N. Crowson, M. Hilton & J.
mainstream women’s organisations was made up of full time housewives and mothers; it is likely that similar motivations encouraged their participation in these groups. The possibility of engendering social change was but one motivation: women’s organisations campaigned for a ‘range of social and economic rights including family allowances paid to mothers, free health care, good housing, provision of local services, equitable state pensions, adequate maternity services, and equal pay for women workers’. However, membership of a voluntary women’s organisation ‘with its rules, processes and procedures, gave large numbers of women the opportunity to learn about the democratic process whilst providing them with the vocabulary necessary to discuss concepts such as political participation and social rights’.

The outlet provided to women through the many voluntary organisations that were active during this period was significant, and was not limited to the mainstream organisations. It was reported in 1964 that ‘over 100 national women’s organisations made up of feminist and political groups, professional associations, religious bodies, and social and philanthropic organisations’ were in existence in Britain. Such organisations, according to Beaumont, ‘offered not just an outlet for the social, cultural and educational interests of members but an opportunity for women as equal citizens to influence and shape the future of British society’. Common interests and shared passions motivated the members of women’s organisations large and small, radical and conservative. As the

Mckay NGOs in Contemporary Britain: Non-State Actors in Society and Politics since 1945 (2009) pp.59-76
28 Ibid. p.63
29 Ibid. p.63
30 Ibid. p.59
97
example of the NCT shows, such groups brought women with shared ideals together, engaged them in activism and effectively created a force for change.

The ideals shared by Rankin et al were in many ways peculiarly middle-class (most of the founder members were middle-class, educated women, a couple also happened to be married to respected Oxbridge academics) they may not necessarily have been misplaced. Nevertheless, Rankin freely admits that as a group, the founder members of the NCA ‘must have been seen as a nutty lot! Middle class, starry-eyed by our own experiences, vocal, determined, all too eager to rush in where angels fear to tread...’31 A strongly held conviction in the power of education in engendering social change (Rankin later went on to teach sex education on behalf of the NCT in secondary schools across the UK) combined with a sense of middle-class responsibility, underpinned Rankin’s commitment to childbirth education. Others were similarly motivated; listening to the reminiscences of the founder members, one is struck by their readiness to defend the NCA’s middle-class origins. These women considered it their duty, no less, to use their position in society to engender change for all childbearing women, regardless of social class. In this sense parallels can be drawn to campaigning efforts of upper-middle class women for the universal availability of obstetric analgesia earlier in the century, and also with contemporary radical movements, such as CND. Indeed, as an example of what has been termed ‘middle-class radicalism’, the activities of the NCT stand out both because of its relevance to contemporary issues, and, paradoxically, its neglect by historians.32

32 See: F. Parkin Middle Class Radicalism: The Social Bases of the British Movement for Nuclear Disarmament (1968) Parkin, referring specifically to the middle class base of CND writes: ‘Where as working class radicalism could be said to be geared largely to reforms of an economic or material kind, the radicalism of the middle class is directed mainly to social reforms which are basically moral in content... Where the former holds the promise of benefits to one particular section of society (the working class) from
The women of the NCT appeared deeply committed to their cause, happy to make use of whatever resources they had available to further it, forfeiting time with their young families, inviting expectant mothers into their homes for antenatal classes, and drawing upon skills accrued prior to marriage and motherhood. They were, crucially, unwilling to accept the status quo; and they did not take kindly to setbacks: Rankin remembers the annoyance of founder members at the response of medical professionals to the NCA in the early days, and the incredulity they felt at this opposition toward what she describes as 'the obvious truth we promoted'.\(^{33}\) Clearly, nothing less than a revolution in attitudes toward women in labour was the goal of many of those who formed the NCA.\(^{34}\)

For all the revolutionary talk, however, the organisation remained relatively conservative in nature. A later recruit to the cause, Betty Parsons, a maternity nurse of Canadian origin, tempered the initial eagerness to engender change by revolutionary means, channelling the energy and enthusiasm of Briance, Rankin and the others into the expansion of the lay-teaching network and the development of the philosophy of childbirth education. Having lived and worked in London since the end of the Second World War, Parsons was aware of the attitudes of some doctors, obstetricians and midwives toward childbearing women, and was keen to use her skills and knowledge to change the way they were treated. However, she emphasised that changing attitudes took time, particularly when such attitudes were bolstered by training and status; she therefore

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which its won supporters are drawn, the latter envisages no rewards which will accrue to the middle class specifically, but only to society at large or to some under-privileged groups... It will be argued that the fact that the main pay-off for middle class radicals is that of a psychological or emotional kind — in satisfactions derived from expressing personal values in action' (p.2). In this sense one can identify important overlaps between the NCT and other examples of 'middle class radicalism' in Britain in the 1950s and 1960s.

\(^{33}\) G. Rankin (2006)

\(^{34}\) Ibid.
advised working alongside doctors and midwives, emphasising the importance of their role. Antenatal teachers would sit-in on Betty's classes, learning how she gave information, answered worries or queries, and taught the practical skills of breathing and relaxation. Learning by her example and with their own conviction in the value of childbirth education as a force for change, the first NCT teachers would, for example, provide their students with cards stating they had received antenatal preparation from the NCT and their desire to practice what they had learned in labour. These cards, it was intended, were to be presented to the ward sister upon arrival at hospital in order to avoid antagonism between the 'prepared patient' and those attending her. 35 In the words of Betty Parsons, NCT teachers had a duty 'to teach ways to ease tensions, not increase them'. 36

As this suggests, avoiding confrontation was crucial, not only for the purposes of furthering the ambitions of the Trust, but also for labouring women. Betty Parsons impressed upon other NCT teachers that what they were engaged in was not the teaching of obstetrics or midwifery. Rather, their objective was to teach women how to understand their bodies during labour and - crucially - to co-operate with the experienced professionals who shoulder the responsibilities for life and death. 37 Plainly aware of the concerns within midwifery that the organisation had the potential to undermine them professionally, though committed to improving childbirth, the NCT followed Parson's advice to refrain from criticism of the medical profession. 'Prove your

35 See J. Kitzinger (1990) p. 101
36 G. Rankin (2006)
37 Ibid.
point by teaching well', she insisted, 'and the women in labour will change medical attitudes'.

The idea that such a strategy was the best way to bring about change for the benefit of women has been criticised. Jenny Kitzinger argues that the NCT* played into the hands of the medical establishment by failing to challenge long-held assumptions about women’s weakness and vulnerability during pregnancy and birth [see above]. Kitzinger’s analysis asserts that in accepting that doctors maintain the right to control their patients’ access to NCT classes, the Trust played straight into the hands of the medical profession, promising ‘better patients’ indoctrinated to exercise obedience, self-control and co-operation throughout parturition. Nevertheless, there is little doubt that the NCT, at this point in its history, considered that in adopting this strategy, they were responding appropriately to the needs of women. This should not be misconstrued as mere naïveté, nor should it be regarded as missed opportunity. On the contrary, NCT members in the 1950s and early 1960s were acutely aware of the innovative nature of the work they were doing, and of the constraints placed upon them by broader societal attitudes, as well as those of the medical establishment. Thus, a letter from Betty Parsons to the Dick-Reads

38 Ibid.

* A further issue relating to the changes that occurred at the NCA in the late-1950s was the achievement of official charitable status in 1959. With this the Natural Childbirth Association was henceforth known as the Natural Childbirth Trust.
40 For example, a great deal of distaste was expressed toward childbirth in general in the mainstream media in the 1950s. Kitzinger (1990), notes how the popular press often portrayed birth as primitive, animalistic and degrading, whilst condemning the NCT’s discussion of childbirth and its invitation to male partners to view “slide shows”, accusing them of obscenity and exhibitionism. My own research has made similar findings. For example, a BBC radio broadcast on the Woman’s Hour programme in 1957 devoted to discussion of natural childbirth was preceded by the following warning to listeners: “We know this is a programme which may not appeal to all our listeners – but since childbirth is something which concerns so
dated February 7th, 1958 demonstrates how a strategic approach was employed in good faith, with the intention to bring about a shift in attitudes by more covert means:

This midwife and that doctor in hospital are becoming very interested, it will take a little time but it is bound to come. I have been doing a lot of underground work with the medical contacts I have from my own work and I find astonishing sympathy for natural childbirth...but staff problems are a very real difficulty – once the attitude toward allowing women to take a husband or friend with them into hospital is changed then the ball will roll swiftly. I am going up to Birmingham on Tuesday to speak at a meeting and I am going bring this matter up...very tactfully and very gently, but quite firmly... [with] gentle persuasion and [by] getting the powers that be to do what we want and make them think that they are following their own desires...I am sure we will reach our goal more quickly, by peaceful methods.41

It is perhaps worth mentioning the addition of hand written notes in the margins of the letter, most probably those of Dick-Read, which read: ‘Also to be borne in mind the question of this word “cult” used by Jeanne Neal in a letter to Mrs. Denbowitz and used by Nixon on television’.42 Being regarded as a ‘cult’, rather than a legitimate...
organisation was undoubtedly problematic in terms of the NCT’s image: there was real concern that many expectant mothers, burdened by anxieties about safety and access to pain relief, would be discouraged from joining such an organisation. Consequently, the NCT had no choice but to sell itself as an organisation in touch with the values of the medical profession, but with the specific needs of childbearing women as its governing concern. With this in mind, the NCT quarterly newsletter in the summer of 1958 refers, for example, to a meeting of the Oxford University Medical Society, at which Dick-Read spoke and showed his film. The meeting was reportedly ‘crowded with midwives, doctors, medical students, physiotherapists, young married couples and undergraduates...’ All very respectable, and not the slightest bit “cultish”! Indeed, the newsletter provides us with an excellent example of the NCT’s mediatory stance: following the report of the Oxford University meeting, one’s attention is drawn to news of an article in the Woman’s page of the Oxford Mail which ‘attracted a great deal of attention’ and ‘requests for speakers on natural childbirth from local women’s organisations’.

Similarly, the accounts of labour contained within the newsletter appear to have been selected specifically because their content supported the NCT’s cooperative ethos. Consider, for example, the experience of Mrs. Anne Bartholemew of West London:

The hospital staff were sympathetic and helpful in enabling the mother to carry out her training, and she found herself able to relax fairly easily if she concentrated on the correct breathing, but if she failed to breath properly with the contraction, it was difficult to

43 Parsons left the NCT in the 1960s.
44 W.T.L: PP/GDR/D.248  NCT Newsletter, Summer, 1958
45 Ibid.
maintain a relaxed state. Two injections of pethidine were given during the first stage, which became difficult for the last four or five hours, but the mother recognised the transition period and enjoyed every minute of the second stage. Her husband was not allowed to be present at the birth, but came in soon after...The mother went to classes with a fear of childbirth implanted by many horror stories, but the confidence given her by her training helped to make childbirth a happy experience.\(^{46}\)

In much the same way, another account of labour — that of Jean Bartlett, an NCT member from South West London — contains the same message of the importance of self-motivated training and practice in natural childbirth techniques alongside cooperation with the medical staff, although her experience was rather different:

This baby was in a difficult posterior position, about which the mother had been told...In spite of not fully understanding the unusual course of her labour the philosophy of natural childbirth enabled this mother to remain patient and relaxed until the end of the long first stage. The continuous presence of her husband (properly educated in natural childbirth) and the home surrounding were an immense help...Her training had enabled her to establish confidence in her attendants, so that she was able to rely on their methods of delivery, though different from those for which she had been prepared...This labour would undoubtedly have been an ordeal without the natural childbirth preparation.\(^{47}\)

The labour reports send a clear message about the NCT's specific aims; the word propaganda is perhaps a little strong, but there is, nevertheless, little doubt about the intentions of the Trust in publishing them. These accounts of labour and delivery also

\(^{46}\) Ibid.
\(^{47}\) Ibid.
demonstrate, albeit implicitly, the continued influence of Dick-Read’s method, which remained an over-arching force on the Trust in the early years. Briance maintained her commitment to Dick-Read, writing to the Minister of Health:

‘There can only be one method of natural childbirth, anything else would unnatural.’\(^{48}\)

All I ask is that those mothers who wish to use this method should be allowed to and encouraged and that the maternity services should have their eyes opened to it and know how to deal with it.\(^{49}\)

By the early 1960s, however, there were those in the NCT who felt that strict adherence to his principles was not advantageous, either to the development of the Trust as an organisation in the future or for the promotion of natural childbirth for the benefit of childbearing women.

Changing strategies.

Dick-Read died, aged sixty-nine, on the 11\(^{th}\) of June 1959. A leaflet printed by the NCT for a reception held in celebration of the centenary of his birth in October 1990 makes the following statement about his contribution to the development of the Trust:

Sadly, the NCT had the benefit of Dick-Read’s personal advice for just three years, but thirty years on his ideas remain fundamental to the organisation’s philosophy. The NCT has become accepted within the NIIS, yet the ideas of Dick-Read and his successors are still not well understood by many providers of mainstream maternity care.\(^{50}\)

\(^{48}\) T.N.A: MH134/139 Midwifery/Natural Childbirth/Dr. Dick-Read’s Method Prunella Briance to the Minister of Health, c. 1959

\(^{49}\) Ibid.

\(^{50}\) NCT A Reception to celebrate the centenary of the birth of the 20\(^{th}\) century pioneer of natural childbirth and first President of the National Childbirth Trust Dr. Grantly Dick-Read, 1890-1959. (1990) By kind permission of E. Hutton.
This statement sums up well the relationship between the NCT and the ideas of Dick-Read. The man appears to have been revered by the Trust on the one hand for the contribution he made to the field – reverence that extended beyond that of Briance and Jessica Dick-Read as this letter to Dick-Read from Edwina Savernake, speaking on behalf of the NCT governing committee, suggests:

The committee is unanimous in [its] hope that you will honour the Association by consenting to be re-appointed president. As the pioneer in the field your name means so much to the cause of normal childbirth.\(^5\)

The NCT were indeed deeply indebted to Dick-Read and his challenge to the treatment of childbirth as a taboo subject – the concept of childbirth education. On the other hand, by the early 1960s, steps were already being taken by the NCT to distance themselves from certain aspects of his philosophy.

Ostensibly, the placing of distance between the NCT and the Dick-Read method occurred because it was felt that the needs of women would be better responded to through the adoption of newer techniques. However, there are suggestions that certain elements within the NCT considered Dick-Read’s approach tainted by the brush of eugenics.\(^5\) Briance herself remained committed to the idea that ‘babies born this way are better babies’ well into the late 1950s, stating in the second NCA newsletter in March 1957: ‘we urgently need in Britain a race of good quality men and women’.\(^5\) However, rhetoric about production of stronger, healthier and more intelligent offspring for the benefit of the future ‘British race’ had far less appeal in the 1950s and 1960s than in the

\(^{51}\) W.T.L: PP/GDR/D.248 Edwina Savernake to Dick-Read, September 1958
\(^{52}\) See: Chapter One, above.
decades before the Second World War. Although it is merely hinted at in the evidence, the association of Dick-Read with theories on 'positive' or reform eugenics is plausible. Moscucci's paper exploring the origins of concepts of natural childbirth asserts that 'the development of "natural childbirth" owed much to the activities of physicians and health professionals who were in sympathy with the aims of reform eugenics'. In the 1950s and 1960s these activities fell out of favour amongst the scientific community; as such association with them was unlikely to have fitted in with the NCT's efforts to gain acceptance from the medical profession.

From a more practical perspective there were those, both within and outside of the NCT, who considered Dick-Read's approach somewhat out-dated, paternalistic, and elitist. Thus, the enthusiasm for his method quickly dissipated for some key aspects of the NCT membership. The initial fervour was replaced by much disappointment and soul searching that more had not been achieved in the first few years of the Trust's existence to improve childbirth for more women. Others perhaps approved of his methods, but

54 Ibid pp. 122-123
56 According to the frank recollections of one former member, several NCT teachers by this stage felt reticent as to the practical value and application of Dick-Read's methods and theories to the majority of mothers. Having personally experienced a Dick-Read birth – one of her children was delivered 'by the man himself' – she felt that his theories rested too much on his personality; perhaps more could be achieved in making natural childbirth relevant to more women by teaching other methods of coping with labour pain, such as breathing and relaxation techniques, rather than by focusing on Dick-Read himself. She requested that her views on this subject remain anonymous. It is interesting to contrast the views expressed here with those of Briance, who deeply regretted never having experienced the technique herself. In the early 1960s, those NCT members who perhaps felt Dick-Read's personality imposed a little too strongly on the NCT ethos tested Briance's essentially 'blind faith' in his methods; she nevertheless remained convinced of the integrity of Dick-Read's natural childbirth. Experience, it is argued here, was a key aspect of NCT teaching; Briance's lack of it in relation to the Dick-Read method is thus incongruous. It does, however, go some way toward helping us to understand why she failed to remain a key figure in the organisation as it progressed throughout the 1960s. See also: S. Kitzinger The Politics of Birth, Chapter Six (2005) pp. 45-55.
were cautious about accepting the implications of references to natural childbirth 'training': if childbirth was to be considered 'natural', did this not negate the need for 'training'? Such a line of enquiry had the potential to undermine completely the work of the NCT. As Eileen Montgomery was to point out in her childbirth manual published in the 1960s, 'natural birth often occurs spontaneously in untrained women and a few of those who have been trained need medical assistance in labour'. Given such contradictions, it was becoming clear that blindly following the teachings of Dick-Read, as Briance had, was proving unhelpful to the ambitions of the NCT. For some at the Trust, new, less controversial approach to childbirth preparation was desirable if they were to appeal to more women, and, crucially to be taken seriously by the medical profession. By the 1960s, the NCT was keen to expand its horizons beyond the promotion of Dick-Read's principles of natural childbirth.

Naturally this caused a great deal of conflict within the organisation itself. Antagonism between those committed to Dick-Read's teachings, such as founder Prunella Briance, and those who saw the benefit of promoting other methods, had begun to manifest itself early in the NCT's history. Around the time that the NCT gained charitable status in 1959, a rift was already beginning to develop between Briance, unwavering in her loyalty to Dick-Read's natural childbirth, and the newly formed official NCT Committee. In the words of Jenny Kitzinger:

Briance's views of the NCT's objectives were very different from those of the committee that eventually became responsible for running the NCT. Unconvinced that

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57 E. Montgomery *At Your Best for Birth and Later* (1969) p.12
Dick-Read offered the only correct method of natural childbirth, the committee preferred to develop another approach.\textsuperscript{58} This new approach, aimed at obtaining the blessing of health professionals, included — significantly — the appointment of an obstetrician as chairperson, and signified a clearly defined change in direction away from the teachings of Dick-Read.

The NCT in the 1960s.

When the NCT was invited to advise the Royal Commission on Medical Education (RCME) on antenatal preparation for childbirth in 1964, the implications of this shift in loyalties was self-evident.\textsuperscript{59} The publications list given to the RCME by the NCT recommended several books based upon the psychoprophylactic method above those by Grantly Dick-Read.\textsuperscript{60} Interestingly, the techniques recommended by these books were regarded as more acceptable to the medical profession because:

One of the more important aspects of psychoprophylaxis is that it teaches that abnormalities may occur and also that labour may be painful, and amongst women who practise psychoprophylaxis there is a ready acceptance of analgesia if labour becomes more painful than they anticipated.\textsuperscript{61}

Popularising concepts of natural birth by securing mainstream acceptance through the establishment of a dialogue with health professionals was clearly part of the NCT’s agenda by this stage. It is significant that the NCT recommended several books by

\textsuperscript{58} J. Kitzinger (1990) p.94
\textsuperscript{59} NCT Newsletter No.3, Autumn 1957 p.2
\textsuperscript{60} J. Kitzinger (1990) p.94
\textsuperscript{61} G. Bourne Pregnancy (1972) p.539
obstetricians to the RCME, such as Elliot Philipp and William Nixon, as well as physiotherapist Helen Heardman and midwife Erna Wright. The NCT obviously considered endorsement of this nature helpful to its cause and it is certainly plausible that the methods advocated by these books were considered more practical, easier to teach and follow, and, importantly, more suited to birth in hospital. According to Wright, who joined the NCT in 1960, such methods prepared women more fully for the type of experience they were likely to have whilst in labour and when giving birth. She states in *Easy Childbirth*, a pamphlet co-authored by the obstetrician Elliot Philipp and published by the British Medical Association (c.1960) her belief that ‘we can condition ourselves to accept most sensations and can find them pleasant so long as we know they have real purpose and are helped to limit their intensity’. Under the influence of Wright, NCT teachers passed onto the expectant parents in their classes the benefits of conditioning the mind and exercising control over the pain of contractions. Breathing exercises and disassociation techniques, based upon Lamaze's method of painless childbirth, now formed the basis of NCT antenatal classes. An expectant mother attending NCT classes in the 1960s could expect to perform a ‘rehearsal of labour’ and was able to consider herself sufficiently ‘well-trained and confident’ to ‘produce her baby by her own efforts, safely and easily’.

As we have seen, the shift toward teaching psychoprophylaxis, or the Lamaze method, occurred at a time that marked a conscious change of image for the NCT. In 1960

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62 The National Archives, (ED 129/27), Royal Commission on Medical Education (RCME (WE) 5), NCT (Feb. 1964)
63 Elliot Philip & Erna Wright *Easy Childbirth: A Family Doctor Booklet* (c.1960) p.1
64 Ibid.
Briance left England for the United States; subsequently, the NCT took steps to sideline Dick-Read's method in its teaching. An article in *Physiotherapy* magazine from May 1967 notes that 'whilst giving credit to the Englishman Dick-Read for his practical pioneer work, much of his theory was swept aside'. Subsequently, it was felt that the word 'natural' was problematic for the future ambitions of the Trust – ironic given that the endorsement of natural childbirth was the organisation's primary *raison d'être*. Former NCT teacher and founder member Amber Lloyd recalls that many of her students came to NCT classes seeking a natural childbirth: 'the word “natural” was used a lot, both by teachers and students'. Nevertheless, she goes on to describe a meeting of area organisers in the early 1960s, at which the appropriateness of the term 'natural' was being discussed:

> It came up in the discussion: “We’re called the NCT, but is it right for us to call ourselves Natural Childbirth when what we are teaching people isn’t natural, its psychoprophylaxis?” The discussion went on, and we said, “Well what can we do, because everyone knows us as NCT, but we’re not Natural?” I don’t know why, because I am normally a very shy person in group, but I stood up and said, “Well why not ‘National’?” … You see, we were teaching people something that wasn’t Natural, it was something else.

The adoption of the title 'National Childbirth Trust' was definitely intended to broaden its appeal amongst expectant mothers and, more importantly, the medical profession. However, there was by no means agreement across the membership that the change was

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66 Amber Lloyd (Interviewed 28th March 2007)
entirely advantageous to the Trust's objectives. Prunella Briance took the name change particularly badly, especially because the decision was made in her absence and without taking her views into consideration. In 1990 she wrote in the NCT journal New Generation: 'It was decided at an area organisers' meeting in 1961 to change the word “Natural” to “National” because doctors were reported to be offended by the original wording. I very much doubt if the more assertive women of the 1990s would succumb to such a suggestion'.

Certainly, the word 'natural' was contentious insofar as it was seen to alienate some members of the medical profession, something the NCT were keen to avoid. Having met with negative reactions from the medical profession in its early days [see Chapter Three, below] the NCT, under the influence of its new president, founder member Phillipa Micklethwaite, counselled patience and politeness, rather than conflict in future relations with doctors and midwives. Being labelled crusaders for natural childbirth, the NCT risked being seen as 'trouble makers' bent upon attacking the medical profession. Removing the word 'natural', it was felt, helped to facilitate relations with the medical profession; as founder member Gwen Rankin remembered: 'we wanted to win through by working alongside doctors and midwives, not in opposition to them'. Not everyone at the NCT felt that this was the best way to improve childbirth for women, and debate over the use of the term ‘natural’ in relation to the NCT's activities continued for decades.

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68 Following the years of bitter conflict that the name change underscored, the distance between Briance and the NCT grew with the NCT pursuing different kinds of teaching and Briance continuing her own work alongside Jessica Dick-Read under the name “The Dick-Read School of Natural Birth” offering private antenatal preparation.
69 New Generation (September 1990) p.5
70 Gwen Rankin (private papers, with kind permission)
between the more 'radical' elements of the NCT's membership and those who toed the party line. Some 30 years later, in an article in the NCT's New Generation magazine by NCT tutor, Wendy Jackson addressed the situation thus:

How often have you heard people say, "No, we're the National Childbirth Trust, not the Natural Childbirth Trust" as though there were something wrong with being natural. By attempting not to offend anybody it appears to me that I sometimes need to become an apologist for a system that is not in the interests of women giving birth.  

But what about childbearing women, the very people whom the NCT claimed to represent? How did they feel about the change of name, and was it in their interests? Because the initials of the Trust remained the same, it could be argued that the impact of the change from 'Natural' to National' on public perceptions of the NCT was minimal. It is of course possible that some women could have been put off by the term 'natural' because of what it implied, but for those who already subscribed to the ideas represented by the NCT, the change in name was largely irrelevant. Perceptions of natural childbirth and the NCT will be discussed in detail later in this thesis. At this point, however, it is of interest to note how many women used the term 'natural' when looking back on their experiences of NCT classes in the late-1950s and 1960s, even after the Trust's change in name and direction [See Chapter Five, below]. In the minds of many, it seemed, the NCT would always be associated with the term 'natural' childbirth. Interestingly, a few of the women who participated in Mass Observation research in the 1990s mentioned the NCT change of name in their responses. 'Natural – so much better!' wrote one, whilst another  

71 New Generation (December 1990) p.5
was unable to remember whether it was ‘National’ or ‘Natural’ Childbirth Trust, but seemed to prefer ‘Natural’. 72

It was, one might suggest, the association with natural childbirth that drew women to the NCT, regardless of its title. It would appear that the impact of the name change was as negligible in practical terms to those teaching on behalf of the NCT as it was to those expectant parents attending antenatal classes. For although the breathing and relaxation techniques might have changed to reflect the NCT’s change of allegiance from the Dick-Read method to psychoprophylaxis, the Trust’s basic ethos – indeed the fundamental premise of childbirth education – had not. Moreover, in spite of specific guidelines, much of what the NCT taught in their classes depended a great deal on the individual teacher’s beliefs, attitude and experience. Minutes of NCT committee meetings point to a degree of centralisation at the Trust; however, teachers were keen to retain some independence. Lois Williams, an area organiser from Sidcup, Kent, suggested at a meeting in 1961 that ‘too great a restriction was put upon individuals if all decisions were to go to the committee’. 73

The NCT was run, from the early 1960s, from an office in central London, nicknamed ‘Head Quarters’; prior to this, private homes had been used both to teach classes and coordinate the organisation’s activities. 74 Funds from subscriptions and private donations made rental of the premises on Seymour Street in London’s Marble Arch a possibility.

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73 NCT: Executive Minutes (January 26th 1961)

74 See Appendix II for details on the membership and structure of the NCT in the 1960s.
Monthly committee meetings were held here, and 'helpers' and 'Area Organisers' (AOs) from around the country would attend these meetings and also regular teaching seminars. Local 'branches' of the NCT were run on a voluntary basis by helpers, overseen by AOs. Regular correspondence took place between 'HQ' and the local branches, and this, along with meetings and seminars, helped established a certain degree of uniformity in teaching methods.

However, when a proposal was put forward in 1968 to publish an NCT 'handbook' detailing the activities of the Trust, there is evidence of reservations concerning a chapter on a 'typical course', indicating important differences in teaching approach. It was argued by Phillipa Micklethwait, the then president of the NCT, that 'a course could not be set down in this way'. There were, she continued: 'varying approaches to teaching, and if a course were outlined too definitely it could have undesirable results such as allowing people to think that a course must contain all the exercises and lectures mentioned, or that this was the only way of preparation for childbirth which the Trust promoted'. 75 This statement suggests that different approaches to antenatal teaching were accepted during the 1960s. Nevertheless, such a situation produced varying degrees of discord in the Trust throughout the decade, as can be deduced from the stories of several former NCT teachers. The influence of Betty Parsons, for example, has already been noted, but other figures, such as Erna Wright, Phillipa Micklethwait and Sheila Kitzinger were also to have significant impact upon the development of the NCT.

75 NCT: Executive Minutes (June 26th 1968)
Although Jenny Kitzinger is critical of the strategies developed in the 1960s, which she argues ‘severely restricted the development of alternative theoretical approaches to the childbirth issue’, different methods of teaching and approaches to childbirth preparation did apparently continue to flourish. Judging from the accounts of former NCT teachers, subtle yet significant variances in teaching style and approach functioned within the narrow confines of NCT bureaucracy; the existence of conflict within the Trust serves to vindicate this assumption. Consideration of these individual contributions dispels the myth that the NCT was a homogenous association – at least during this period – or indeed that it was, despite its best efforts, representative of a movement with well-defined and cohesive objectives. For example, Deirdre Mackay, a former NCT teacher based in Cheshire, remembers:

Within the Trust ...there were occasions when I was criticised and ridiculed; I was trained by Sylvia Close whose practical knowledge and confidence-giving teaching was way ahead of many other teachers. Those teachers disapproved that I taught mothers that they needed to be upright and ambulant in labour, they should avoid routine giving of pethidine (up to 700mgs at one hospital) and many other such examples that are now a natural part of our classes. I was criticised by my assessors when becoming an Advanced Teacher for wasting mothers’ time giving them hints on how to cope with backache labour when a maximum dose of pethidine was what would solve their problem – ‘I was dangerously close to rocking the perilous boat of the Trust’s relationship with hospital staff’!\(^76\)

\(^76\) Deirdre Mackay *Forty Years in the Life of Deirdre Mackay* (unpublished, 2006) By kind permission of Deirdre Mackay.
This is not to say that the NCT did not go to great lengths to ensure consistency in its teaching, often criticising and sometimes rejecting those who ‘did not toe the line in terms of beliefs or life-style’.\textsuperscript{77} In addition to regular meetings and correspondence between HQ and local branches, the NCT also employed its monthly members’ newsletter as a means of establishing cohesion amongst its membership. The newsletters functioned as a source of information, updating helpers and AOs as to the Trust’s activities. Newsletters listed local events, such as film screenings, conferences and teaching seminars, and kept members informed about what was going on in other local areas, as well as at HQ. They also served as a means of communicating NCT strategy. For example, newsletter No.7 (Autumn 1960-Spring 1961) stated that reports from AO indicated a ‘slow but real improvement in relations with the maternity services’. Letters to the Trust indicated, it was claimed, ‘increased friendship and support from doctors and midwives, etc.’ An increase in ‘doctors and other members of the medical profession’ applying for membership of NCT was also reported. The strategy of cooperation with the medical profession, which was regarded a key to the Trust’s acceptance as a significant voice in the childbirth debate, was thus conveyed.

Reports of the births of former class attendees were another important means of standardising teaching [see above]. Three or four such ‘birth accounts’ were printed in every newsletter, and in some ways they served to provide teachers with a ‘blueprint’ of prepared childbirth. Although each account was different, there were similarities and issues such as cooperation were always emphasised. For example, in her account of the birth of her first baby, Mrs. C Darmandy from Caithness reiterated the principle of

\begin{footnote}
\textsuperscript{77} Kitzinger \textit{The Politics of Birth} (2005) p.49
\end{footnote}
cooperation with the medical staff. She wrote of an initial ‘battle’ with her GP over the issue of her husband being present during her confinement, but stressed that it was only after ‘obtaining permission from the matron’ that she and her husband were allowed to share the experience. Clear messages were therefore communicated via the newsletters about what was and what was not acceptable when preparing women for childbirth. For example, the NCT ‘rule’ that any member offering instruction to an expectant mother must first get the permission of the woman’s doctor or midwife was both implicitly and explicitly maintained in this way.

Still, many teachers drew upon their own skills and experience for their antenatal teaching. Mackay had trained as an obstetric physiotherapist prior to becoming an NCT teacher in 1965. She was also deeply influenced by Sylvia Close, an NCT tutor renowned for her ‘gentle assertiveness training and loving caring attitude’ as well as for her approach, which focused upon remaining active and upright during labour.78 In contrast, Erna Wright, whose personality is described by Gwen Rankin as ‘belligerent and dynamic’, brought to the NCT her training in midwifery and her steadfast belief in the benefits of psychoprophylaxis.79 These factors manifested themselves in Wright’s teaching, which, whilst it was not everyone at the Trust’s taste, represented a dynamic

78 Deirdre Mackay Mid-Cheshire NCT – How it all Began (1991) By kind permission of Deidre Mackay .
79 The NCT made much of the recruitment of “midwife” Wright, clearly regarding her professional status as endorsement of its position with regards the medical maternity services. However, in 1967 it was revealed in the press that Wright had not completed her training and therefore could not properly be called a “qualified” midwife. The Trust defended Wright, arguing that she was being presented as a scapegoat for the ‘infighting and bickering’ between the NCT and the Central Midwives Board that was occurring as a result of the concern that proponents of natural childbirth were encroaching upon midwifery. In 1967, Barbara Entwistle, the then Supervisor of Midwives, asked in an internal CMB memo, ‘What action can be taken against these handy-women who are seeking to encroach on the midwifery profession?’ [T.N.A:DVSl1218 Records of the Central Midwives Board Memorandum re: training of NCT teachers, B. Entwistle c.1967] With the public upbraiding of Wright, it would seem she got her answer.
‘no-nonsense’ approach to childbirth education. Used to Close’s compassionate teaching methods, Mackay described her shock upon attending a course run by Wright and another teacher, Ruth Forbes: ‘I heard aggression, fighting with the medical profession, no attention paid to the baby, and certainly no class reunions (you’re a teacher – that’s not your job).’\(^8^0\) Thus, although a particular teaching method may have been advocated by those at ‘Headquarters’, a degree of dissent was evident at grass-roots level, judging from the reminiscences of former NCT teachers.

Often it was the experience of being exposed to natural childbirth through reading, giving birth and dealing with the negative attitudes of the medical profession, as well as ‘official’ training from the NCT, which shaped teachers’ philosophy and methodology. It must be remembered that NCT teachers were volunteers in the early days, mothers of young children who drawn to helping other mothers due to an interest in and enthusiasm for natural childbirth methods. Many local classes started informally – mothers and mothers-to-be chatting over cups of tea, showing one another films, and sharing books – as well as advice and experiences. Lois Williams, for example, was deeply influenced by a number of factors surrounding her experiences of pregnancy and childbirth, and felt compelled to help other expectant mothers as a result. She remembers, somewhat wryly, the birth of her second child – and her second attempt at following the Dick-Read method, much to the displeasure of the maternity ward staff. A former stage actress, Williams chose to record the experience thus:

\[^8^0\] D. Mackay *Mid-Cheshire NCT – How it All Began.* (Unpublished memoir, 1991)
Scene: A maternity home at Hampton Court, January 1956. Still have shave, bath and enema despite strong labour. Newly delivered mothers are wheeled back in to the ward, saying ‘Never again!’ I find out why once in the labour ward.

Senior Midwife: (large and loud-voiced) “Take the Gas and Air!”

Lois: (in the middle of a strong contraction, doesn’t answer)

Senior Midwife: (poking me hard on the shoulder) “Didn’t you hear what I said?”

Lois: (amazed at this woman) “I’m alright at the moment, thanks.”

Senior Midwife: (huffy) “Well, it’s there!” And she marches, heavily, out of the room.

For the next hour or so the ward is full of nurses coming and going. Each time they pass the bed they catch it with their hips which jars me. They are laughing and telling each other stories about the New Year party held the previous evening. Concentration is very difficult but I quite unable to summon energy/courage to ask them to be quiet. Am just managing the breathing and relaxation — lying, eyes closed, when, Enter the Dragon.

Senior Midwife: (clapping me on the shoulder) “And what’s the matter with you then, eh? Given up the ghost?”

Lois: “I’m trying to relax.”

Senior Midwife: “You’re what?” (Laughing heartily) “Did you hear that?” (to the nurses, who giggle) “She thinks she can relax — No, my dear, we have to pay for our pleasures.

That does it; control goes; gas and air is grabbed, and I am crying with anger and pain, and floating somewhere, hazily, miserably, while the Dragon shouts at me. Adam is born safe and sound and beautiful, but I am weeping for us both.81

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81 L. Williams Experiences of Childbirth: 1950-1962 (unpublished) By kind permission of Lois Williams
Undoubtedly Williams, like many others at the NCT drew upon these experiences when teaching women how to prepare for childbirth. What made NCT antenatal classes unique was that when teachers were instructing expectant mothers on the many aspects of childbirth – how labour starts, what their bodies were doing whilst in labour, what to expect upon arrival at hospital, how to deal with staff, etc. – as well as teaching them the techniques of breathing and relaxation to help them cope with the pain, they were very often doing so from personal experience. However, in addition to imparting the knowledge they had gained through their experience and training, NCT teachers provided an information service, the principal aim of which was to reassure expectant mothers and direct them toward the appropriate self-help techniques to see them through labour and childbirth. To this end, teachers would also respond to feedback from their students: Gwen Rankin, for example, requested the women she taught write down ‘warts and all’ birth stories, ‘not a platitudinous vote of thanks, but a constructive criticism of the classes and their worth – and I got it!’\textsuperscript{82} Rankin greatly valued the feedback she received, she is adamant today that it was much more important than any ‘method’ of natural childbirth. Hence, when it became apparent to her that the regimented breathing patterns that were a feature of psychoprophylactic preparation for birth were not suitable for every woman, she modified her classes in response.\textsuperscript{83}

\textsuperscript{82} Cited in G. Werkmeister “Don’t Forget the Breathing” \textit{NCT New Digest} (July 2006)

\textsuperscript{83} G. Rankin (Interviewed 5\textsuperscript{th} December 2006)
For many teachers, including Rankin, the most important aspect of any kind of childbirth preparation was ‘making it relevant’. Sheila Kitzinger, who taught NCT classes in the 1950s and 1960s, claims to have never used the term ‘natural childbirth’, considering it open to too much misunderstanding. Drawing upon her training as a social anthropologist, and her theories on birth as an expression of culture, Kitzinger’s classes were based more upon the ‘emotional and relationship aspects of the experience’, rather than focused exclusively upon relaxation and what happens in labour. In fact, Kitzinger remembers that she preferred to omit the teaching of exercises altogether. ‘We did the breathing’ she recalls, ‘but mostly we talked about what we thought about birth, what our expectations were.’ Rankin describes the way in which Kitzinger would also demonstrate to her students how breathing and relaxation could be effective in dealing with pain. She did this by squeezing the arms or inner thighs of expectant mothers (and fathers!), gradually increasing the pressure until it became unbearably painful. She would then instruct her subjects to begin breathing deeply, encouraging relaxation, and she would squeeze again; this time the pain would be lessened. By demonstrating the relationship between pain and breathing in this practical way, Sheila ensured her students understood the relevance of their preparation and would, in turn, have the confidence to use it during labour.

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84 Ibid.
86 S. Kitzinger (Interviewed 8th April 2005)
87 Ibid.
88 G. Rankin (5th December 2006)
89 Apparently Kitzinger performed this technique upon the men who attended her classes in order to demonstrate the male attitude to pain and to reassure women that they were indeed naturally better equipped to cope with the pain of childbirth than men. Rankin describes how the men would put up a show of bravado at first, claiming not to need the breathing techniques, then would scream in agony as Kitzinger (who was a strongly built woman) increased the pressure!
NCT teachers clearly demonstrated a large degree of pragmatism and practicality in their teaching and, hence, in their promotion of the techniques of natural childbirth. This was in spite of the influence of strong personalities, such as Erna Wright or Betty Parsons, who, according to some founder members, tried to steer the Trust in a particular direction. A degree of diversity was vital for the NCT’s future development, particularly as its reach began to spread beyond the South East of England where it originated. NCT teachers encountered a variety of attitudes toward natural childbirth, and regional classes, such as those offered in Cheshire by Deirdre Mackay, were ‘slow to get going’, the hospitals ‘suspicious’. Furthermore, changes in society, triggered by factors such as immigration, also demanded a more sensitive and adaptable approach to teaching about natural childbirth. Mackay recalls the embarrassment she felt when one couple she taught invited her to dinner at their home shortly after their baby was born: ‘During the course of the meal I discovered that she was a Dutch West Indian whose knowledge of medical English terms was minimal, and she asked me “I’ve always wondered – what is the pelvic floor?”’.  

Facing New Challenges.

Another challenge the NCT faced was that the issues affecting childbearing women had changed, yet again. The recommended rate of 70 percent for hospital confinements was reached in 1965, despite the increase in the birth rate. By 1968, the rate was around 80

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⁹⁰ Deirdre Mackay *Mid-Cheshire NCT – How it All Began* (unpublished memoir, 1991)  
⁹¹ Ibid.
percent. The recommendation of the Peel Committee in 1970 that 100 percent of births should take place in hospital, and that ‘small isolated obstetric units should be replaced by larger consultant led and general practitioner units in general hospitals’ signalled the dawning of a new era for maternity service provision, the end result of two decades of indoctrination to the medical definition of childbearing as a pathological process.

Having steadfastly maintained a non-confrontational position with respect to the medical profession throughout the 1950s and 1960s, the realisation that many members were dissatisfied with the medical care they received led the NCT to ‘revert to a less conciliatory stance’.

Before 1970, the NCT was a proactive organisation, defining natural childbirth in positive terms. Moreover, the methods and techniques were something that were intended to be combined with more conventional, medical techniques – the use of analgesic drugs, for example. However, as discontent grew amongst women with their treatment under the NHS system of childbirth, the NCT was forced to confront issues such as the practice of excluding fathers from the delivery room, the appropriateness of hospital routines such as shaving and enema, lack of privacy and emotional support, and the indiscriminate use of drugs and technologies that were increasingly becoming part of the experience of giving birth for most women. The routinisation of medical intervention was arguably, by this stage, a fait accompli; the changes such issues represented put the

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93 Ibid.
94 Ibid.
95 Indeed, pain relief was still a big issue: by 1970 97 percent of women giving birth in the UK were given some form of analgesia. See: J. Moorhead & NCT New Generations: Forty Years of Birth in Britain (1996) p.32
NCT in a somewhat awkward position. Could the NCT really claim to have been an influential force on the maternity services, given the way the NHS system of childbirth had developed by the early-1970s, and what did this say about the strategies employed by the Trust throughout the previous decade?

If anything, birth under the NHS had become more, not less, medically defined and women were apparently less satisfied with their experience than ever before. The question of whether NCT classes helped women cope with the experiences they were likely to encounter giving birth under the NHS was raised, both by critics and those within the organisation. Sheila Kitzinger questions whether the NCT was really equipped to deal with these issues in the late 1960s and early 1970s. Its antenatal classes were, in the early days, essentially didactic: 'You relaxed, you breathed and received a large dose of reassurance, or practised conditioning exercises that trained you to react automatically to signals, and that was it'.

However, because of the way maternity care had developed by the 1970s, the NCT was forced to re-evaluate its approach. The Trust increasingly focused on its campaigning efforts, forging relations with the press to highlight issues such as induction of labour (the rate of which had increased from 8.9 percent to 38.9 percent in a decade by 1974). A growing interest in home birth was also registered by the Trust; the Epping Forest NCT branch held a home birth study day in 1975, for example. The NCT continued to provide antenatal education, which remained the cornerstone of its philosophy. Yet it was force

96 S. Kitzinger The Politics of Birth (2005) p.48
to re-evaluate its relationship with the medical profession, and henceforth, its approach to teaching.

As will be discussed in Chapter Three [below], following a brief flurry of interest in concepts of natural childbirth in the 1950s and 1960s, for various reasons the medical profession abandoned its interest in the issues the NCT stood for, and the gap between mainstream and alternative became an ever-widening chasm. Partly this was due to the increased influence of technology and the growing dominance of medical specialisations – such as obstetric anaesthetics – in the delivery room, but it was also because understanding of natural childbirth itself had changed. Thus, as birth became increasingly medicalised, natural childbirth in response came to be defined in negative terms – in terms not of what it was, but what it was not.

Sheila Kitzinger, in a passage from her book The Politics of Birth (2005) alludes to this shift in meaning, and to the sense of disillusionment with the medical profession that accompanied it:

As time went on, the language I used changed. I deleted many words and phrases [from my teaching] progressively over the years; references to ‘old wives’ tales’, for example. Now I value the stories handed down from mother to daughter, and my real suspicion is likely to be about ‘obstetricians’ tales’. 97

By continuing to align itself with the medical profession, did the NCT fail to engage fully with what women needed from an organisation ostensibly committed to educating and enlightening women about the processes of labour childbirth? Sheila Kitzinger certainly

97 ibid. p.49
thought so. The NCT was, even in the 1970s she claims, 'terrified of causing disruption'.

She remembers being asked at a meeting, "Why are you raising these issues? We were always invited to the Matron's sherry parties, but she didn't invite us to the last one!" 'I was rocking the boat', Kitzinger says of her personal approach to birth education, 'but, if there were ever a boat that needed to be rocked, this was it'. Nonetheless, notwithstanding its reticence to be seen as a confrontational organisation, the NCT were beginning to make the leap from an organisation single-mindedly committed to engendering change through childbirth education to one that was, in addition, actively engaged with policy development.

The Influence of Other Childbirth Organisations.

The publication and distribution of information leaflets was, by this stage, an important part of the Trust's work, as was the conduct of research. These activities earned the NCT the respect of obstetricians, such as Peter Huntingford, who questioned the way the maternity services had progressed over the twentieth century. They were also indicative of yet another change in strategy for the NCT. During this period the NCT first began advocating informed 'choice' in childbirth, something reflected in the literature produced by the Trust since the 1970s. This change in approach – the NCT was not initially pro-choice, rather it promoted as particular way of giving birth – was partly a product of the results of research undertaken by the NCT and feedback from students at its antenatal classes. However, it was also underpinned by other factors, not least the

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98 S. Kitzinger (Interviewed 8th April 2006)
99 Ibid.
100 See: P. Huntingford Birth Right: The Parents' Choice (1985)
politicisation of birth issues [see Chapter Five, below] and the increased influence of other organisations committed to the needs of consumers of maternity care, such as the Association for Improvements in Maternity Services (AIMS).

AIMS, like the NCT, came into being in the late-1950s. Unlike the NCT, AIMS never aligned itself with any particular ‘method’ of natural childbirth; indeed, prior to the explosion of the induction rate in the early 1970s, the organisation lobbied for more technical developments, but argued that these should be ‘more competently applied’ and supported by thorough research. 101 Sally Willington, the founder of AIMS, like Briance, gave birth in the 1950s and was similarly shocked by the treatment she received in hospital. Unlike Briance, however, Willington was motivated not by a deep conviction in the rightness of natural childbirth, but rather by a sense of the wrongness of the unfavourable conditions she encountered during her confinement in an NHS institution. Coupled with this was a curiosity about the experiences of other women and a questioning: ‘Was the hospital just average, or as bad as I thought? Why was it all so dreadful? What happened to other women?’ 102

Willington recalls the exasperation she felt trying to find answers to these questions:

This was the 1950s: nothing was written in the way of magazine articles, childbirth was not discussed. I didn’t know how to communicate with women so I decided to write a letter to a newspaper stating my own opinions and asking if other women agreed with me. I was confident it would be published. Nothing happened. I sent it to other newspapers.

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Nothing. After nine months (significantly enough) the Observer boasted that it was a liberal paper and not afraid of new subjects. So I wrote and asked why, in that case, had they not published my letter? They replied that it was neither topical nor amusing. At last I got angry. I wrote them a “fake” letter about the uses of rosemary and rue and the whereabouts of walnut trees. Sure enough it was printed! When they realised, the editor said it was a good hoax and in return agreed to publish my original letter.\textsuperscript{103}

In the letter, Willington pointed out how mothers in hospital endure ‘loneliness, lack of sympathy, lack of privacy, lack of consideration, poor food, unlikely visiting hours, callousness, regimentation, lack of instruction, lack of rest, deprivation of the new baby, stupidly rigid routines, rudeness, a complete disregard of mental care or the personality of the mother.’\textsuperscript{104} Such treatment she argued amounted to nothing less than cruelty; indeed the organisation she proposed to tackle this situation was not originally known as AIMS, but was in fact called the “Society for the Prevention of Cruelty to Pregnant Women” – an allusion to the RSPCA, which was dedicated to tackling cruelty toward animals. ‘It occurred to me,’ Willington states wryly, ‘that valuable pedigree animals had very good care, grown men sitting up all night with them and never left alone!’\textsuperscript{105}

AIMS set about organising local groups, which were involved in collating evidence from mothers about their treatment during their confinement, usually in the form of questionnaires, and presenting the results to the Local Hospital Management Committees. Collecting this information was, together with spreading the word – getting the subject of childbirth out in the open – vital to AIMS in achieving its objectives, which were:

\textsuperscript{103} Ibid.
\textsuperscript{104} Ibid.
\textsuperscript{105} Ibid.
1. To become a nationwide organisation of influence through equal individual effort on the part of members.

2. To banish, through influence, the dark-age attitude toward towards the psychology of childbirth.

3. In the long-run possibly to raise money to build an "ideal" maternity centre as an example to be followed.

4. Education from earliest age for both boys and girls toward an attitude of responsibility, humanity and dignity.\textsuperscript{106}

However, it was in response to worrying letters from mothers, which spoke of physical and mental abuse, and the response of professionals to women’s complaints – brushing them aside, claiming women were too drugged to recall anything clearly – that AIMS launched into active campaigning, fighting on behalf of women for the redress of grievances.

Press interest in the activities of AIMS was healthy from the start, with items appearing on radio and television and in newspapers and magazines. AIMS was portrayed as a radical organisation in the press: Willington remembers *The People* newspaper referred to her as the ‘Angry Young Woman’, the female answer to the ‘Angry Young Men’ making waves in contemporary literary circles.\textsuperscript{107} However, in spite of its publicly declared confrontational stance, AIMS was involved in dialogue with the Ministry of Health from the early days. In 1961, the Ministry had published a report on *Human Relations in Obstetrics*, committing hospital authorities to integrate and develop policies aimed at remedying the causes of complaint exposed by AIMS. The proposed reforms

\textsuperscript{106} Ibid.
\textsuperscript{107} Ibid.
reflected the very same issues upon which AIMS was basing its campaigns – antenatal clinics, companionship and information during labour, comfort and convenience for mothers. Nevertheless, the organisation was disappointed to note that many had still not been implemented some twenty years hence – due largely to the relative powerlessness of the Ministry to issue directives on maternity policy independently of obstetrics [see Chapter Three, below] – in spite of calls from AIMS to bring the report up to date. Thus, despite a relatively conducive relationship with the Ministry of Health, which had consulted AIMS for advice on recruiting midwives in the 1960s, AIMS found the attitude that “the consultant is in charge of his unit” pervaded and that only through lobbying individual hospitals could change be implemented.108

Through lobbying individual hospitals, keeping up to date with procedures and publishing the results in leaflets and its Quarterly Journal – AIMS’ tactics differed enormously from the NCT’s pedagogical approach. Awakened to what they regarded as the inappropriateness of increased obstetric intervention, the ‘Angry Young Women’ spoke out against it, basing their arguments on the finding of AIMS members’ own research and the many letters the organisation received from mothers distraught by their experience. The NCT, on the other hand, still refused to dispute the appropriateness of obstetric management of childbirth; hardly surprising given that the NCT’s panel of advisers now included several obstetricians.109 Fourteen years after Briance et al established the principle of childbirth education as a means of promoting natural


childbirth, it is with a sense of irony that one observes how the concept had to be widened during the late-1960s ‘to prepare women for the procedures most of them were actually going to experience.’\textsuperscript{110}

Looking back on 25 years of AIMS in 1985, Sally Willington regrets that ‘women themselves have failed to protest loudly enough and long enough on their own behalf’. She continues:

I spent the first ten years believing that if people were born right it would change society – then I realised we have to change society in order to be born right. So it’s a political question.\textsuperscript{111}

As Willington’s statement implies, the years between 1956 and 1970 were years of idealism in many ways. Whilst AIMS may not have spoken about any particular method of natural childbirth, initially their aims and those of the NCT were similar – educating and informing mothers to bring about change in the maternity services – although their approach varied considerably. As we have seen, the NCT urged women to engage with self-help techniques and to take the responsibility to challenge the care they received upon themselves, politely, covertly and always within the confines of the existing culture. AIMS on the other hand argued that the maternity services had a responsibility to women to change and improve, and that doctors and midwives had duty to listen to women’s complaints about their treatment and respond accordingly. By the 1970s, however, it was obvious that for both these organisations, the idealism they shared was not going to be enough to achieve their common objective.

\textsuperscript{110} Ibid.
\textsuperscript{111} S. Willington “Origins of AIMS” AIMS Conference Bulletin (1985)
Both AIMS, which did not use the term natural childbirth – preferring instead the term ‘normal childbirth’ when referring to birth that takes place without unnecessary medical intervention – and the NCT, which was using the term to a far lesser degree that in the past, were disappointed not to have made greater progress in changing the maternity services according to their philosophy at this point. If anything, the beginning of the 1970s marked the beginning of a deepening ‘maternity crisis’ [see Chapter Four, below]. However, it was the very existence of this ‘crisis’ that made organisations such as AIMS and the NCT so vital: the crisis was not so much about the quality of obstetric care, but was, rather, concerned with the ‘system’ of childbirth treatment.\(^\text{112}\) Thus, although AIMS and the NCT took different approaches, both made a significant contribution toward establishing an alternative to this mainstream. Moreover, whilst, by this stage even the NCT disassociating itself from the original idealism embodied in the methodological approaches to natural childbirth, as birth grew increasingly technocratic and was ever more defined in medical terms, natural childbirth essentially came to represent the alternative.

To an extent this explains why, conversely and despite the obvious setbacks, the views of the NCT were, by the 1980s, at last beginning to be taken being taken seriously. It also explains why such organisations as AIMS and the NCT proceeded to position themselves at the centre of the childbirth debate throughout the 1970 and 1980s, raising such issues as the safety of home versus hospital birth, the appropriateness of obstetric technology and the importance of continuous support during labour. The NCT and AIMS

were of course two very different organisations, both of which claimed to represent
cildbearing women in their own way. The NCT, originally so committed to the ideal of
atural childbirth, chose to ‘play it safe’ and attempted to win over the medical
profession in the 1960s and early 1970s. It focused on engendering change by educating
and informing expectant parents, and preached cooperation whilst maintaining an aura of
alternativeness. AIMS, essentially a ‘pro-choice’ organisation reluctant to espouse a
particular way of birth yet radical in its condemnation of the NHS system of childbirth,
chose a more confrontational stance. Lobbying the health authorities and questioning the
authority of the medical profession was key to AIMS’ no-nonsense approach.

It was not until the 1980s, with the medical model of maternity care well established as
mainstream that the efforts of both AIMS and the NCT began to pay off: disaffection with
the obstetric model of care during childbirth amongst many women, coupled with the
growing influence of the ‘consumer’ on public policy in the 1980s placed these groups at
the forefront of the childbirth debate. The questioning of obstetric (and, to a certain
extent, midwifery) practice, which, it was argued, was becoming increasingly routinised,
was both a reaction against, and a product of, contemporary childbirth culture.
Organisations such as these were vital in countering medical dominance in the childbirth
arena, and for espousing alternative views, which were gaining credence as evidence
began to emerge which showed that the indiscriminate application of childbirth
technology (including the universal hospitalisation of birth) could no longer be justified,
not even on the grounds of safety. However, such changes were quite unforeseeable
during the 1960s, during which time the NCT and AIMS worked diligently, conducting
research, publishing information and lobbying the health authorities, preparing women (and their partners) for childbirth and informing them of what to expect from the experience.

In an address to NCT members celebrating twenty-five years of the Trust’s work, Gwen Rankin looked back at the 1960s as a time of great progress for the NCT:

By the late 1960s the NCT had responded to the needs of more parents, which arose out of the growing experience of teachers preparing women and men for childbirth. Many parents missed the support and friendship of ante-natal classes that the Trust offered, which were informal, helpful, and open for discussion at all times, after the birth was over; at this time many women felt that they needed support as much as during the swift stressful hours of labour - and so the post-natal support work of the NCT began to grow, and it is now well-established and spreads through mother-to-mother help wherever Trust ante-natal classes are in operation and in some places precedes the formation of such classes. The worrying decline in the numbers of British women who breastfed their babies was another stimulus to activity, and all ante-natal teachers reported wide interest in breastfeeding and urgent need for help and supporting establishing the contented co-operation between baby and mother.¹¹³

The concept of postnatal support and the encouragement of breastfeeding were not new ideas, but, alongside the campaign to allow fathers into the delivery room and including them in antenatal preparation by encouraging fathers’ attendance at NCT antenatal classes, they were now seen as an integral part of the NCT philosophy. The inclusion of

these issues – which were based upon the results of research carried out by the NCT into
women’s experiences in childbirth, as well as feedback from antenatal class attendees –
signalled a further departure from strictly methodological approaches to natural
childbirth. The shift from ‘pedagogy to politics’ (as Sheila Kitzinger puts it) reflected
both changes in the perceived needs and wants of expectant parents, and wider social and
cultural changes, such as growing women’s employment and the rise in the average age
of women having their first child.

As the demands of parents grew and were articulated more assertively in the 1970s and
1980s, the NCT and other organisations committed to representing parents needed to
become more politically aware. Moreover, increasingly, natural childbirth was seen as
being about more than breathing and relaxation, or preparing for labour; even as early as
1970 it was beginning to be regarded as a deliberate ‘lifestyle choice’. Of course, this
had a negative effect also, with those who were unsure of some aspects of the NCT
approach feeling excluded. Often, those who did subscribe to the NCT ethos were
disappointed to discover the maternity service unable, and perhaps unwilling, to provide a
framework to support the NCT’s ambitions. The stereotyping of NCT members certainly
did not help matters. Sheila Kitzinger remembers the reception her NCT students would
sometimes get when they arrived on the labour ward armed with all the NCT had taught
them. In the case of one woman, actually an NCT teacher, Kitzinger recalls, the ward
sister had written in large red letters on the patient’s notes ‘NCT TEACHER: HANDLE
WITH KID GLOVES!’.

114 S. Kitzinger (Interviewed 8th April 2005)
Seen as troublemakers unwilling to accept the status quo, NCT members and other like-minded individuals were easy to dismiss. The stereotype – rooted in the Trust’s white, middle-class, South-East of England origins – perpetuated throughout its fifty-year history and, in many ways, served to hold back the ambitions of the NCT. In spite of its attempts to align itself with the medical profession and in spite of its growing popularity amongst many expectant parents by the 1970s, the simple fact that it represented an alternative – and this at a time when the gap between the mainstream and the alternative was widening – meant the Trust and the values it represented continued to be marginalised. Those individuals and organisations making similar claims on behalf of childbearing women were indeed similarly marginalised. In the words of one NCT teacher, ‘the doors were being held shut because those on the outside were holding them shut’.¹¹⁵ Promoting alternative ideas and raising awareness through campaigning and education could only achieve so much. Without the support of the maternity services and the medical profession that controlled them, impacting upon mainstream maternity care in any meaningful way was to prove challenging indeed.

¹¹⁵ N. Smith Interviewed 28th Feb 2006
CRANKS AND CRACKPOTS: PROFESSIONAL RESPONSES TO NATURAL CHILDBIRTH IN THE 1950S AND 1960S.

Some say we are cranks... We are not against pain killing drugs, we want them when we ask for them and not before. We are against the trend of drugging a mother into complete unconsciousness...¹

The Significance of the Medical Profession

The very fact that the NCT were so keen to woo the medical profession in the 1960s, so willing to expend energy trying — in the most part, unsuccessfully — to influence obstetricians' and midwives' attitude toward childbirth, is indicative of the de facto controlling power of the medical profession in the childbirth arena. The profession's authority, moreover, transcended practice, extending into policy development with the result that the maternity services were essentially moulded to fit the obstetrician's view of childbirth. As we have already established, the issues of safety and, though perhaps to a lesser extent, pain relief, had, by the 1950s, already tipped the balance in favour of the medical model of childbirth, a fact borne out in the dramatic increase in institutional birth, and the concomitant decline in domiciliary midwifery. Commentators such as Tew and Oakley have described this process in terms of gender. Oakley has argued that 'the achievements of male obstetrics over female midwifery are rarely argued empirically, but always a priori, from the double premise of male and medical superiority'.² Tew adds that the medical profession effectively 'redefined normality in pregnancy and labour to

¹ Lady Savernake, NCT The Aberdeen Press & Journal (23rd April 1959)
justify the widespread practice of antenatal, intra-natal and post-natal interventions at their disposal, so that the need, as they perceived it, for most births to take place in hospital became inevitable.3

The narrative of medicalised childbirth in the second half of the twentieth century is perhaps called into question when one considers the response of the midwives and doctors to the principles of natural childbirth. This is because midwifery, in spite of suggestions to the contrary, in fact retained considerable influence in maternity care in England throughout the twentieth century: unlike in the United States, the majority of births were—and still are—attended by midwives. With midwives on the ‘front line’, so to speak, of birth in the United Kingdom, whether a mother had the opportunity to practice the techniques of natural childbirth was likely down to the decisions made by her midwife. Hence, professional acceptance of natural childbirth, both in principle and in practice, was a far more complex situation than that which is hinted at by the medical versus midwifery model: it was not simply a case of midwives for, obstetricians against. As will be demonstrated here, the response of both professional groups was sometimes unlikely and far from homogenous; it changed over time and was in turn underpinned by changes within the maternity services, as well as wider social and cultural changes.

Obstetrics and Natural Childbirth.

It would be misleading to suggest that all obstetricians entirely dismissed the principles of natural childbirth; remember, the spiritual father of the concept was an obstetrician and, furthermore, since the 1950s several respected obstetricians have spoken out in favour of natural birth. Nevertheless, many were guarded in their response to these ideas, either for reasons of professional self-interest or plain old scepticism. Some individual clinicians spoke out directly against them, others – albeit a tiny minority – embraced them and incorporated them into their practice. The profession as a whole quite often simply ignored them all together; the Royal College of Obstetricians and Gynaecologists (RCOG) has never made public their position on natural childbirth specifically, although it is possible to surmise the views of the profession as represented by the RCOG in other ways. The dearth of material directly relating to methods of natural childbirth in the archives of the RCOG, for example, is in itself significant. It is not surprising, however, as there was often a large degree of deviation between what obstetricians said and did in public, and what they thought in private. Whilst some prominent obstetricians may have spoken out publicly in support of natural childbirth principles, there is evidence to suggest that many outwardly condemned natural childbirth whilst privately accepting its fundamental principles. Those anxious to uphold the values – and value – of their profession were unlikely to openly support controversial, new and untested theories, particularly ones that openly condemned aspects of contemporary practice. Actions and words were, in this case, intimately linked, but not in ways that were immediately obvious.
The earliest evidence of reactions to concepts of natural childbirth amongst medical professionals is contained in the response of the Medical Research Council and the Ministry of Health to the work of Kathleen Vaughan in the early 1930s. Jane Lewis notes that Vaughan ‘published several articles on the value of exercise for pregnant women and the best position for natural labour, but her application for a Medical Research Council grant was refused and the Ministry of Health could not see any particular relevance in her work’. Lewis places the reaction to Vaughan’s work within the context of attitudes towards antenatal care more generally in the early twentieth century. She notes, for example, that in 1916 ‘a writer in the BMJ did not feel it was necessary for all women to receive ante-natal care, and midwifery texts did not include full sections on the subject until well into the 1920s. The first full text on antenatal care did not appear until 1935’.

Changes in attitudes toward antenatal care that took place after the 1930s perhaps served to facilitate medicine’s nascent recognition of concepts of natural childbirth, which were emerging at this time. Also important was the shift in attitudes toward exercise during pregnancy. Many influential midwifery textbooks from the early twentieth century advised pregnant women against any form of physical activity; even light work such as using a sewing machine was frowned upon, in spite of ‘the knowledge that poor muscle tone seriously affected the labours of many multiparous women’. Hence, notes Lewis, again with reference to Vaughan’s antenatal programme, ‘little notice was taken of the

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5 Ibid. p.124
6 Ibid. pp.125-126
idea of exercises until J.S. Fairburn adopted Vaughan's ideas and started ante- and postnatal exercise classes at St Thomas's Hospital in the late 1930s.  

Moscucci, in her discussion of the origins of natural childbirth in Britain, also places emphasis upon growing awareness of the importance of 'physical and mental hygiene in the management of pregnancy and birth' in the early part of the century. Moscucci illustrates how concerns about the extent of 'meddlesome midwifery' – a reference to the growing interventionism that pervaded obstetric practice at the time – coupled with emerging theories on the impact of environmental variables such as diet, exercise and occupation led to a chorus of disapproval, not only from health reformers, but also from 'government officers, obstetric specialists and general practitioners'. Evidently, there were those in the medical profession who deplored the tendency to intervene unnecessarily, claiming it amounted to an 'orgy of interference', the penalty of which was high maternal mortality and morbidity.  

Moscucci's work demonstrates how, in spite of – indeed because of – the trend in obstetrics toward a culture of intervention, a space opened up within which ideas about alternative ways of managing childbirth were able to develop. As we have seen, Vaughan and later Fairburn and his former pupil Dr. Cyril Pink, as well as Grantly Dick-Read were amongst the first medical practitioners involved in the advocacy of natural childbirth. According to Moscucci, their ideas were fostered by the climate of concern about the direction of obstetric medicine and also by the focus on preventive medicine.

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7 Ibid. p.126
9 Ibid.
championed by the public health services. Thus, it is interesting that she places the origins of natural childbirth firmly within obstetrics, although she does acknowledge the significance of external influences such as the response of reformist eugenics to the perceived demographic crisis attributable to the persistent decline in the birth rate.¹⁰

If we consider natural childbirth as a movement that emerged from within obstetrics in the 1930s, the reaction of the profession is intriguing. It is a theoretically established and empirically well-supported fact that obstetrics in first half of the twentieth century was pre-occupied with safety and the reduction of the maternal mortality rate, which remained high into the 1930s. If anything, Vaughan and Fairburn were driven by concerns not dissimilar to those of their more orthodox colleagues. More importantly, these ideas were easily incorporated into obstetric practice, which, as already noted, was moving toward acceptance of the value of clinical antenatal care. Thus, in spite of the significance of its value as an antecedent to later concepts of natural childbirth, what ripples the work of Vaughan and Fairburn made upon the relatively placid sea of orthodox professional opinion were few; the same could not be said for the work of Grantly Dick-Read, however.

From very early in his career, Dick-Read’s theories were viewed with suspicion, derided or dismissed out-right by many in the medical profession. Whilst it can be argued that much of the criticism he received stemmed from his own unfavourable observations about the future trajectory of intervention-led obstetrics, Dick-Read’s first thesis,

¹⁰ See: Chapter One, above.
completed in 1920 when he was still resident accoucheur at the London Hospital, contained, as noted in Chapter One [above] 'a great deal of orthodoxy'. In it he detailed the ways in which labour could be conducted 'in a manner likely to minimise women's pain'; yet, upon showing it to his chiefs at the London, Russell Andrews, Bertie Lee and Drummond Maxwell, they showed 'neither amusement nor contempt'. Nonetheless, he received nothing in the way of encouragement to explore the ideas expounded in his thesis further. Rather, he was told by Drummond Maxwell "Look here, old chap. The truth is we think you really ought to learn something about obstetrics before you start writing on the subject".

Dick-Read initially went to great lengths to seek the approval of his colleagues for his theories. The foreword to his 1932 manuscript is notable for what Noyes refers to as its 'moderation and reasonableness', which Dick-Read anticipated would establish 'a frame of mind conducive — at least — to the careful examination of his arguments by those for whom the book was not primarily intended: his colleagues of the medical profession'. Nevertheless, continues Noyes:

'[Grantly Dick-Read] did not always conceal his feelings by moderation. He could never have been in any doubt that his condemnation of certain of his colleagues, coming from an "unknown" would raise the ire of large sections of a profession not used to the public airing of such opinions.'

11 A Noyes Thomas Dr. Courageous (1957) p.64
12 Ibid. p.65
13 Ibid.
14 Ibid. p.96
15 Ibid.
Regarding the criticism of Dick-Read in this way solves, to a degree, the apparent paradox inherent in professional reactions to his teachings: whilst his personal papers reveal private sympathy and support for his theories from various influential colleagues, they also reveal a more general acceptance of the tendency of the profession to close ranks against the possibility of any threat to the *status quo*.

For example, a letter from Dick-Read to former RCOG president Sir Eardley Holland, dated 9th of February 1949 reveals the incredulity with which he (naively, perhaps) regarded the professional reaction to his work:

Re: Discussion of my method some years earlier. Your remark has always remained fixed in my mind: “My dear boy, there is nothing new in this; old X, who got struck off the rolls, talked about this years ago”. I believe you actually tried it for a time and the results were so unorthodox that your colleagues suggested that “Holland was using hypnotism”. That was a rumour that had to be dispensed with... In 1932, dear John Fairburn kindly read the galley of my first book. He agreed implicitly with it, brought it round to my room in Harley Street, talked it over with me and finally said: “You are not going to publish this are you?” I told him I was because I believed it to be true and he said: “Well, you young fool, you realise it will ruin your practice? Of course it’s true”...¹⁶

Dick-Read refused the advice offered by his distinguished colleagues – even that of Fairburn, who spoke as one with experience of using ‘alternative’ methods in obstetric practice. Indeed, he was to remain loftily adamant that he worked ‘not for the

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¹⁶ Wellcome Trust Library, London: PP/GDR/D.150 Personal Correspondence [Doctors’ Letters]: Grantly Dick-Read to Sir Eardley Holland (9th February 1949)
gynaecologists, but for the women of the world'. Holland, with whom Dick-Read corresponded regularly for a number of years, persistently urged him to 'take more time to win the sympathies of the profession as distinct from the public'. 'You seem to have alienated the sympathies of the rest of the gynaecological world', Holland lamented. Dick-Read, nonetheless, refused to alter his position, preferring instead to point to his credentials with Royalty, claiming that 'both Her Majesty and the Princess read my books, and were anxious these tenets should be given at least a trial'.

Judging from the evidence of relations between Dick-Read and the medical profession, professional reactions to his theories in the 1930s and 1940s were largely underpinned by suspicion. Was this suspicion grounded, as Dick-Read believed, in anxiety that his theories threatened to undermine the authority of orthodox obstetric practice, thereby damaging the prestige of the obstetric profession? Citing the respected American obstetrician Joseph de Lee, author of a number of influential obstetric texts, Dick-Read wrote to Holland that whilst de Lee had mentioned his work on natural childbirth (in what he referred to in his letter as de Lee's 'great textbook'), he warned the Englishman:

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17 Ibid.
18 W. T. L. PP/GDR/D.150 Sir Eardley Holland to Grantly Dick-Read (8th January, 1949)
19 W. T. L. PP/GDR/D.150 Grantly Dick-Read to Sir Eardley Holland (9th February, 1949). In 1948 when Princess Elizabeth was expecting her first child, Prince Charles, reports appeared in the British press and abroad that the Princess was 'preparing, by careful study of the nature of childbirth and doing muscular exercises, to have her baby without anaesthetic'. The soon-to-be Queen's then obstetrician, Sir William Gilliatt, was reportedly 'not a great believer in natural childbirth' and although the Princess had 'read Dr. Dick-Read's book' the report stressed: 'In all these matters she will, of course, be advised by her obstetrician'. The Daily Mirror (28th June 1948). Reports of the Princess' interest in natural childbirth appeared keen to whip up the controversy between orthodox obstetric practice and Dick-Read's alternative approach. According to his biographer, one report went so far as to hint that Dick-Read, and not Sir William Gilliatt would attend the Royal confinement. The controversy certainly gave his opponents the opportunity to publicly attack his methods. One renowned obstetrician went as far as to accuse him of 'selling books to the house'; others hinted that that it was a carefully planned publicity stunt. Dick-Read, however, maintained he knew nothing of the Princess' intentions until the reports appeared (see A Noyes Thomas Doctor Courageous (1957) pp.189-191
It could not come for many generations because the profession would continue to maintain a hold over women by preaching that labour was a dangerous and painful incident, which required the highest professional skill for a satisfactory outcome.²⁰

It is possible, however, that it was Dick-Read's conduct in his relations with his colleagues – particularly his unbridled criticism of modern obstetric practice – that alienated them to a greater degree than did the fundamental principles of natural childbirth. It is also possible, if controversial, to consider criticisms of the man and his methods at face value. The derision he encountered – the 'gibes and titters' at meetings of the Royal Society [of Medicine] that accompanied discussion of his ideas, the references to 'Old Dick, the jovial windbag of nonsense', the persistent knock-backs from acceptance at the RCOG – could, arguably, have had as much to do with the lack of credibility attributed to the as-yet un-tested theories of natural childbirth to which Dick-Read held steadfast, as they had to do with concerns with maintaining obstetrics' control over childbirth. Lacking, as they were, legitimisation in the form of clinical (as opposed to empirical) trials, it is easy to accept that it was difficult for the elite of the obstetric profession to take his theories seriously. Had he made assertions that were backed up by evidence from accepted scientific research methods, such as the double blind, or randomised controlled trial, his contemporaries may have forgiven his eccentric and elaborate writing-style. As it was, Dick-Read's persistence despite the lack of quantifiable evidence to support his ideas served to aggravate the exasperation of his colleagues. In this respect, Dick-Read was his own worst enemy.

Dick-Read’s self-aggrandising behaviour, bolstered by the letters of support and encouragement he received from women, arguably alienated him from many within the ranks of obstetrics. Nevertheless, he maintained good professional relationships with several eminent obstetricians and was even invited by Eardley Holland to submit a chapter to an influential textbook, *British Obstetric Practice*, in 1950. Notwithstanding this show of support for the principles of natural childbirth, Holland – judging from his letters – certainly felt that Dick-Read required a degree of ‘guidance’ in this matter. On the 23rd of February 1950 for example, Holland wrote to him regarding the title, which, he suggested ought not to be *Natural Childbirth*, but rather should indicate ‘the nature of the theory and methods...’ Fellow contributor Claye – a ‘strong supporter’ of Dick-Read who was himself submitting chapters on “The Management of Normal Labour” and “Analgesia and Anaesthesia” – suggested the title “Physical and Mental Preparation for Childbirth”.21

Interestingly, in his letter, Holland advises Dick-Read to ‘*bear in mind the class of people for whom it would be intended*’.22 It is not entirely clear what he meant by this. It could be that he is referring to the professional-class – those who were most likely to study a book like *British Obstetric Practice*. On the other hand, it is possible Holland was alluding here to the widely held assumption that Dick-Read’s ideas appealed to *women* of a certain class. Either way, one gets the distinct feeling that what he considered problematic was the term ‘natural childbirth’. Thus, whilst Holland expresses his hope that Dick-Read will contribute – something he expressly regards as ‘essential’ –

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21 W.T.L.PP/GDR/D.150 Eardley Holland to Grantly Dick-Read (23rd February 1950)
22 W.T.L.PP/GDR/D.150 Eardley Holland to Grantly Dick-Read (23rd February 1950) [Emphasis mine]
the tone of his letter is indicative of the *sensitivity* of the profession to unorthodox ideas in the management of childbirth, yet it also demonstrates that it was not entirely against them. Similarly telling is the following statement – referring to Dick-Read’s desire to use the title *The Psychosomatic Approach to Physiological Childbirth* and to highlight what he regarded as the ‘neglect of the psychosomatic aspect of obstetrics’ – taken from a letter dated June 1st 1950: ‘It is precisely to fill this disgraceful gap,’ writes Holland, ‘that you have been asked to write this chapter. Leave the word “physiological” out; be objective and matter of fact. NO RHETORIC’. 23

Ultimately, Holland hoped to demonstrate to Dick-Read that he was ‘appreciative and sympathetic to [his] work’. ‘It is my ambition’, he wrote in June 1951, ‘to get your teaching in this book right across to a wide circle of special readers’. Nevertheless, Dick-Read continued to exasperate Holland by refusing to cooperate by compromising his theories. Certainly, his ego did not take kindly to having his ideas curtailed in the way the more experienced obstetrician was suggesting, as the following excerpt, from a letter addressed to Holland dated 22nd June 1951, clearly shows:

They honour the man who invented a gas apparatus, but one who changes, in few years, the whole approach to childbirth, discovers the cause of pain in labour, and devises a means of minimising it without danger to mother and child, is told by your successor as president of the RCOG: “there is no place for you in this country”. You cannot expect, or indeed wish me to write solecisms in an authoritative textbook. I would prefer to continue as an international writer than to mould my work to weaker pattern. 24
Dick-Read's intransigence must have been frustrating to those colleagues who felt they were trying to help the cause of natural childbirth, such as Holland; it was, nevertheless, a product not only of his unwavering faith in his theories, but also of the apathy demonstrated toward them by the medical profession as a whole. Thus, it seems that in spite of Holland's optimism that attitudes were changing - albeit 'very slowly' - for every supporter of natural childbirth, there were many who were critical, and many more who simply chose to disregard it completely. Dick-Read suspected that the lack of attention paid to natural childbirth could be attributed to the fact that the 'ire of some of the most influential and prosperous obstetricians, gynaecologists and anaesthetists was raised by the preaching of methods which, if widely adopted, might make considerable inroads into their incomes'. Undoubtedly, Dick-Read's attack on the medical profession had the potential to harm many a prestigious career. As a reviewer for the *British Medical Journal* boldly pointed out as early as 1942, Dick-Read's *Childbirth*

25 With regard to the proposed chapter by Dick-Read in *British Obstetric Practice* (Eds: Eardley Holland & Aleck Bourne), factors extraneous to the immediate editorial issues (not least of which was the 1954 print workers' strike, during which paper prices rose dramatically) initially hampered publication of the book. The first edition was eventually published in 1955 and included Dick-Read's chapter under the title *The Psychosomatic Approach to Childbirth* (pp.1061-1083). The approach taken in this chapter (which, not insignificantly, appeared toward the end of the second volume) reflected Dick-Read's later work on the value of antenatal preparation for childbirth, particularly in the subsequent *Antenatal Illustrated* (1958), which uses diagrams and descriptions of relaxation exercises in a similar way. The chapter makes several references to "natural childbirth", but these appear toward the end of the paper and are mostly in reference to the possible benefits of natural childbirth. Dick-Read's contribution is also included in the second edition of *British Obstetric Practice* (1958) (pp.1127-1150), again toward the end of the second volume. No major changes were made to the text, but the diagrams were updated with photographs of women performing the exercises and relaxation. The third and final edition, published in 1963, four years after Dick-Read's death, omits the chapter he wrote. In its place is a chapter written by Sheila Ransom and W.C.W. Nixon entitled "Psychophysical Preparation for Labour" (pp.1199-1216). This paper is partly a narrative account of the development of obstetric physiotherapy in Britain and psychoprophylaxis on the continent. There is a paragraph on Dick-Read's theories of Natural Childbirth, but the paper is indicative of the broadening of the meaning of natural childbirth to include techniques other than those advocated by Dick-Read. As such it is, in essence, an account of the development and significance of a holistic approach to pregnancy and childbirth, which was beginning to gain currency in the early 1960s [see Chapter One, above].

26 A. Noyes Thomas *Doctor Courageous* (1957) p.112
Without Fear 'accuses the medical profession in general and the consulting obstetrician in particular of gross mismanagement of all cases of normal pregnancy'.

This raises the question of Dick-Read's motives: was he simply angry at the disdain displayed toward him from obstetrics, or was his intention to create a rhetorical dichotomy in order to undermine the profession? According to his biographer, Noyes Thomas, Dick-Read was victimised by the obstetric profession. He was subjected to 'an insidious whispering campaign' the aim of which was to 'discredit Dick-Read and his practice'. This culminated in the anonymous reporting of Dr. Dick-Read to the General Medical Council (GMC) for advocating 'cruelty to women' – ironic, given that he himself was effectively accusing the entire obstetric profession of cruelty, albeit of a different nature. Whilst of course acknowledging that Noyes Thomas's account of Dick-Read's career is neither impartial nor critical, it is interesting to observe Dick-Read's conviction that he was locked in some kind of ideological battle with the obstetric profession. Perhaps he was setting himself up as a martyr; certainly he considered it his sole responsibility to question the hitherto indisputable superiority of the obstetric profession.

Although he claimed he was committed to the fundamental principles of obstetric practice, neither he nor his theories appeared entirely congruent with 'the profession'. He appeared oblivious to the possibility that his own actions, such as his refusal to abide by accepted professional parlance in his lectures, or employ a dispassionate academic

27 Cited in Ibid p.159
28 A. Noyes Thomas Doctor Courageous (1957) p.112
writing style, were an obstacle to professional acceptance. Nor was he sensitive to the idea that his theories might be met with a warmer reaction were he to make more of an effort to court professional opinion, or at least to ‘play by the rules’, for example, achieving respect through publishing the findings of clinical trials and so on. He was clearly held in high regard by several influential obstetricians, and was granted permission by the General Medical Council to practice obstetrics professionally, but since the main professional body (the RCOG) refused to accept him, his career was undermined.

Judging from Dick-Read’s correspondence, he felt dejected at the lack of recognition from the RCOG; this only strengthened his conviction in the righteousness of his cause, and stimulated in him greater criticism of certain aspects of contemporary obstetric practice. In some ways Dick-Read’s career became a self-fulfilling prophecy: from the outset he contrived to stand out from his colleagues; professional rejection assured this was the case. Dick-Read’s competence as a practitioner was never in doubt; his ability to advance professionally was, nevertheless, seriously compromised as much by the persona he created, as by the controversial nature of his ideas. Effectively, through his writings and lectures, he succeeded in creating an almost mythological image of himself embodied in the persona of the outsider, the pioneer figure. This, one might suggest, made it very difficult for his colleagues to relate to him professionally.29 Claiming a position of superiority that appeared to place him above the rules of the profession made criticism of

29 The title of his biography, Dr. Courageous, written by A. Noyes Thomas in close collaboration with Dick-Read and his wife Jessica and published in 1957, is significant in this respect.

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his ideas all the more easy, and served to stifle professional debate of them almost entirely.

Being accepted into the profession would almost certainly have provided more scope for Dick-Read to develop his ideas. As inflammatory as some aspects of Dick-Read’s teachings (not to mention his personal modus operandi) were to the medical profession, and in spite of the contemptuous attitude of those who were (perhaps) suspicious of the impact his ideas might have on them professionally, there is some evidence of pleas for acceptance of his principles more generally. This support was, moreover, not merely limited to the private correspondence of colleagues with whom Dick-Read had an amicable working relationship. For example, his books were, notwithstanding a few exceptions, well received in the medical press. What criticisms were dished out were usually aimed at his use of language, which some thought was inappropriate, unnecessary, and overly exuberant. For example the British Medical Journal (BMJ) review of the third edition of Childbirth Without Fear (1954) states:

The new chapters and changes in this edition are characterised by repetition rather than innovation and are coloured by extravagant phraseology and by the author’s concern to do battle with all who have questioned or criticised his work.30

It seems there were those within the obstetric community who did support Dick-Read, or were at least sympathetic to his ideas. Nixon, whose book Childbirth (1955) was heavily influenced by the teachings of Dick-Read, worked hard, and against the general tide of his colleagues’ opinion, to bring natural childbirth to his patients at London’s

University College Hospital in the 1950s. In his correspondence with Holland, Dick-Read notes Nixon's 'use of [natural childbirth] procedures' and his 'remarkable success' therewith. However, despite the respect that Nixon commanded as a senior consulting obstetrician (he was president of the RCOG from 1953 to 1959), he was, according to Dick-Read, ridiculed for his belief in natural childbirth to the extent that he was called a 'pariah' whose students, when taking examinations at the RCOG were referred to as 'students of the heretical college'. It is important, however, to acknowledge the limitations of such views, which reveal more about Dick-Read than Nixon. Nixon remained a highly respected member of the obstetric community in spite of his associations with natural childbirth, most likely due to his balanced views on the subject, and his focus on the preparatory aspects of the discipline.

Nixon made a distinction between the physiological and the psychological/emotional aspects of childbirth, whilst avoiding a dogmatic approach to either. His views on natural childbirth were essentially pragmatic and progressive, shaped, not insignificantly, by his experience as an obstetrician, rather than through steadfast belief in the principles or methods originally advocated by Dick-Read alone. Having said that, he did not shrink from using the term 'natural' when referring to birth. Thus, he states in Childbirth:

> Having a baby, even in the nineteen-fifties, is quite a normal event...it can be a most exhilarating and exciting experience. I have seen Chinese mothers having their babies in

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31 W.T.L: PP/GDR/D.150 Dick-Read to Eardley Holland (17th February 1953)
32 Ibid.
33 Having said that, it might be hypothesised that Nixon's interest in Dick-Read's theories stemmed back to his interest in eugenics. Nixon was a member of the Eugenics Society, as was Eardley Holland in the 1940s. As discussed in Chapter One, above, Dick-Read was developing his ideas on childbirth at a point in history when the debate on eugenics was at its height in Britain. Such associations possibly underpinned Nixon's support for Dick-Read's natural childbirth.
the natural way and taking a very active part and pleasure in the delivery. I do not plead for a return of "the good old days" — the days of infection and of unskilled and ignorant midwifery...I am trying to suggest that by getting away from Nature as we do, she hits back at us. For instance, I believe that we are more sensitive to pain nowadays, and we can only overcome this by learning to understand that certain reactions are quite normal and natural. It is by explanation that we shall help to rid ourselves of that fear which has been built up as a result of ignorance...Proper explanation of the birth process will do much to eliminate fear.34

Nixon was perhaps unique amongst obstetricians of his era insofar as he was able to reconcile his position as a 'faithful devotee' of Dick-Read with his forward-looking approach to obstetrics.35 Later he was to collaborate with the midwife and childbirth educator Erna Wright [see above], becoming interested in the benefits of psychoprophylactic training for childbirth. His approach to obstetrics was always to focus upon the needs of mothers and babies, for example by stressing the need for continuous support during labour, rather than upon a particular method of delivery, and this earned him the respect of colleagues such as Alec Bourne who remembered:

I was struck by the modern teaching of human relations under the direction of Professor Nixon. Thus, the pregnant woman realises she should not just be a 'case' but a real human being, as she had been in her home, and the knowledge of modern pain-killing techniques during labour removes so much of her natural fear that for this reason too she will face labour with almost calm indifference and certainly unafraid. Professor Nixon

has also created a maternity department renowned for kindly personal relations between the doctors, midwives and patients... 36

Nevertheless, rather than being a radical figure, Nixon was also a product of his time. ‘Human relations’ was increasingly being considered an essential element of modern obstetric practice in the 1950s and 1960s. Local authority maternity units, under the management of the burgeoning NHS, were especially under scrutiny from the public, and articles criticising the care of expectant mothers in hospital, such as that which appeared in the People newspaper in September 1955 relating to the ‘horrors of hospital treatment’ did little to further the cause of extended institutional confinement. 37 What perhaps made Nixon’s position on natural childbirth more acceptable within the professional community was his understanding of it being an approach that was perfectly suited to birth in a hospital setting. 38

As the concept of natural childbirth moved away from association with Dick-Read, gradually becoming — under the influence of ideas of painless childbirth from the Continent — more reductionist in its focus (see Chapter One, above), it began to be regarded by some medics as an ideal mechanism for placating mothers who were nervous

36 Ibid. p.65
37 The article, printed in the People on Sunday 11th September 1955, is referred to in a letter from Grantly Dick-Read to William Nixon (15th September 1955) W.T.L: PP/GDR/D.152
38 One needs to be careful not to associate natural childbirth at this stage with the campaign for home birth, which did not make an impact until decades later. In the 1950s, very few were questioning the move to greater hospital confinement. Expectant mothers, doctors, midwives and groups campaigning for better maternity services all apparently supported the notion of hospital delivery for all, which was seen as a safer and more comfortable option than birth at home. Nixon, speaking at a conference held by the National Birthday Trust in 1962, made his position on hospital delivery very clear, declaring “surely the days of taking out an appendix on the kitchen table have gone, and yet delivery under such conditions is still perpetuated...” (Cited in S. Williams Women and Childbirth in the Twentieth Century (1997) p.217). Clearly he did not consider his position on the undesirability of home birth at odds with his position on natural or prepared childbirth.
of delivering in hospital. This is the thesis expounded by Arney and Nell, in reference to the US context, which argues that sometime around the late-1940s and early 1950s obstetricians embraced concepts of natural childbirth once they realised they could be used to make women more 'cooperative' during childbirth.\(^{39}\) In the English context, such attitudes do not appear widespread; nevertheless, an example may be found in surgeon-gynaecologist to the Queen, Sir John Peel's* measured, yet plainly supportive foreword for Betty Parsons' 1963 publication *A Way to Fearless Childbirth.*\(^{40}\)

Writing this foreword gave Peel the opportunity to add his voice to the debate on alternative methods of childbirth. Thus, he was keen to emphasise his distaste for the term 'natural childbirth' and also to drive home the point, made by many obstetricians at this time, that no system of training – whatever name it goes by – will guarantee painless childbirth. More significantly, Peel appeared to embrace Parsons' book because it advises women to learn techniques which they can use to *help themselves* during labour, thereby reducing both their own fears (which, he accepted may be exacerbated by the hospital environment) *and* the pressure felt by over-worked hospital staff. This is, one might venture, was as much a rallying cry to the medical profession as it was to expectant mothers: embracing techniques of preparation and relaxation could benefit patients *and* hospital staff, both during parturition and the antenatal period. Thus, writes Peel:

> For too long, in my opinion, doctors and midwives have been artificially divided into the enthusiasts and the nihilists, into the believers and the unbelievers of natural childbirth.

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\(^*\) Significantly, in the late 1960s, Peel chaired the Standing Maternity and Midwifery Advisory Committee, the controversial report of which recommended 100% hospital delivery.

\(^{40}\) B. Parsons *A Way to Fearless Childbirth* (1963)
In the country up to 80 per cent of all births have always been normal and physiological, but let it be admitted that pressure of work and serious lack of facilities have all too often caused an apparent lack of human kindness in the attendant and fear and panic in the patient... One of the serious problems confronting both doctors and midwives in caring for expectant mothers during the antenatal period and sometimes during the early stages of labour is to find the time necessary for that personal and individual attention which means so much to the patient. Antenatal clinics are crowded and there are too few doctors and midwives to go around... 41

This statement is revealing of the tendency in obstetrics to distil those aspects of natural childbirth methods that were useful, or addressed particular problems in maternity care (such as human relations), and that could be adapted with relative ease into orthodox practice. Some obstetricians regarded psychoprophylaxis, for example, more as an attempt to provide a solution to the age-old ‘problem’ of painful parturition rather than a distinct system of childbirth, effectively reducing it to a form of ‘verbal analgesia’. 42 The inclusion of chapters on psychoprophylactic preparation for childbirth in some influential obstetric textbooks by the 1960s is certainly indicative of the tendency of obstetrics to regard the technique as part of its ever-growing arsenal against pain during labour. For example, the fourth edition of Donald’s *Practical Obstetric Problems* (1969) contains a detailed outline of the theoretical origins of psychoprophylaxis and the benefits of its practical application. The chapter, written by Alan M. Giles, a fellow of the RCOG and the Royal College of Surgeons (RCS), stresses the importance of physical and

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41 Parsons *A Way to Fearless Childbirth* (1963) pp. vii-viii
42 The term “verbal analgesia” was originally used by the French obstetrician Pierre Vellay, a colleague of Lamaze, to describe the application of Pavlov’s original theories on conditional reflexes to childbirth. See Donald *Practical Obstetric Problems* 4th edition (1969) pp. 548-556
psychological preparation in order to prevent pain during labour. Whilst this may negate the need for the routine administering of pharmacological relief, the role of the doctor is not displaced. Thus:

There is no place for lay teachers...the quality of teaching is of great importance. The teacher should be someone with full knowledge and experience of midwifery. Order of preference would be doctor, midwife, physiotherapist... 43

Similarly whilst it is pointed out that the 'atmosphere of the labour room should not be that of a busy casualty department', the attitude is taken that a medical setting is entirely appropriate – given a few modifications in design to create 'interest and distraction' – for the practical application of the technique. What is clear from this particular article is that psychoprophylaxis was viewed as an alternative method of pain relief that could nonetheless be understood and absorbed into orthodox obstetric practice. Giles goes to great lengths, for example, to point out the scientific foundations of psychoprophylaxis, emphasising how the method was built upon neurophysiological principles initially developed by Pavlov and refined by Russian obstetricians Platonov, Velvosky and Nicolaiev. He states unequivocally that:

Psychoprophylaxis is a definite discipline, combining the necessary psychological conditioning and simple exercises, the purpose of which can be readily understood by patients, physiotherapists, and not least by midwives and doctors. 44

44 Ibid, p.555. See Chapter One [above] for a discussion of the differences between the two approaches. Psychoprophylaxis was taken as having a sound clinical basis, whereas Dick-Read' natural childbirth was based largely upon its main protagonist's observation of birth in 'uncivilised' cultures. It is significant also that Dick-Read was regarded by some of his colleagues as a 'crank' unworthy of membership of the governing body of British obstetrics, the RCOG.
Giles, and other obstetricians who wrote about and employed techniques of psychophysical preparation for labour in their practice, appeared suspicious not of the techniques themselves, but of the problems that could arise were they controlled by lay teachers – or worse, women themselves – rather than clinicians. One concern was that enthusiasts of natural/prepared childbirth techniques were likely to advise women to eschew pharmacological pain relief. Obstetricians such as Will Nixon argued that there existed 'a great danger that the mother may be taught to regard doing without analgesia as meritorious in itself', and that this in turn may cause greater distress on her behalf, leading inevitably to feelings of failure.\textsuperscript{45} Nixon was convinced that as there was a place for psychotherapeutic or 'natural' methods, there was also a place for modern pain relieving drugs, and that when used with skill they could in fact 'help a mother toward the experience she wants, giving rest and relief when needed and allowing her to be active and aware when this is important for her'.\textsuperscript{46} In other words, what would be most appropriate in ensuring women felt positively about their experience was a combination of 'alternative' and 'mainstream' approaches to pain relief.\textsuperscript{47}

Absorbing alternative approaches into the mainstream by adapting them to fit in with orthodox practice, arguably made them more acceptable to the medical profession, not to

\textsuperscript{45} Sheila Ransom and W. C. W. Nixon "Psychophysical Preparation for Labour" in \textit{British Obstetric Practice} 3\textsuperscript{rd} Edition (1963) p.1214
\textsuperscript{46} Ibid.
\textsuperscript{47} See Arney and Nell (1983) for a discussion of how alternative methods of pain relief flourished in American obstetrics for a short time in the middle of the century, initially functioning alongside pharmacological methods before eventually being eclipsed by them. According to Arney and Nell: 'Women seized pain from obstetricians and, for a short moment, made it their own. But then with extraordinary rapidity obstetrics mobilised a "rush to knowledge" to analyse this new aspect of childbirth. Joined by social scientists who modelled the quality of childbirth obstetrics recaptured pain, relocated it so that it stood outside women, in between them and the optimal childbirth experience which could only be achieved with obstetrics' managerial assistance'. (p.19)
mention less likely to undermine the hegemony of obstetrics. However, the idea of presenting both options in this way was not fully explored until the late 1980s and early 1990s, when it was adapted to fit the notion of choice in childbirth [see Chapter Six, below]. In actual fact, despite some interest, very little investment was made in researching alternative techniques, even when highly respected members of the medical profession publicly extolled their virtues. Some obstetricians even complained that too much was being made of these ideas to the detriment of “good obstetrics”. For example Wilson-Clyne in his Textbook of Gynaecology and Obstetrics (1963) declared his concern that ‘too much time and effort [was] being expended on relieving the patient’s supposed dread of the unknown, by constantly stressing the naturalness of childbirth’.\textsuperscript{48}

Citing Kerr and Moir’s Operative Obstetrics, Wilson-Clyne advises obstetrics to exercise sound common sense in its response to the growing interest in natural childbirth. According to Kerr and Moir:

\begin{quote}
The contention...that we should get back to ‘physiological labour’ will not solve the problem, however desirable it may be to persuade young mothers to look upon pregnancy and childbirth as a natural sequence of matrimony and not to worry about it, as did their grandmothers. As a matter of fact, only a few become unduly concerned about these events – excepting of course, a large number who are annoyed at the recurrence of pregnancy. Robustness of body and mind, however, is no insurance against the disturbances and complications of pregnancy and childbirth.\textsuperscript{49}
\end{quote}

The view that conducting further research into natural childbirth techniques was misguided was widely held and can be traced back to the Medical Research Council’s

\textsuperscript{49} Cited in Ibid p.385 [Author’s emphasis]
refusal to fund Kathleen Vaughan's studies in the 1930s. The problem of attaining adequate funding certainly served to dampen the enthusiasm of those who believed in the potential of alternative methods in the 1950s and 1960s. In 1959, for example, the respected physician Elliot Phillip contacted the National Birthday Trust, an organisation that had already done much to further the cause of universal access to adequate pain-relief during childbirth, requesting their consideration on the matter of training British midwives in the method at the Paris hospital where the psychoprophylactic method popularised by Lamaze originated.  

The scheme was never to get off the ground, and a similar request for research funding from a sister of midwifery based at a London Hospital was also declined by the NBT. The Trust was not entirely unsympathetic, however, and stated in a letter to the midwife in question, a Miss Kathleen Fowler, that 'we must continue to explore alternative methods of childbirth'. Nevertheless, the letter continued that such approaches were at variance with that of the Trust, which it was claimed, prioritised the 'mothers interest...first, last, all of the time'. The suspicion that vested interests were behind medical practitioners' flirtation with alternative methods of childbirth is also voiced in the letter – the Trust were aware that such methods were sometimes regarded as making patients more cooperative with staff, and that the authorities would ultimately save money were fewer women using pharmacological pain relief. It goes on indignantly to state:

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50 W.T.L.SA/NBT/H.5/8 Correspondence between Elliot Phillip and National Birthday Trust (June 1959)
51 W.T.L.SA/NBT/H5/9 Correspondence between Kathleen Fowler (SRN) and the National Birthday Trust (c. 1961)
52 Ibid.
53 Ibid.

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The National Birthday Trust Fund encouraged research [that led to the development of] safe pain relieving drugs. Why should mothers not be allowed to have them? If they are so much more relaxed and relieved by these drugs that they forget their breathing exercises, so what?54

The message was clear: relaxation and breathing exercises could be useful, but were no substitute for the hard-won technological advances from which women were now benefiting in the delivery room.55 In fact it was becoming more generally accepted, even within the obstetric profession, that natural childbirth techniques 'had their place', but the question of whether this was in the delivery room is particularly pertinent. As far as the medical profession was concerned, by the 1960s natural childbirth had become less about the conduct of labour than it was about preparation for labour. Consequently, the location of natural childbirth shifted to the antenatal clinic, apparently solving the problem of how and where alternative approaches could be incorporated the mainstream. As the focus on didacticism increased, natural childbirth discourse became less fixed upon the unbridled criticism of modern obstetric practice. In response, obstetrics made room for "antenatal education" based upon the principles of natural childbirth and the controversy between the two camps temporarily subsided. Yet neither side could claim victory. The medical profession continued its crusade for scientific advance in the name of safety; the natural childbirth movement devoted its energy to antenatal preparation and

54 Ibid.
55 In the end, the NBT granted Miss Fowler the sum of twenty pounds to fund a research trip to Brussels, but not before corresponding with the Royal College of Midwives in order to quiz them on her character. The RCM replied that Miss Fowler had trained under a consultant named Perchard at Mile End Hospital, where she developed an interest in techniques of hypnosis. It was noted, rather unnecessarily, that Miss Fowler did not have a good reputation at the RCM; she was described as a 'tiresome' woman, who always wanted 'her own way'.55
allowed the medical profession to dominate labour ward culture. For the rest of this period, therefore, debate concerning natural childbirth methods all but disappeared from obstetric discourse. For the time being at least, natural childbirth was the midwives' problem.

Midwifery and Natural Childbirth.

As with obstetrics, it is almost impossible to make general observations about midwifery’s attitude to alternative approaches to childbirth. If natural childbirth divided obstetricians, it most certainly divided midwives also. Persuasive as it may be, the medical versus midwifery paradigm, which has dominated debate on childbirth over the last thirty or so years, fails to stand up to scrutiny when faced with the complexity of professional responses to natural childbirth. In her research into maternal and child welfare in the interwar period, Louise Tracy noted how changes in midwifery practise over the course of the twentieth century, beginning with the 1902 Midwives Act, which established midwifery as a profession in its own right, cast doubt on the validity of arguments that posit (female) midwives firmly within the context of a ‘female’ childbirth discourse on the one hand, and (male) doctors within a specifically ‘male’ childbirth discourse on the other. For example, suggests Susan Pitt, in the hospital environment midwives had ‘fewer opportunities to learn and practice female discourse’ and, as a consequence they ‘increasingly adopted methods belonging to the male discourse’.

Since the 1960s, the Association for Improvements in Maternity Services (AIMS) have

protested 'as much about the way pregnant women have been dealt with by midwives as about their treatment by doctors'?58 This statement, which appears to support Pitt's claim, is interesting, for it forces us to reassess the role of midwifery in the medicalisation of childbirth, and therefore raises questions about midwifery's reaction to alternative principles and practices.

Certainly, we should not automatically assume that midwifery wholeheartedly supported notions of natural childbirth in the middle decades of the century, nor should we take for granted the supposition that traditional midwifery had some kind of affinity with the principles of natural childbirth. Leap and Hunter's study of midwifery in the first half of the twentieth century has shown, for example, that whilst births attended by midwives in both home and hospital settings in the late 1940s were essentially 'natural' insofar as women laboured without pain killers or medical intervention, the 'natural' births of the pre-NHS days were a far cry from 'natural childbirth' as it is known today.59 According to Leap and Hunter:

Women usually knew little about their bodies, which would make the process of giving birth very frightening. Birth was viewed as an extremely painful event and there was no expectation of it being an emotionally fulfilling experience. Births were very much 'managed' by the helpers present, with the midwives and doctors disinfecting, sterilising

58 Ibid. Citing a speech by the Chairwoman of AIMS given at a seminar entitled "From Shellshock to Natural Childbirth" held at the Wellcome Institute in 1992. See also an Occasional Paper published by AIMS entitled "History of AIMS 1960-1990" (1990). AIMS Chair Beverley Lawrence Beech writes of midwives that they 'like women...had been duped over the years into the belief that obstetric technology was of benefit to everyone, and that they would become "more professional" if they embraced the obstetric model of care. When these midwives were confronted by women who were challenging that view, they often reacted defensively. Within the profession there are midwives who agreed with the women and deplored the reduction in status of the midwife and her subordination to obstetric dictums'.

and generally attempting to create a mini-hospital within the home. 'Delivering' was the key word: the woman was 'delivered' of her baby by the birth attendant whose job it was to organise everything and tell the woman exactly what to do.  

Even before the shift to the norm of hospital birth, midwifery practice was being influenced by a distinctly medicalised protocol. Midwives had operated under strict professional guidelines following the Midwives Act of 1902, and by the 1950s registered midwives were required to undergo at least twelve months intense training in all aspects of antenatal, postnatal and intra-partum care, garnering experience in complicated as well as uncomplicated deliveries. Nevertheless, there is a consensus amongst historians of midwifery that midwives' autonomy was progressively eroded throughout the twentieth century. This erosion is intimately linked in the literature with the decline of domiciliary midwifery, which was swift after the mid-1940s. The response of midwifery to concepts of natural childbirth in the 1950s and 1960s is especially fascinating - not to mention extraordinarily complex - when viewed against the backdrop of these changes.

Grantly Dick-Read would certainly have been observing the changes to the midwifery profession that were occurring around the late-1940s with a critical eye. Given his passionate belief that labouring women should never be left alone, he, perhaps more so than anyone in his profession, knew the pivotal role played by the midwife. He would also have been aware that the success of his methods relied upon the willingness of

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60 Ibid, p.143
midwives to accept them into practice; for all his efforts to gain acceptance from the obstetric profession, without the acquiescence of midwifery, natural childbirth was destined to remain on the periphery of the maternity services. It was with this in mind that Grantly Dick-Read courted midwifery in the 1950s, travelling the length and breadth of the country delivering lectures, attending meetings and conferences, hosting luncheons and suppers, spreading the gospel of natural childbirth to midwives. Judging from the correspondence between Dick-Read and regional branches of the Royal College of Midwives, this extended tour of duty was immensely successful.

Generally speaking, midwives liked Dick-Read. The letters received by his office from the representatives of midwifery (such as those from the Senior Midwifery and Nursing Officer, Maidstone, Kent, a lady by the name of Miss Sanders) demonstrate that he was a popular speaker at meetings, teaching days, events and conferences. For example, Miss Sanders writes in January 1955, 'that the majority of midwives and health visitors in Kent are very keen in teaching relaxation and natural childbirth procedures'. Most letters express the midwives' gratitude and appreciation and the fact that many found the lectures delivered by Dick-Read 'interesting' and 'instructive'. And whilst some resistance to Dick-Read's approach is evident – one letter refers to a senior midwife

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62 Dick-Read indicated in correspondence with the RCM in December 1956 that in fact he had received several letters from mothers asking him to put them in touch with their local branch of the Royal College of Midwives. He also expresses his deep concern about the number of women who wrote to him documenting their experience of unpleasant treatment at the hands of midwives during labour. Such letters could only have bolstered his views about the urgent need to educate midwives about natural childbirth. See: PP/GDR/C.57 (Correspondence: 'Midwives')
63 W.T.L.PP/GDR/C.57-60
64 W.T.L.PP/GDR/C.57 (Miss Sanders to Dick-Read, 24th January 1955)
65 W.T.L.PP/GDR/C.57 (Correspondence re: Association of Supervisors of Midwives Annual Meeting, 16th June 1947)
based at a Kent clinic who refused to countenance such theories on the basis that she quite simply did not ‘believe’ in them – this is balanced by indications that ‘one or two midwives’ had already taken the initiative to incorporate natural childbirth principles into their practice, some with a great deal of success. 66

Midwifery, on the whole, appeared open to discussion about the concepts of natural childbirth being promoted by Dick-Read and his supporters in the 1940s and 1950s. For example, from the mid-1950s, there is some evidence to suggest that the RCM were particularly keen on incorporating Dick-Read’s teaching into postgraduate midwifery training. 67 Lecturing to graduate midwives in 1954 on ‘the results of physiological childbirth’, Dick-Read broached the subject of how natural childbirth differed from orthodox/accepted methods. Orthodox methods, he stated, ‘preached and practiced’ the assumption of unbearable pain, administered drugs routinely, carried out invasive procedures indiscriminately, made no allowances for antenatal preparation, engendered a decline in breast feeding and an increase in separation of the mother and infant, and excluded husbands’ from involvement – ‘except to pay the bill!’ 68 In pointing out these negative features, Dick-Read placed distance between the orthodox [obstetric] conduct of labour and natural childbirth. More importantly, he also emphasised the similarities between the principles of natural childbirth and those of midwifery in the conduct of

66 PP/GDR/C.57 (Dick-Read to Miss Sanders, 19th January 1955)
67 In the mid-1950s the RCM invited Dick-Read to teach at a number events and study days for postgraduate midwives across the UK. This indicates that at this stage there were areas where the RCM felt Dick-Read’s teaching would be valuable to qualified midwives; indeed, he received several letters of appreciation from midwives who attended the courses. These letters reveal midwives were interested in different aspects of his teaching, both preparation in the pre-natal period and the conduct of labour. W.T.L:PP/GDR/C.57
68 W.T.L: PP/GDR/C.57 (Notes from lecture given by Dick-Read on “The Results of Physiological Childbirth” at the 24th Midwives Postgraduate Course, Kent, 22nd September 1954)
labour. For it was this aspect – and the related aspect of antenatal preparation – to which midwifery was drawn, in contrast to obstetrics which had focused almost exclusively on the issue of pain and its relief.

A recently published popular history of childbirth makes the claim that in the United States at a time when it looked as though midwifery might be superseded altogether, ‘the natural childbirth movement celebrated midwifery for its old-fashioned gentleness and common sense approach’. Such claims suggest that traditional midwifery practice and methods of natural childbirth shared a unique affinity with one another. However, the situation is in fact more complex than this suggests. Certainly, there were aspects of natural childbirth that were closely tied to the values of midwifery at the time; the conduct of labour is clearly one of these. Thus, as Myles Textbook for Midwives 4th Edition (1961) states, the basic principles for midwives in the management of labour resemble closely those espoused by advocates of natural childbirth. Hence pupil midwives in the 1960s were instructed that they must:

- Understand and meet the woman’s psychological needs;
- Provide good bedside care (exercise vigilant observation. This is an integral part of good nursing, and the midwife requires sufficient knowledge and experience to recognise normal progress and detect deviations from the natural course);
- Refrain from unnecessary interference (Nature is capable of performing her function without aid in most instances; meddlesome midwifery increases the hazards of birth).

It is also pointed out that these principles were not confined to labour only, indeed, the management of labour 'begins during the prenatal period' and involved 'building up the woman's general health' and 'gaining her confidence, promoting courage and serenity' as well as 'giving expert supervision and advice' and 'detecting abnormalities'. Even more revealing however, is Myles' reference to women's fear of labour and the midwife's duty to help her overcome this. Stressing the value of companionship during labour, the 1961 edition of Myles maintains on page 261 that:

Loneliness breeds fear, and fear is the archenemy of the woman in labour, who is going through one of life's most tremendous experiences...emotional requirements must be met. It is essential that women are kept informed regarding the process they are making. Women who scream out in labour do so more out of fear than from pain.71

The parallels between this statement and the principles of Grantly Dick-Read's natural childbirth are obvious, but does the fact that a well-known midwifery textbook espouses principles akin to those of natural childbirth necessarily lead to the conclusion that the two are in fact analogous? Perhaps it would be more reasonable to suggest that one did indeed inform the other, but that important distinctions set them apart at this stage. Undoubtedly midwives regarded natural childbirth as a field in its own right, distinct from the practice of midwifery. Tellingly, Myles states, on page 264:

Some women feel very deeply regarding being permitted to experience what is known as "natural childbirth" with the profound joy in hearing their baby's first cry. Although a midwife may think it is more humane to administer inhalation analgesia she must respect

71 Ibid. p.261
and comply with the mother’s wishes, which, in this instance, will have no untoward effect on mother or child.  

This is interesting, for it seems to indicate that although midwifery felt an affinity with certain aspects of the natural childbirth philosophy, in terms of pain and its relief – the very thing certain members of the obstetric profession had seized upon, albeit for a brief moment in the 1950s and 1960s – a great many midwives remained suspicious and intolerant of natural childbirth techniques. As such, midwifery was keen to distance itself from the techniques of natural childbirth, emphasising that its role had always been to support women, both physically and emotionally, in labour. It was the ‘duty’, no less, of midwives ‘to help mothers achieve their ambitions for an ideal birth, imparting a sense of achievement and satisfaction’. 

An article in Midwives Chronicle and Nursing Notes from 1957, for example, acknowledges that tension can be the ‘arch-enemy’ of the labouring woman, being ‘known to increase pain and distort the smooth course of labour’. It is the midwife’s duty, therefore, to eliminate ‘all known causes of tension’, of which fear is but one. However, the article warns of investing too much in this governing principle of natural childbirth techniques, pointing out the ‘danger of replacing fear with frustration’:

A result of propaganda and the dissemination of knowledge is that women are coming to their labour with preconceived ideas. An ambition for a normal, natural birth is most

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72 Ibid. p.264
73 C. L. Beynon “Teaching and Training for Childbirth” in Midwives Chronicle and Nursing Notes (March 1957)
74 Ibid.
desirable, but it should not become a fanatical zeal for either a painless birth or for a birth without drugs or instruments if either should prove advisable.\textsuperscript{75}

The suggestion was that unwavering commitment to natural childbirth methods – particularly those narrow, reductionist approaches that promised women painless birth – could be detrimental in some cases. Women’s hopes for natural childbirth should indeed be acknowledged, but it is emphasised that they should be incorporated more generally into good midwifery practice. Thus:

We can help them to achieve [their ambitions] if reasonably possible and if not, we can assure by our understanding that they are not left with any sense of failure...Present propaganda tends to focus too much on the actual birth to the detriment of higher more permanent aims of childbearing.\textsuperscript{76}

The popularity of natural childbirth techniques, therefore, precipitated a period of self-reflection for the midwifery profession, at a time when midwives were questioning their role and the very future of midwifery practice. The question of whether to emphasise the normalness and naturalness of labour was a particular point of debate: ‘what about the mother who undergoes a prolonged labour and instrumental delivery due to some mechanical defect over which she has not control?’ questioned a 1958 article in Nursing Notes.\textsuperscript{77} Surely the feelings of failure and disappointment that would inevitable ensue could undermine women’s confidence in midwifery? And what about the focus upon support and companionship, the twin cornerstones of traditional midwifery and the natural childbirth movement? Whilst it was agreed that companionship and support were

\textsuperscript{75} Ibid.
\textsuperscript{76} Ibid.
\textsuperscript{77} J. Williams “I Plead for More Childbirth Classes – Open Letter” in Midwives Chronicle and Nursing Notes (November 1958)
doubtless imperative to a positive childbirth experience, there was real concern that 'constant support [was becoming] an impossible ideal in English hospitals'. Women expected the continuous support of a midwife in labour, but in increasing numbers they were describing labour as 'the loneliest and most miserable' experience of their lives. And it was not the pain of childbearing about which women were complaining, but rather the unkind treatment and 'callous indifference' of the midwives they encountered in hospitals.

The impersonal, sometimes inhuman, treatment of hospital patients was by no means limited to the maternity services. However, the natural childbirth debate magnified the sense of discontent amongst mothers; the midwifery profession responded by addressing the issues it raised from a standpoint that emphasised the pragmatism and practicality of midwifery practice, rather than bowing to pressure to adapt in ways called for by natural childbirth advocates [see Chapter Two, above]. In 1960, the Royal College of Midwives organised a conference in Oxford, the aim of which was to address the theme of "Human Relationships in the Care of Mother and Baby". One of the chief focuses of the conference was antenatal education. There is no indication that the growth in the popularity of natural childbirth directly motivated the RCM's decision to hold the conference or to focus particularly on the education of expectant parents in the many

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78 "The Mental Health Act 1960: Considerations for Midwifery Training" (Author unknown) Midwives Chronicle and Nursing Notes (March 1961)
79 This is a direct quote from An Open Letter to All Midwives from Joan Williams, S.R.N., S.C.M., and Health Editor of Woman magazine, first printed in Midwives Chronicle and Nursing Notes in October 1958. The letter was originally produced for the Central Council for Health Education as a contribution towards their 1957 Seminar for Medical Officers. The subject under discussion on this occasion was Education for Motherhood, with the emphasis on natural childbirth. A copy of the letter can be found the Private Papers of Dr. Grantly Dick-Read housed at the Wellcome Trust Library. W.T.L.PP/GDR/C.54
aspects of pregnancy, childbirth and early parenthood. Human relations and the significance of the psychological and emotional aspects of labour and birth had been addressed in midwifery discourse throughout the 1950s, nevertheless, the 1960s was the first time a pedagogical approach was adopted to tackle these issues.

The conference set new standards for midwifery practice by re-emphasising that it was not enough to ensure the physical safety of mother and child through scientific obstetric care. As a result, the role of the midwife was redefined as one whose duty it was to assist in the production of ‘a happy healthy child who, within the framework of a good family background is given every opportunity to develop into a healthy, happy parent’. The involvement of the midwife during the antenatal period was regarded as crucial from this standpoint. According to the Preparation for Parenthood report, published in 1966, there was concern within midwifery that the antenatal teaching provided by the Maternity Services, and the extent to which it was meeting the needs of expectant mothers and fathers, was inadequate. The dominance and leadership of the NCT in this field only served to highlight further the Maternity Service’s inadequacy. Thus, whilst the RCM does not explicitly refer to the NCT or their teaching methods in Preparation for Parenthood, the report (which is based upon a survey of expectant mothers and mothers of first babies in maternity hospitals, homes and departments, carried out in two phases between 1961 and 1962, and 1964 and 1965) perceptibly reflects the influence of the

80 Royal College of Midwives (RCM) Preparation for Parenthood (1966) p.8
NCT childbirth education philosophy, with the emphasis on the idea of natural and prepared childbirth.\textsuperscript{81}

Again, the response of midwifery was to reaffirm its role. The concluding remarks of \textit{Preparation for Parenthood} confirmed that whilst antenatal classes were helpful to the majority of mothers during their labour, ‘in far too many cases the hospital staff were not aware of the instruction the mother had received’ – something the NCT was already addressing. The report recommended that ‘each Local Authority and Hospital Board should ensure that at least one member of their staff and preferably more should have attended courses on the various methods of preparation for childbirth in current use’.\textsuperscript{82}

However, whilst the RCM appeared to support closer communication and the development of greater understanding of contemporary methods of childbirth preparation, it made very clear its position that control of antenatal education ought not be placed in the hands of lay-teachers. The RCM’s report stressed that ‘only trained personnel should

\textsuperscript{81} \textit{Preparation for Parenthood} makes numerous references to the benefits of relaxation and breathing exercises and recommended they were taught to expectant parents, although there is no suggest that they lessened the pain or duration of labour. There are also numerous references to expectant parents “fears” and “anxieties” and the need to build confidence through antenatal teaching. Another issue tackled by the report is the location and style of classes, in particular the “inappropriate” atmosphere of the clinic and the need for “informal” settings that do not resemble “class rooms”, is highlighted. Amongst the recommendations of the report were also suggestions that fathers are included more closely in their wives’ pregnancy, and that this involvement ought to begin in the antenatal class. To precipitate this, for example, changes in the design of maternity units that would allow fathers increased access to his wife and new baby are recommended. In addition, the practice of “rooming in” – allowing the mother to remain with her newborn infant at all times – is also addressed. The report acknowledges the benefits of such practice (which was first advocated by Grantly Dick-Read and later supported by the NCT) but recognises the practical problems associated with it, particularly on large and noisy hospital wards. Above all, pregnancy and childbirth are presented as a defining event in the life of a \textit{family}. Moreover, pregnancy, childbirth and parenthood, it is implied, impinge upon society in definite ways, shaping each generation. The implications of this, according to \textit{Preparation for Parenthood} meant that educating expectant parents should be a priority of the Maternity Services. As such the report reflected the campaigns of proponents of natural and prepared childbirth, even if it fell short of acknowledging them directly.

\textsuperscript{82} RCM \textit{Preparation for Parenthood} (1966) p.64
give antenatal instruction in preparation for labour.\textsuperscript{83} Ostensibly this condition had practical basis: there is a close need for liaison between clinic and labour ward staff so that both are aware of each other's methods.\textsuperscript{84} However, there is no hint that the RCM considered that it might be beneficial to establish such a relationship between labour ward staff and the lay teaching network of the NCT, even though the Trust had been calling for exactly that for almost a decade.

The attitude displayed by the RCM in this instance is symptomatic of the guarded way in which midwifery responded to the ideas propagated by representatives of alternative approaches to childbirth. Whilst some midwives may have agreed with, and indeed supported, these ideas \textit{in principle}, and whilst attempts may have been made to incorporate them into practice, this was done in such a way that midwifery's role was not undermined in anyway. Indeed, as these ideas gained popularity, midwives' response was, interestingly, not to distance themselves from them so much as to manage and manipulate them, thus blurring the boundaries between natural childbirth methodology and the practice of midwifery. It is plausible that the hoped for effect of such a strategy was the eventual subsuming of those approaches that might be considered alternative within standard practice, though not for reasons one might expect.

Behind the 'practical concerns' that were often cited by the Royal College of Midwives and the Central Midwives Board as an inhibitive factor in the application of alternative or natural childbirth methods and techniques, there is evidence to suggest a degree of

\textsuperscript{83} Ibid. p.65
\textsuperscript{84} Ibid. p.65
concern existed amongst midwives as to the implications it might have upon them professionally. On the 18th of January 1968, a meeting between representatives of the medical profession and those of the NCT took place to discuss the training of midwives in antenatal preparation for childbirth. The establishment of a dialogue to debate this issue is, of course, significant. It indicates that the medical profession was indeed beginning to see eye to eye with the NCT on at least one aspect of its philosophy: the desirability of antenatal education (see above). However, the minutes of the meeting indicate that the relationship between them was not one based upon mutual trust or understanding. As Mrs Rankin went to great length to point out, speaking on behalf of the NCT, their work was voluntary and their aim merely to help mothers and work with the approval of doctors, Mrs Entwistle, representing the CMB, gave the 'midwives' point of view' in no uncertain terms. It was her consideration, she said, 'that lay teachers giving instruction to expectant mothers was encroaching on the midwifery profession'.

In her opinion, it was wrong 'for a lay person to try to fulfil the duties that were specifically within the province of a doctor or midwife'. Mr Ahmet, representing the Royal College of Obstetricians and Gynaecologists, supported her in this view. Nevertheless, he thought that cooperation between the CMB and the NCT was possible, if the teaching given by the Trust was under the supervision of a qualified midwife.

The attitude displayed by the CMB was in no way novel; in fact similar concerns had been voiced some twelve years earlier in a Ministry of Health memorandum relating to the mention of relaxation/preparation in a speech on antenatal care given at a meeting of the Association of Executive Councils in 1956 (around the time the NCT was

85 T.N.A: DV11/357 Minutes of a meeting of Representatives of the Approvals and Examination Sub-Committee CMB (18th January 1968)
86 Ibid.
established). Several articles on antenatal preparation and the teaching of relaxation had also appeared in the national press, prompting the Ministry to debate what the establishment of a Natural Childbirth Association (NCT) meant for the future of maternity services. The memo notes:

The Central Midwives Board and the Royal College of Midwives are seriously concerned, as are we, about the activities and proposals of the [Natural Childbirth] Association to use lay instructors and set up their own antenatal clinics... This seems to me to be bordering on an ethical problem...  

The Ministry of Health doubted that the NCT or the values they represented were in fact 'likely to undermine good, standard maternity practice or influence public opinion'. The threat they presented was considered insignificant, the alternative they offered nothing but a 'flimsy lay suggestion' that was 'surely inadequate for mothers who have good professional services available'. Nevertheless, the Ministry acquiesced that were Briance to garner any great support 'for her gospel' it might be considered a 'reflection of present methods'. Thus, it was agreed that the important thing was to stress the 'value of good antenatal care without reference to the NCA', even though it was recognised that 'a more general acknowledgement of the value of physical and mental factors may be all to the common good'.

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87 T.N.A.MH134/139: Midwifery/Natural Childbirth/Doctor Dick-Read's Method Private memorandum issued by the Minister of Health (c.1956.)
88 Ibid.
89 Ibid.
It is with a sense of irony that one observes how midwifery closed ranks against the natural childbirth movement as represented by the NCT in the 1950s and 1960s, particularly given that midwifery supported the notion of antenatal education. One can speculate that, were the representatives of the profession more willing to set their concerns about the threat posed by the NCT’s lay-teaching network to one side, midwifery and supporters of natural childbirth would have had much common ground, particularly in the area of antenatal education, upon which to build a relationship. The lack of receptiveness amongst midwives at this time can be partly explained, nevertheless, by considering the issues and problems faced by the profession at this point in its history.90

Marjorie Tew describes modern midwifery as ‘a successful but uneasy profession’.91 Midwives had had to deal with the consequences of the move from home to hospital birth, which impacted significantly upon their profession, as did the creation of the National Health Service in the late 1940s. The growing dominance of doctors in the maternity arena was another important factor in the diminishment of midwives’ autonomy and responsibility. A memorandum from the CMB to the Ministry of Health relating to Maternity Medical Services Policy between December 1947 and December 1948 indicates, for example, that the CMB was never consulted on the Minister’s

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90 Midwifery’s response to concepts of natural childbirth was closely related to the contemporary issues with which the profession was faced. For example, as Richard Barnett asserts: when ‘birth moved from home to hospital, obstetricians supplanted midwives as the professionals “in charge” of birth, and the natural childbirth movement’s claim that birth pain was in some part related to the stress of hospital birth was redeployed in what many midwives perceived as a struggle for continuing professional recognition and even existence’. See: R. Barnett “Obstetric Analgesia in Britain, 1948-79” in Wellcome History, Issue 31 (Nov, 2005)
decision to implement a GP Obstetric Service. The memorandum expresses the midwifery profession’s alarm at the move and the concern that, ‘in effect [the midwife’s] responsibilities will differ little from those of a maternity nurse’. Ministry of Health files relating to the changes that were occurring to the Maternity Medical Services around the late 1940s indicate there was much confusion about exactly what the midwife’s role was to be in the future. One thing that does stand out is that in discussion of the issue, only the CMB and the other representatives of midwifery mention ‘normal birth’. If midwives were now beginning to regard themselves as the ‘guardians’ of ‘normal birth’ without unnecessary interventions, given the adverse circumstances, it was hardly surprising that they expressed suspicion when faced with what many midwives regarded as yet another challenge to their autonomy.

Briance’s army of lay teachers represented merely one aspect of this challenge. The entire philosophy of natural childbirth was something midwifery had a hard time coming to terms with, particularly given the circumstances outlined above. To begin with, although the natural childbirth movement has been portrayed as in support of traditional midwifery – at the heart of which is, arguably, domiciliary midwifery – the NCT did not take steps to oppose the shift to increased hospital confinement. Indeed, the Trust developed its own programme of teaching in response to it, employing techniques – such as those of psychoprophylaxis – that would better serve women labouring on the maternity ward. Furthermore, as Jennifer Beinart points out, both Lamaze and Dick-Read’s methods were taught within the context of the nursing home or clinic, spaces

\[92\text{T.N.A.MH137/182: NHS Legislation & Regulations (Maternity Medical Services Policy), 1947-1948. (Memorandum issued by the CMB to the Minister of Health, Dec 1947)}\]
which were themselves expressions of the obstetric model of childbirth and were of
course controlled by (male) doctors. Thus:

The tendency of the natural childbirth movement to uphold the central role of the doctor
derived directly from Dick-Read and Lamaze, as well as from earlier campaigns on
maternity.\textsuperscript{93}

This tendency was manifest in the lauding of the medical profession by the NCT in the
1960s, and resulted in the fostering of mistrust between professional midwifery and the
representatives of natural childbirth that would take decades to overcome.

That is not say that individual midwives did not support the use of techniques of natural
childbirth. Notable characters such as Erna Wright, the renowned midwife who was
associated with the NCT’s antenatal teaching programme – not to mention countless
others who were less well known – celebrated the cause. A former-midwife, highly
regarded for her clinical skills when she worked in Mill Hill in North West London
during the 1950s and 1960s, remembers how her knowledge of breathing and relaxation
techniques were appreciated by the mothers whose labours she attended, including that of
her own niece in 1952. An enthusiastic exponent of natural childbirth throughout her
career – she was apparently interviewed on the subject for television in the 1960s – this
particular midwife (who is now in her mid-eighties) remains convinced of its benefits,
both for mothers \textit{and} for midwives.\textsuperscript{94} Yet, on the whole, midwifery remained ambivalent
on the subject. As another former-midwife remembers, in the 1960s, ‘we only spoke of

\textsuperscript{93} J. Beinart “Obstetric Analgesia and the Control of Childbirth in Twentieth Century Britain” in Garcia,
Kilpatrick and Richards \textit{The Politics of Maternity Care} (1990) p.128
\textsuperscript{94} Telephone interview with H. Lovell (2\textsuperscript{nd} July 2005)
“normal” or “abnormal”. It was only in the 1970s and having children myself that I first read about natural childbirth’.  

The Nadir of Natural Childbirth?

By the late 1960s ‘the whole childbirth business’, in the words of a former-midwife who trained at the Simpson Memorial Hospital, Edinburgh, ‘changed, almost without anyone really been aware of it’.  

Women generally gave birth in hospital, which was considered the norm at this stage. They were still attended to by midwives, but it was the midwife’s job to ensure the routines of the hospital ward were strictly adhered to. The midwife interviewed for Devlin’s study recalls:

[Women] were processed like machines...[they] accepted the doctor's decision at that time. They assumed without question that if one is ill, or having a baby, one trusts the doctor and he makes the decision. Women put themselves in the hands of the professionals and they sorted them out in their own way. We did not have monitors in my day, but we were inducing them and putting them on drips. We kept women in the first stage of labour up and wandering around although many wanted to stayed in bed...Then, as they progressed, we wheeled them round the corner and put them in the delivery room...  

Doctors were becoming increasingly involved; however, it was still the midwives who were considered ‘in charge’ of the delivery – unless medical aid were considered necessary. But the fact that midwifery was now practiced within the confines of the  

95 Postal response to questionnaire from J. Dow (15th July 2005)  
96 Cited in Devlin Motherhood (1997) p.116  
97 Ibid.
maternity ward meant that they were subject to the rules and regulations of the hospital environment – not mention the stress. Brusque treatment at the hands of midwives – something mothers complained bitterly about in myriad letters to the NCT – was exacerbated by the strict routines imposed by labour ward protocol. As the decade drew to a close, it was with regret that many midwives observed a new era of maternity care dawning. The Peel Report of 1970, with its recommended 100 percent institutional delivery, hastened a shift in childbirth culture. With the high-tech, medically defined model of childbirth dominating policy development, the efforts of a handful of doctors and midwives – no matter how committed to the ideal of natural childbirth – could do little to change the landscape of the maternity services. Indeed, the 1970s might well have been the nadir of the natural childbirth ‘movement’: after an initial flurry of interest in the techniques promulgated by the supporters of Dick-Read and Lamaze in the 1950s and 1960s, support of natural, prepared or “painless” childbirth in midwifery discourse became sporadic at best.

There is no greater indication of just how distanced mainstream midwifery practice had become from the principles of natural childbirth during the 1970s than the following statement, taken from Myles’ *Textbook for Midwives* in 1981:

> Pregnant women are inadvisably exhorted by certain groups to demand “natural childbirth” and to refuse any interference. But when left to nature labour can be long, painful and exhausting to the mother and lethal to both mother and child. Women today are not aware of the disastrous results of natural childbirth at the beginning of this century and in some under-developed countries today. Childbirth had been made safer, shorter and easier by the very scientific procedures some misinformed women object to.
Reverting to primitive methods is a retrograde step, which has no justification and cannot be condoned.  

This statement is particularly pertinent when one considers it was made almost two decades since the 4th Edition of the same textbook had argued for understanding and support of women who expressed a wish for a natural birth.

Judging from Myles' emphatic condemnation of natural childbirth, might we assume that midwifery – which had hitherto demonstrated genuine, but not unwavering support – had joined forces with obstetrics in terms of its attitude toward alternative methods of childbirth? Such a question forces us to look more closely at the period leading up to the publication of this edition of Myles' textbook: the 1970s. What happened to maternity policy and practice during this period? Why did the distance between mainstream and alternative approaches to maternity care widen to the extent it did? Perhaps it was, quite simply, a product of inertia: doctors and midwives accepting the doctrine of the medical model without challenging or questioning it. This explanation seems far from satisfactory however. As mainstream maternity care became increasingly medically defined, an undercurrent of dissent was sustained from within midwifery, and even obstetrics. These dissenting voices joined forces with childbirth educators, campaigners for women's rights and others with a similar agenda. The challenge they represented became progressively more radicalised as the decade wore on, particularly when faced with issues such as the rise in medically induced labour, and the growing dissatisfaction of women with standardised maternity care. Employing the language of natural

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98 Cited in Oakley and Richards "Women's Experience of Caesarean Delivery" in Garcia, Kilpatrick and Richards Mothers and Maternity Policies in the 20th Century (1990) p.185
childbirth to articulate their position, the nonconformists remained in the minority for much of the 1970s, yet their stand against the seemingly irrepressible force of technological intervention in labour and childbirth would, eventually, contrive to change childbirth. It is precisely this activity which links the narrative of the early campaigns for natural childbirth in the 1950s and 1960s, with that of later movements to challenge medical hegemony in maternity care provision. The 1970s was, therefore, a pivotal decade in the history of this idea.

I used a natural childbirth method on my first birth in hospital two years ago and had no need of anaesthetics or medical intervention...After the delivery and a minimal cuddle my first child was snatched away...I want to be free to cuddle my second infant after birth as long as we both want this. When I became pregnant again, to my dismay my GP told me, 'There is no chance of your having the baby at home'. This was the policy of the local practice as it was thirteen miles to the local hospital. I am now temporarily registered with a sympathetic doctor who will deliver my baby at home; the local midwife has agreed to deliver me...so one could say I have won the battle. But should one have to battle for such a basic right?\(^1\)

In their 1983 film The Meaning of Life, the satirist British comedy team Monty Python’s Flying Circus addressed – in typically sardonic manner – the issue of childbirth in contemporary Britain with sketch entitled The Miracle of Birth. In it the expectant mother – puffing and panting as she is pushed along hospital corridors on a trolley before herself being ‘delivered’ to the waiting medical staff, gloved and gowned and holding court in a brightly lit operating theatre – asks politely, “What do I do, doctor?” To which the reply is “Nothing dear, you’re not qualified!” Here birth is presented as a performance, and it is the doctors who assume the leading role, the myriad machines that clutter the operating theatre, their supporting cast. The labouring woman lies silently supine amidst these machines, practically forgotten about: the doctors value machines

apparently more than their patient. Instructions are barked between medical staff and routines are followed to the letter; birth is regarded as a disease: “don’t worry dear, we’ll soon have you cured!” There is no place in the performance for the woman’s husband, who is told emphatically, “Only people involved are allowed in here!” Of course, the sketch was an exaggeration, a wryly-observed take on contemporary events; it was nevertheless a reflection of technocratic childbirth culture during the 1970s and early 1980s. Is this really what birth in England in the late-twentieth century had become? And if so, what did this mean for the cause of natural childbirth?

**Having a Baby in the 1970s.**

1970 was the year that the Report of the Peel Committee recommended that facilities should be provided to allow for ‘one hundred percent hospital delivery’.² Although it has been highly criticised by some authors – not least for its methods of enquiry and ‘disregard of for the need to substantiate claims with evaluated results’³ – in many ways the Peel Report represented little more than the official seal of approval on the trend toward universal acceptance of hospital birth that had been developing since the late 1940s. The Standing Maternity and Midwifery Advisory Committee, under the chairmanship of Sir John Peel, was originally set up to consider and advise on the future of the domiciliary midwifery service and the related issue of maternity bed needs. But, according to Tew, by now ‘everyone had been indoctrinated to accept the medical view that childbearing was an illness, to be treated like other illnesses by doctors’.⁴ Indeed,

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³ Tew *Safer Childbirth* (1998) p.204
⁴ Ibid. p.204
prior to the publication of the report, the influence of obstetrics in maternity service provision had grown exponentially: already by the mid-1960s, midwives had fewer and fewer opportunities to witness normal birth within a community setting and the growing emphasis on the obstetric training of GPs was threatening to erase the family doctor's involvement in intra-natal care. As such the report was testimony to the declining status of professional midwifery, and also of general practitioner obstetrics in the community setting.

By 1970, with pregnancy and childbirth now largely defined in medical terms, the possibilities for experimenting with alternative childbirth methods during labour and delivery – already limited – supposedly narrowed further under the rigid routines of the labour ward and the overwhelming control of obstetric orthodoxy. Those midwives and doctors who had been enthusiastic about natural childbirth in the 1950s and 1960s found they were increasingly curtailed by the strict rules and protocols of the labour ward. As early as 1959, the year the Report of the Cranbrook Committee was published, the Royal College of Obstetricians and Gynaecologists was advancing the view that hospital confinement for all births was most desirable in terms of safety (for both mother and

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5 Tew discusses the training of general practitioners in obstetrics in *Safer Childbirth* (pp.67-69). Her account notes how, from 1948, it became a requirement for all GPs who wished to provide maternity care to be included on the 'obstetric list'. The criteria for inclusion on the list included six months experience in a consultant obstetric unit. The number of GPs choosing to attend births, rather than just providing antenatal and post-natal care, diminished in the decades following this requirement. In the 1950s and 1960s, deliveries were taking place less and less in the home, and by the 1970s, a great number of GPUs (General Practitioner Units) were closed. According to Tew, the GPs' independence in this field was marginalised as a result.

6 Natural childbirth discourse all but disappeared from obstetric literature and barely a mention of the subject can be found in obstetric textbooks of this period. Mention of natural childbirth was also scarce in the standard midwifery textbooks of the 1970s and 1980s and some even criticised the concept outright (see below). Limited discourse on alternative approaches to birth continued in some midwifery and nursing journals, however, articles on the subject were rare in the 1970s until a resurgence of interest in natural childbirth in the mid to late 1980s. See Chapter Five, below.
child). Physical safety, moreover, claimed superiority over emotional interests, and although counter-arguments were presented, not least by the NCT, medical opinion proved tremendously influential and persuasive – or, as Tew puts it: ‘the opinion which carried most weight, regardless of evaluation, were those of the most prestigious and politically most powerful players – the hospital specialists’.

If, by 1970, the influence of the ‘hospital specialist’ upon maternity policy development was more or less absolute, what did this mean for the supporters of natural childbirth? How did the maternity services respond to their challenge, if at all? The Ministry of Health made it clear to the National Childbirth Trust as early as 1956 that their concern ‘is not what is done during childbirth, but in the organisation of the service’. Further, in 1959, a Ministry of Health memorandum, referring specifically to natural childbirth methods, stated categorically that such matters were ‘a clinical matter which must be left to the obstetricians and doctors responsible for the supervision of expectant mothers’. Thus, whilst the Ministry acknowledged the use of these methods, its reaction demonstrates keenly how the conduct of labour had become a medical issue. Whether natural childbirth was practiced or not was not a policy issues; the ‘discretion of the

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7 Paragraph 46, on ‘Care During Labour’ states: ‘During labour a mother should be assured of receiving the help of a midwife and a doctor. Should it become necessary for the midwife to call for medical aid, this help should, as far as possible be given by the doctor who has been responsible for the mother’s antenatal care. If any sudden emergency should arise, either the doctor or the midwife should summon immediate help from an experienced obstetrician and anaesthetist with all the equipment necessary for resuscitation, including blood transfusion. The help of a paediatrician should easily be obtainable should the baby require and special treatment...’ RCOG Archives (M24/2) Report of the Maternity Services Committee (1959)

8 M. Tew Safer Childbirth (1998) P.201

9 TNA: MH134/139 Ministry of Health: ‘Midwifery/Natural Childbirth/Dr. Dick Read’s Method’

10 TNA: MH134/139
individual doctor or midwife *in charge of the case* was paramount'. Hence, by 1970, natural childbirth had made little impact upon maternity policy in terms of the conduct of labour.

Furthermore, by 1970, the reconstruction of birth as a medical procedure effectively closed the space that had opened up for experimentation with alternative methods of pain relief. The management of pain, as we have seen, was a subject of enormous interest and debate in the 1950s and 1960s, but by the 1970s discussion of pain relief largely took place within this limited high-tech paradigm. When the *Maternity in Great Britain* survey was conducted in 1946, sixty percent of women delivered without any form of analgesia or anaesthesia; lack of pain relief was a common complaint amongst the mothers who took part in the survey. By 1970, according to research by the NBTF and the RCOG, a mere *three percent* of women delivering in British hospitals received no analgesia/anaesthesia. This was largely regarded as a positive example of how far the maternity services had progressed since the 1940s.

The shift to hospital played a pivotal role in widening access to pharmacological pain relief, and the relationship was symbiotic. By the 1970s the obstetric anaesthetist had been added to the growing number of medical specialists involved in pregnancy and parturition. With the introduction of the epidural, the elimination of pain, rather than its management, became the holy grail of obstetric anaesthesia. Although its application in

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11 TNA: MH134/139 My emphasis.
obstetrics was in its infancy in the 1970s, the epidural – which required hospital delivery for its administration – was already beginning to impact upon childbirth culture. According to research carried out by Beinart into obstetric analgesia in the second half of the twentieth century, when a shortage of anaesthetists threatened to deny women an epidural, some were choosing to have their labour induced in order to guarantee one.\textsuperscript{14} Even AIMS joined the campaign for epidurals to be made more widely available in the 1970s, before later having serious reservation about them.\textsuperscript{15}

To discover exactly what all of this meant for a woman having a baby in 1970, it is helpful to refer to a British Cohort Study set up in that year. The \textit{British Births Survey}, collected data on the births and families of just under 17,200 babies born in England, Scotland, Wales and Northern Ireland in a particular week in April, and was sponsored by the Birthday Trust Fund and the Royal College of Obstetrics and Gynaecologists. The focus of the study was fairly narrow and it was principally concerned with the medical aspects of childbirth, which of course is itself revealing, although there were references to antenatal education and developments in human relations. It was stressed that of the 17,200 births not a single maternal death had occurred, ‘a reflection of the improved health of the population’ \textit{and} ‘the quality of care given to pregnant, labouring and puerperal women in the UK’.\textsuperscript{16} The survey mainly focused on improvements in maternity services since the 1958 Perinatal Mortality Survey, and in particular

\textsuperscript{14} Beinart "Obstetric Analgesia and the Control of Childbirth in Twentieth Century Britain" in Garcia, Kilpatrick and Richards \textit{The Politics of Maternity Care} (1990) p.124
\textsuperscript{15} Ibid. See also: Chapter Two [above].
\textsuperscript{16} Chamberlain \textit{et al}, \textit{British Births, 1970 Vol. 2: Obstetric Care} (1978) With regard to Perinatal Mortality, the study was ‘only concerned with living and live babies’ but it was pointed out that the perinatal mortality rate remained high despite some improvement since the 1958 Perinatal Mortality Survey.
highlighted how the conduct of labour had changed. The major changes recorded by the survey were thus:

1. Greater sophistication of pain-relieving techniques.
2. Greater awareness of the mother's emotional needs.
5. Greater use of obstetric forceps and the ventouse.
6. Greater use of caesarean delivery.
7. Less likelihood of women being left on their own to endure a prolonged labour.\textsuperscript{17}

Hence \textit{British Births} is, arguably, testament to the medicalisation of childbirth; whilst emotional needs \textit{were} acknowledged, the increase in obstetric intervention was presented in clearly positive terms. For example, a significant rise in induction was recorded: by 1974 20.6 percent of labours were medically induced, and it was noted that the incidence of operative deliveries was greater when labour was started in this way. However, the report does not adopt a judgemental tone when making this point. Rather, \textit{British Births} goes on to sanction a greater degree of obstetric intervention to counter the problems that may arise from inducing labour, stating:

\begin{quote}
If the use of increased induction and increased augmentation of labour is continued, it is obvious from the data presented that there must be a greater need for labour monitoring equipment to recognize the early signs of impending foetal hazard.\textsuperscript{18}
\end{quote}

\textsuperscript{17} Chamberlain \textit{et al}, \textit{British Births 1970} (1978)
\textsuperscript{18} Ibid.
This statement demonstrates two things. Firstly, that contemporary opinion was weighted toward more, not less, obstetric intervention, and secondly that the greater use of technology in labour was self-perpetuating. 19

_British Births_ is also testament to the greater incidence of hospital delivery. The shift from home to hospital was certainly causally related – among other things – to attitudes toward labour pain, which was itself cast as an obstetric problem. Provision of pain relief remained the principal consideration and was, by now, ‘expected by most Western women’. 20 Although it was stressed that ‘childbirth is a normal function’ it was accepted that ‘most women find it painful and so the relief of pain is an important part of obstetrical care’. 21 As with earlier surveys, data on pain relief revealed inequalities between the social classes both in terms of attitude and provision, though it was acknowledged that pain, being individualistic, was impossible to survey accurately. Nevertheless, one of the most glaring class biases revealed by the survey with respect to pain relief was in the use of ‘alternative’ methods. The ‘psychoprophylactic methods’ as they were referred to, were recorded as having been used by 263 women (a mere 1.6 percent of the total surveyed). Of these women, the majority were from social class groups II, and I and were aged between 25 and 26 years. It was speculated that this group were ‘probably well motivated’ having reported ‘80.2 percent attendance at antenatal instruction compared with the total study population figure of 26.2 percent’.  

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19 The implication of this statement is the legitimisation of what was later referred to in natural childbirth literature as a “cascade of interventions”. See: Glossary of Terms
20 _British Births_ (1978)
21 Ibid.
Furthermore, with reference to regional differences, it was noted that psychoprophylaxis was more common in the southeast than other areas of the UK.

*British Births* thus portrayed psychoprophylactic methods as having minimal impact upon services for the majority of childbearing women in the UK. The methods were presented as a niche concept, and although they were not criticised *per se*, little scope was provided in which to explore them further. Indeed, the report was keen to point out that of the 263 women who had employed the techniques during labour, only 31 (12 percent) used no other pain relief. Interestingly, given this attitude, the notion of antenatal education is positively represented in *British Births, 1970*. The survey exposed what is referred to in the report as a 'disappointing response' with regard to antenatal education: three quarters of respondents indicated that they received no antenatal instruction of any kind. These figures were further broken down by age, class and parity, revealing that over half of primigravidae attended some antenatal classes – mostly those provided at the local authority clinic – and that proportionately more women who delivered at home, in the private sector or in a GP unit were likely to avail themselves of antenatal education. The conclusion, based on this data, was that where antenatal education was concerned, given that 84.8 percent of deliveries took place in hospital, the most desirable situation was to prepare women for childbirth at hospital-based antenatal classes. The reasoning behind this was that if women were prepared for childbirth by the hospital team attending deliveries, they could then explain the individual procedures practised in the labour wards of that hospital.
Arguably, this demonstrates how the concept of antenatal preparation for childbirth (which, as we have established, was rooted in the theory of natural childbirth) was usurped by the mainstream. In broader terms, it also exemplifies how the entire process of pregnancy and childbirth had been placed under the medical gaze. Certainly, *British Births* provides insight into the strange relationship between mainstream medical maternity care and the concept of antenatal education in the 1970s. The architects of the survey expressed a keen desire to learn about antenatal preparation and its effects. There is evidence to suggest that they were aware of the influence of psychoprophylaxis and wanted to discover, amongst other things, what exercises were involved, who taught the classes, what their status was, where the classes were held, and whether husbands attended.²² This perhaps signified that the concept of *childbirth preparation* was increasingly considered an essential aspect of pregnancy and childbirth for a growing number of women in the UK. Although the study did reveal 'disappointing' levels of attendance, particularly amongst mothers from the lower social strata, the assumption was that antenatal instruction did have a role to play in the future of the maternity services, even if the alternatives with which it was often associated with did not.

The Role of Childbirth Education.

The maternity medical services were definitely becoming more attuned to the benefits of antenatal education. By 1970, according to Rhodes' *Short History of Clinical Midwifery*,

'virtually all antenatal clinics had preparation classes', most often run by midwives or physiotherapists. Indeed, since the early days of the NHS antenatal classes had been offered to pregnant women in increasing numbers. Nevertheless, it must be pointed out that these were, often 'treated as an optional extra compared with clinical antenatal care'. Thus, although the health authorities appeared to value the concept of antenatal education, this by no means represented the nascent acceptance of alternative ideas in mainstream maternity care. However, some links are evident. For example, similar techniques – of breathing and relaxation – to those taught by the NCT were also taught at some NHS antenatal classes. Also similar motives underpinned the development of health authority classes, namely the reduction of anxiety and the building of confidence of expectant parents. However, the assumption was always, it seems, that practicing breathing and relaxation and reducing fear and anxiety could be helpful to pregnant women, but that it should not get in the way of the provision of clinical maternity care.

Even so, by the 1970s the health authorities were making a concerted effort to extend provision of antenatal education with a number of initiatives. Training in parentcraft had been included in the pupil midwife’s syllabus for many years, but, according to Brammer enquiry into antenatal classes provided by the health authorities, in 1972 all midwifery-

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25 See for example the Royal College of Midwives report on *Preparation for Parenthood* (1966) which recommends the implementation of classes in breathing, exercise and relaxation stating that 'each Local Authority and Hospital Board should ensure that at least one member of their staff and preferably more should have attended courses on the various methods of preparation for childbirth currently in use'. (p.65)
training institutions were urged to review their arrangements to ensure that all pupil midwives received adequate training. Several studies gathered data on the effectiveness of antenatal instruction, investigating factors such as reduction of length of labour and reduced need for pharmacological pain relief, and addressing the social and emotional benefits of instruction. However, did this activity indicate that antenatal education was bridging the gap between alternative and mainstream? The simple answer has to be no, for several reasons.

Firstly, there was no consensus of opinion about the value of preparation for labour. Even when the value of training was accepted, questions remained concerning the emphasis on ‘painless’ or natural childbirth. An article on training for labour in Midwives' Chronicle and Nursing Notes, for example, suggested that women must be told that labour is a ‘painful process and that this is not just an abnormality of the mind’. Secondly, there was an increasingly large conceptual gap between antenatal education and the conduct of labour [see Chapter Three, above], which was compounded by research that appeared to show that attendance at class did not appear to make any serious difference to the state of mind of the patient upon admission. A third issue was that the development of antenatal education in the public sector was a top-down process. The effect of this was two-fold: firstly, antenatal classes organised by health authorities

28 For example: M. Williams & D. Booth Antenatal Education (1974) & B. Rathbone Focus on New Mothers: A Study of Antenatal Classes (1973)
29 Williams & Booth Antenatal Education (1974) p.162
31 Ibid. p.158
were influenced by the definition of childbirth being endorsed by the medical profession. This had obvious implications upon the content of classes. Secondly, because the midwife or doctor referred women to antenatal classes – both local authority classes run by midwives and those offered by the NCT – there was always the possibility that 'selection' would take place – either consciously or sub-consciously.

In other words, midwives/doctors would only refer to classes those patients for whom they considered antenatal instruction would be appropriate. Clearly this had an impact on the demography of antenatal education: although the assumption was that demand was growing amongst pregnant women, it was evident that attendance was divided along lines of social class. Indeed, Rathbone's findings indicated that 'the most important factor influencing [antenatal class attendance] seems to be the amount of [formal] education received'. Antenatal class attendance was also negligible amongst the growing numbers of expectant mothers from ethnic minorities, younger mothers, and mothers giving birth for the second or subsequent time. However, women's agency in attending antenatal classes must not be overlooked. Whilst midwives and doctors were responsible for referring their patients to appropriate antenatal instruction, women themselves exercised choice when it came to attendance. The question of whether women themselves considered antenatal instruction relevant is therefore an important one. This question was beginning to be addressed in the 1970s, yet it would be some years before

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32 See: Chamberlain “Antenatal Education” Midwife, Health Visitor and Community Nurse (September 1975) pp.289-292
33 Rathbone Focus on New Mothers (1973) p.8
34 See Chapter Five, below for a discussion of what women “wanted” from the maternity services.
'authoritarian teaching' gave way to more individualistic approach and greater consideration of expectant parents' particular feelings and concerns about childbirth.35

Arguably, the failure of the health authorities and the medical profession to grasp the essential meaning and value of antenatal education underpinned women's apparent lack of receptiveness to the concept. Antenatal education certainly suffered from its didacticism. Rather than concentrating on such values as emotional support and the creation of social networks, many antenatal classes in the 1970s focused on physical preparation, such as breathing exercises and relaxation, as well as indoctrination in the routines of the labour ward. Thus, whilst the concept of antenatal education did seem to impact upon maternity services, rather than positively influencing policy and challenging mainstream childbirth culture, it appears to have been absorbed into it.

Sheila Kitzinger has critiqued this process of homogenisation. She writes, 'every society has its own birth culture'. In northern industrial societies, and increasingly in the developing world, this is medical and technocratic'.36 Traditionally throughout the world, however, birth is a social, rather than a medical, process. Kitizinger argues that, in a technocratic birth culture, rites are employed in the same way as in traditional cultures: the ultrasound-scan, the antenatal clinic, the electronic foetal monitor, episiotomy – these are the rituals of the medicalised model of birth. Where, then, does childbirth education fit in? Had it become yet another ritual within an essentially 'technocratic' birthing culture, or did it symbolise the growing relevance of alternative approaches to childbirth?

35 Williams & Booth Antenatal Education (1974) p.9
36 Kitzinger (2005) p.1
The changing concept of natural childbirth

It was argued in the previous chapter that in the 1950s and 1960s a small number of obstetricians and midwives were finding ways of implementing natural childbirth techniques into maternity care. However, rather than challenging orthodox practice or changing maternity policy, such activity, which was largely motivated by the growing interest in the management of pain, represented the subsuming of natural childbirth principles into the mainstream. In the 1970s, interest in natural childbirth or psychoprophylaxis waned amongst the obstetric community and midwives (although some areas of midwifery still retained an interest in the principles, insofar as they informed antenatal teaching). Discourse on the management of pain and the conduct of labour took place within a 'high-tech' paradigm, where little space was available for alternative ideas to flourish. As birthing culture became more dominated by the orthodox obstetric model of hospital-based childbirth throughout the decade, the distance between the mainstream and the ideal of natural childbirth became even wider.

'Normal' childbirth in the 1970s and 1980s took place in hospital. The incumbent routines — shaving of the pubic hair, enema and episiotomy, electronic monitoring, managed 'third stage' [delivery of the placenta - see Glossary of Terms] — became part of the experience. Increasingly women expected to have access to obstetric anaesthesia, particularly (by the early 1980s) the epidural. These expectations combined with
spiralling rates of medical intervention and caesarean section to cement an image of normal birth that was far removed from the idyllic representation proffered by natural childbirth advocates. Yet a consequence of this widening gap between alternative and mainstream was by no means the quieting of natural childbirth discourse, nor was it the unquestioning acceptance of obstetric orthodoxy. Rather, what happened was that the concept of natural childbirth changed in response to the contemporary situation. Firstly, its supporters grew ever-more radicalised; even the NCT, which had spent two decades aligning itself with the medical profession, took on a more radical appearance in the 1970s. Secondly, the issues that concerned natural childbirth advocates changed, and whilst the fundamental principles remained intact, natural childbirth was effectively deconstructed and recast in terms that were contrary to ‘high-tech’ medicalised childbirth culture.

In the 1970s the approach of authors writing about childbirth was less upon preparation and more upon the experience of labour and birth – for both mother and baby – as well as the conditions in which birth took place. In 1966, Dr. Frederick Leboyer, a respected surgeon specialising in obstetrics and gynaecology, and director of the Paris Faculty of Medicine, developed a radically new approach to childbirth that he called ‘birth without violence’. Leboyer was convinced that the emotional environment of birth had profound impact and life-long effects upon the newborn infant, a thesis expounded in his classic Birth Without Violence.37 Leboyer was very different in his approach to Dick Read and Lamaze. Firstly, he dismissed the use of ‘techniques’, arguing instead that ‘attitudes’ –

the spirit in which acts are performed rather than the acts themselves – that are important.\textsuperscript{38} In \textit{Birth without Violence}, he wrote:

Where can we begin?

The mother has to be taught about natural childbirth. But how can we prepare the child?

We must begin by understanding.

Understand \textit{why} the newborn baby suffers so much …

We must listen to them, we must try to hear, to understand. And we shall be halfway there.\textsuperscript{39}

For Leboyer the environment of birth played a crucial role; the attitude of those present was, of course, a key part of this environment and the thoughts and emotions, particularly those of the mother around the time of birth had, he believed, profound consequences for the baby. Where Dick Read and Lamaze had focused almost exclusively on birth from the point of view of the labouring woman, Leboyer thought birth should be a positive and un-traumatic experience for the mother \textit{and} her baby. Clearly the two were related – Dick Read some thirty years previously had claimed natural childbirth benefited babies as well as their mothers – what is different about Leboyer’s approach is that it is \textit{about} the baby and his/her experience of \textit{being born}, rather than the mother’s experience of giving \textit{birth}.

It is possible that Leboyer, writing in the early 1970s, considered the message of natural childbirth had been overstated; hence he asked:

What about the mother?


\textsuperscript{39} Leboyer \textit{Birth without Violence} (1975) p.14
Radiant expression, ecstatic smile. But what is she smiling about? The beauty of her child? Not really. She’s smiling because it’s over.

She has completed ‘her’ natural childbirth; she had been only been half-convinced by the phrase, so she’s amazed. And relieved. And — justifiably — proud of herself.

She’s smiling with delight.

She’s pleased ... with herself ...

As for the child ...⁴⁰

Whilst advocating natural birth as a precursor to birth without violence, but Leboyer pointed out ‘methods’ and techniques of natural or prepared childbirth failed to consider the importance of the period beyond the moment of birth. Although Dick Read had emphasised the benefits of ‘rooming-in’ and establishing breast-feeding immediately after delivery, these factors were not by any means the pillars upon which his philosophy rested. The psychoprophylactic approach proposed by Lamaze, moreover, was concerned only with coping with the pain experienced in the first and second stages of labour and stopped short at the moment of birth. Leboyer focused attention on the previously disregarded ‘third-stage’ of labour — the delivery of the placenta — as well as the critical moments immediately after birth. Thus, he considered the practice of clamping and cutting the umbilical cord immediately upon delivery nothing less than barbaric, arguing instead for the baby to be delivered to the mother’s stomach, the cord remaining intact until it ceased to pulsate and the newborn’s breathing established independently:

⁴⁰Ibid. p.13
To sever the umbilicus when the child had scarcely left the mother's womb is an act of cruelty, whose ill effects are immeasurable. To conserve it intact while it still pulses is to transform the act of birth. 41

Leboyer was deeply concerned with the naturally violent transition that birth represented, as well as the way in which contemporary attitudes and practices had exacerbated it. Conducting birth in the way he proposed – gentle delivery, skin-to-skin contact, delayed severing of the umbilical cord, placing the newborn in deep, warm water thereby ‘letting the child discover an environment which is as near as possible to that from which it has just come’42 – was to help ‘Nature’ to make this transition easier. For Leboyer, this entailed a deeper understanding of the forces of birth, thus, he wrote:

Nature, it is said, never moves in sudden leaps.
Yet birth is just such a leap. An exchange of words, of levels.
How can we resolve this contradiction? How does nature smooth over a transition whose very essence is so violent. Very simply.
Nature is strict, but loving. We misunderstand her intentions, then blame her for what follows.
Everything about birth is arranged so that both leaps and landing can in fact be gentle. 43

Leboyer's work was criticised by feminists for its attitude toward mothers. Indeed, the mother is characterised as the ‘enemy’ of the baby – standing between it and life – a ‘monster’ whose body crushes and contorts the baby as it struggles to be free of her body.

41 Ibid. p.40
43 Leboyer Birth without Violence (1975) pp.43-44
Responding with exasperation at this admonishment of the mother, Kitzinger declared that ‘a women who is led to think she is a torturer is hardly likely to trust herself to handle her baby with loving sureness’. Nevertheless, it is significant that such ‘a large number of women, and particularly pregnant women should have immediately adopted such a positive attitude to Leboyer’s work’. Michel Odent – who was inspired by Leboyer to develop his own theories on childbirth (see below) – argues that criticism against Leboyer is misdirected and the product of misinterpretation of his message. Drawing upon the theories of psychoanalysis propounded by Winnicott, Bowlby and Klein, Odent focuses our attention upon the centrality of the notion of ‘mother love’ in Leboyer’s work: ‘It is from their own birth that females learn to mother’ he claims. Creating the correct environment in which ‘mother love’ could flourish – encouraging skin-to-skin contact, for example – was thus a crucial component of birth without violence.

It was this aspect of birth without violence to which mothers seem to have been drawn. An article in a prominent midwifery journal from June 1979, for example, particularly highlighted the benefits of skin-to-skin contact for mothers who participated in a pilot study of the method undertaken at Kings College Hospital, London. Although the study was intended to ascertain the benefits of the method for the newborn infant, not to provide insight into the mother’s reaction to the birth, on discussion with the mothers,

44 Ibid.
46 Ibid.
47 For example, a 1977 article in The Guardian newspaper on NCT antenatal classes by Jane Walmsley entitled “The Egg and I” states: “Colin and Debbie are having their ‘first’ using the Leboyer method, because Deb thinks it’s nice when they put the baby to rest on your stomach before cutting the cord”. (The Guardian, October 27th, 1977)
the skin-to-skin contact was described as a ‘very special experience that none of them would have missed’.

48 Subsequently, there seems to have been some enthusiasm for certain aspects of the Leboyer approach amongst a small number of midwives. For example, midwife Moyra Heggie’s testimony in Devlin’s study states: ‘Leboyer’s approach, with a darkened room, massage, music, and use of water, influenced us as midwives in the late 1980s and we wanted to use it’. 49 However, Kitzinger was wary about the adoption of what she called ‘modified Leboyer’ in hospitals, claiming they merely provided a ‘sop to the mother’; essentially, keeping her happy and reassured by delivering the baby with ‘hushed voices and lights lowered’, and putting the ‘child on the mother’s body’ before whisking the infant away to a brightly lit room to be checked over by the paediatrician.

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Although Leboyer’s teaching went beyond the birth itself as the pinnacle of achievement and experience, and whilst he was adamant birth without violence was not simply another ‘method’ of natural childbirth, it appears to have been perceived as such insofar as adoption of his techniques in hospitals was concerned. Whether simple misunderstanding or wilful misappropriation of Leboyer’s work was responsible for this

48 D. Henschel “Tranquil Delivery at Kings College Hospital” Midwives Chronicle and Nursing Notes (June 1979 pp.170-173) The article notes that initially midwives and obstetricians ‘jumped to our defences’ given that ‘the book accused doctors and midwives of callous handling of babies at and immediately following birth’. Nevertheless, the author was impressed, upon witnessing a Leboyer birth, that ‘dramatic results’ could indeed be achieved using this ‘method’. A pilot study of the Leboyer way of birth was subsequently undertaken and it was duly noted that the babies appeared to show fewer signs of the distress associated with conventional methods of delivery. The study concluded that the Leboyer environment was calmer and more pleasant for all involved with the birth, although any scientific evidence for the benefits of Leboyer birth would be dependent on a much larger study.


is debatable, yet, as Murray Enkin in the foreword to Michel Odent’s *Entering the World* (1984) asserts:

Many professionals – and many mothers as well – have looked on Leboyer as yet another technique to be included in their armamentarium. If this were true, as such the Leboyer ‘technique’ could and should be looked on and evaluated as should any intervention. Its objectives should be explicitly stated and it should be evaluated by properly controlled clinical trials ... a meticulously controlled randomized clinical trial of the ‘Leboyer technique’ – dim light, delayed clamping of the cord, a warm bath for the newborn – carried out in our own unit by McMaster failed to show any benefit to either mother or baby over a gentle birth under more conventional conditions. We were disappointed but not surprised. Doctor Leboyer was neither surprised nor disappointed. I can still see his gentle smile as he admonished me: “You study too much. You should not study, you should feel”. 52

Leboyer’s approach called for a shift in *attitudes* toward childbirth, which, as was also the case with Dick Read, was borne of a profound concern with contemporary, western childbirth culture. Therefore, Leboyer was not unique in this sense: the voicing of such anxieties was in fact a common thread that runs through the work of many natural childbirth ‘pioneers’. Michel Odent, whose work can also be viewed as a reaction to the ‘technological regimentation and control of childbirth’ believed, as did Leboyer, that attitudes toward birth had implications far beyond the delivery room. Odent’s early work on childbirth was informed by the writings of Ivan Illich on the ‘limits to medicine’, which addresses the fundamental question of where to draw the line ‘between what

51 Professor Emeritus, Departments of Clinical Epidemiology and Biostatistics, Obstetrics and Gynecology, in the Faculty of Health Sciences, McMaster University, Canada. 52 M. Odent *Entering the World* (1984) p.16
people can do for themselves or with the help of friends and family, and what they require professional help for. Odent pursues Illich's critique of medical technology 'with consideration of the conditions of birth in industrialised countries using the 'Leboyer phenomenon' as a focus for discussion'. Thus, through his work he explores the possibilities for birth and emphasising the growing dichotomy between how childbirth is and how it could – or indeed should – be.

Odent – also a Frenchman – developed his theories at his clinic in Pithiviers Hospital, France in the 1960s where he initially worked as a surgeon general. Odent would often be asked to assist in the maternity ward with complicated deliveries that required the assistance of a doctor, but his experience in obstetrics was minimal and he relied a great deal on the midwives' guidance. The work of two particular midwives inspired Odent in his early years at Pithiviers. He writes:

It wasn't so much what they actually said or did that made me really pay attention to obstetrics for the first time, but rather the fact that the fifteen-to-twenty-year interval between the times they had each studied midwifery had made such a difference in their respective practices. For instance, Gisele, who was older, would wait patiently for the baby to be born. At the end of the delivery, she would simply say: "Don't hold back, relax, let yourself go..." Gabrielle on the other hand was eager to prepare a woman from the start of the pregnancy, to help her with breathing during labour, and to encourage her to control herself during birth... I saw more and more how much a woman's experience

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54 Ibid.
of labour depended upon the personality and attitude of the attendant. Women were attracted by Gabrielle's youthful enthusiasm and expressed a greater interest in her, but they were probably more likely to have an easy birth with Gisele.55

Odent had always been convinced, even as a surgeon, that keeping intrusive interference to a minimum created fewer immediate risks and he remained steadfast to this conviction whilst working obstetrics, applying it to the development of his own philosophy of birth. Another aspect of Odent's approach was that it looked beyond a narrow medical perspective, considering birth not as a 'medical problem' but rather as an 'integral part of sexual and emotional life'.56 Because he viewed birth in this way, it was crucial for Odent that birth was returned to women, who, he argued the tide of medical intervention had swept aside, leaving them with only a marginal role. Other 'methods' had, moreover, failed to restore women to their proper central role; thus, in using the Lamaze method, Odent writes:

The woman actually colludes in her own denial, by adopting a system that 'controls' her response to pain, her breathing, her position, and even the sounds she makes - the most basic aspects of a labouring woman's behaviour.

With regard to Leboyer, he goes on:

Although Leboyer's insights into the child's experience of birth gave rise to a new consciousness in our clinic and in the world at large, childbirth professionals have regrettably managed to interpret his idea of birth without violence as the 'Leboyer method', in which attention is focused on the child at the exclusion of the mother.

56Ibid. p.6
Odent's approach was not a 'method'; rather he called for greater understanding of the needs of women during labour and childbirth. He did not tell women what to do; instead he showed them what childbirth could – should – be. This had little to do with painless childbirth, as is exemplified by a birth story retold in Odent's book Birth Reborn:

*After a while the contractions begin, coming fast and furious... For a second I have a doubt; why didn't I have an epidural? Then I would not be going through this pain. It seems I can't take it - it's too much all at once; I am not a heroine. I start screaming and that helps... The midwife and Dr. Odent arrive, serene and reassuring...With Eddie and Dr. Odent at my side, I walk into the birth room. The sun is streaming through the windows...I undress, the room is semi-dark: brown tiling on the walls, a warm-coloured floor, and a big platform with multi-hued cushions, and a big birthing chair...In only ten minutes, I feel a tremendous urge to push. The midwife is there instantly...Dr. Odent comes in. The waters break... The midwife suggests I adopt a semi-squatting position, supported by Eddie... As each contraction overwhelms me, I am still moaning very loudly, but just for the length of the contraction. Everyone else is quiet calm and supportive... Suddenly I can feel the head coming down... One push and I feel our baby coming out...I am stunned, not a word is spoken...All is so peaceful and so intense...*

Importantly, as this birth story confirms, Odent's approach did not exert pressure on women to perform. If anything, the pressure was on the childbirth professionals to alter *their* attitude and create the correct environment in which women could give birth instinctively. The embodiment of this environment was the *salle sauvage* (or primitive room), a prototype of which was set-up at Pithiviers. The room was homelike and painted in warm, cheerful colours, furnished with a low platform, rather than a bed, so

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not to impose one particular labour position. Odent thought that ‘a place to give birth should be more like a place to make love than a hospital’ and he was keen to point out that the birthing (not delivery) room represented more than merely ‘attractive décor or a strategy to encourage a variety of labour positions: it was a place where a woman could do exactly as she liked, feel physically and emotionally free to act and move about as she wished’. 58

Cultivating this sense of freedom was integral to Odent’s approach. He believed that women had easier births when they let go of their inhibitions, allowing them to tune in with their bodies and lose self-consciousness. The environment of birth was crucial: he points out that many mammals retreat into semi-darkness during labour, arguing women too need a ‘sanctuary, a safe, quiet place where the light is dim and there are no intrusions’. 59 The support of a loving midwife ‘who says little but stays in close physical contact’ is crucial. 60 However, if women were to give birth instinctively – that is if they chose to adopt certain positions, or to shout, groan and make noise, to be naked, to get into a pool of warm water if they wished 61, to nurse their babies immediately at their breast without being ‘taught’ – attendants needed to give their support and patiently watch and wait, not intervene in the process. Until obstetric practice changed to allow

58 Ibid. p.12.
60 Ibid. See Odent Birth Reborn (1984,2005) pp.3-19
61 Michel Odent was one of the first people to advocate the use of water during labour, for pain relief and relaxation. Some women in his unit even gave birth in the water, although this apparently was no the original intention in installing the pools. He writes in Birth Reborn ‘Sometimes women are so relaxed in the pools that they are reluctant to emerge from the water, even when they feel labour progressing quickly. Here, too, women seem to know that it is not at all dangerous to give birth in water; there is no risk to the newborn, who, after all, has known only watery environments. A baby will start to breath air through its lungs only after it comes to the surface of the water and suddenly feels the difference in atmosphere and temperature for the first time. We have never made a point of having babies born under water, but this unexpected event does happen several times a month (twenty to thirty times a year)’. p.50
women an active role in the birth of their babies, the birthing room, in normal circumstances, was no place for the [male] obstetrician.

Odent was keen to emphasise the inherent safety of birth, whilst at the same time pointing out that emergency medical treatment should always be available if needed. His work highlighted the way in which natural and prepared childbirth methods – as well as the medical model of childbirth – were misguided; instead he stressed the importance of the supportive yet taciturn midwife over both interventionist obstetrics and the ‘methods’ purported to be natural childbirth. Preparation for dealing with the pain of childbirth had its place – Odent respected the theories developed by Dick Read, Lamaze and Leboyer – but it was by no means the most important aspect. Pain was accepted as part of giving birth. Odent never claimed that birth could be ‘painless’. Understanding the psychological, as well as the physiological, process of birth – including pain and how it is perceived – was crucial to Odent; for him the notion of ‘controlling’ pain was missing the point. In this sense Odent’s contribution to the narrative of natural childbirth was absolutely crucial in two ways. Firstly, it shifted the focus of natural childbirth discourse away from training and the following of methods towards a more anti-interventionist, anti-medical stance. In this sense his work empowered women to a far greater degree that earlier methods did, for it taught them to trust their own bodies, and their own ability to give birth. Secondly, it idealised childbirth not by claiming it could be painless, but by stressing that pain was natural, and that by letting go, by not attempting to manage and control and process, but accepting it for what it was, birth could be a wonderfully profound experience.
Observing natural childbirth discourse in the 1970s and 1980s, we can see that increasingly pain was translated into terms such as ‘energy’ and the ‘force’ of birth. Rather than dismissing pain, or trying to control it, natural childbirth proponents of this era appeared to be accepting the ‘naturalness’ of pain. The legendary American midwife and natural birth activist Ina May Gaskin described contractions as ‘rushes’ in her influential book *Spiritual Midwifery* (1975). Gaskin’s approach combined traditional midwifery with her unique approach to childbirth, which was developed whilst living and working in a hippy commune in Tennessee, USA, in the 1970s. *Spiritual Midwifery* was a record of her work at the ‘Farm’ as the commune was called; it was part anthology of birth stories and part midwifery textbook. Again, as with Odent’s record of his work at Pithiviers, Gaskin does not advocate a particular technique or method, rather, in line with her midwife-led approach, she reiterates the importance of loving support, gentleness of touch, patience and pragmatism. As with Odent, Gaskin demonstrated, via the stories of the women who gave birth at the Farm, and through the use of photographs, the way birth could be. Thus, Gaskin transformed the language and imagery of birth: one woman describes her vagina as ‘really psychedelic; like the big, pink petals of a flower opening up’. ‘It was really beautiful’, she goes on, ‘It really surprised me and I felt like I had new respect for my body’.  

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62 Ina May Gaskin *Spiritual Midwifery* (1975) See p.87 “Contractions don’t have to hurt. They are energy rushes that enable you to open up your thing so that the baby can come out. If you have the attitude that they will hurt, then you’ll tense up and not be able to completely relax and it will take the baby longer to come out and you won’t have any fun either. It’s a miracle to be able to create more life force and there is no room for complaining.” – Barbara, mother of three babies.  
63 Ibid. p.214
Spiritual Midwifery was doubtless a product of its time. References to feeling 'high' and 'far out', or descriptions of psychedelic vaginas were clearly not to everyone's taste; in fact it was imagery such as that found in the pages of Spiritual Midwifery which came to define the natural childbirth in the 1970s, perhaps contributing further to the widening of the gap between alternative and mainstream. Nevertheless, Gaskin, in considering childbirth a rite of passage, an integral part of the sexual life of the woman both as an individual and in terms of her relationship with her partner, made an important contribution to childbirth literature. However, it was the work of childbirth activist and antenatal educator, Sheila Kitzinger, which finally shifted the focus of the childbirth movement away from preparation and methods. Kitzinger – who claimed to dislike the term natural childbirth – began writing about birth in the 1970s, having taught antenatal

Fig. 1: Image of a baby's head emerging from the petals of a flower, from Spiritual Midwifery (1975) by Ina May Gaskin.  

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64 Ibid. p.214
classes for the National Childbirth Trust. Her approach to antenatal teaching was unique: whilst she acknowledged the influence of Dick-Read and Lamaze, her approach was based upon her background as a social anthropologist and her experiences as a mother teaching women and their partners about childbirth. Her ideas about childbirth thus rested upon the belief that the experience of bearing a child was central to a woman's life and that this experience was, moreover, deeply influenced by the cultural values and beliefs of the society to which a woman belonged.

The fact that Kitzinger was not a doctor or a midwife is important. And whilst she was an antenatal teacher for the NCT, an association devoted (in the 1950s and 1960s at least) to the teaching of the principles of Dick-Read and Lamaze, her approach marked a radical departure from conventional natural or prepared childbirth. For Kitzinger, the experience of childbirth was crucial; listening to women and learning about their experiences formed the basis of her approach. She worked tirelessly, conducting research in order to find out how women felt about childbirth, her findings setting the standard for the childbirth debate in the late 1970s and the 1980s. She insisted:

66 In The Experience of Childbirth (1978), her first significant contribution on the subject of childbirth, clearly influenced by Dick Read's ideas, she writes: 'When a woman has her baby happily, she spreads a different spirit - a mood of gladness rather than the dread and horror that is associated with old wives' tales and the gory accounts of labour which many women are able to produce for the benefit of expectant mothers'. She warns, however, that 'Dick-Read's ideas and methods ... have usually been very much diluted by the time they reach the pregnant woman visiting her antenatal clinic'. Moreover, referring to Lamaze, she continues: 'mothers who have imagined that their labours would be completely painless have often suffered an unpleasant shock. A woman not prepared for the powerful sensations of labour and the astonishing force of uterine contractions may easily panic and be worse off than if she had no instruction at all'. p.22
67 S. Kitzinger The Experience of Childbirth (1978)
68 Sheila was a founder member of the National Childbirth Trust.
What [women] say is important because a happy birth is not a matter of following a method or obeying a set of rules, like carefully following a knitting pattern or the instructions on using a computer. There is no right or wrong way to have a baby. Our personalities and life-styles are different and no one should – or can – dictate your experience.69

This was as much a rejoinder to advocates of methodological approaches to natural childbirth as it was to the medical profession. Nevertheless, although Kitzinger was critical of misguided devotion to natural childbirth, her criticisms were largely concentrated upon the ‘technocratic birthing culture’ that had developed in the industrialised west in the twentieth century. Thus, she claimed:

Many women feel as though they have been sucked onto a conveyor belt and are being processed through pregnancy and birth like cars in a highly mechanised automobile plant. They feel guilty when they do anything which holds up the process: asking questions or daring to be persistent in stating what they want. The message they receive, even though unspoken, is that they are being ‘bad patients’, are naïve and selfish, and if they reveal concern about anything other than safety, they do not care about their babies.70

Through listening to women, Kitzinger developed an approach that emphasised the need for ‘choice’; she warned, however, that choices about birth ‘are never as simple as selecting a can of beans from a supermarket shelf’.71 Birth, rather, involved powerful emotions and was not just a ‘matter of pushing a baby out of your body, a demonstration

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70 Ibid. p.11
71 Ibid. p.10
of biomechanics, but concerns fundamental human values'.

Thus, whilst she advocated the use of 'birth plans' to help women articulate what they wanted from their 'birth experience', she saw these not a shopping lists representative of consumerist notions of 'choice', but rather as an 'important means of facing up to the reality of birth as a major life event and growing in self-confidence'. Kitzinger moreover, claimed she never intended birth plans to be a blueprint for a perfect birth, dictating how labour 'ought' to be or how women 'should' behave. On the contrary, she emphasised the problems that could arise when women who - having prepared for a Lamaze or Dick-Read birth - had imagined their labours would be completely painless. Such women were apt to suffer an unpleasant shock if they were unprepared for the powerful sensations of labour and the astonishing force of uterine contractions. Indeed, what Kitzinger implied was that childbirth was an experience for which one could never prepare or plan. She overcomes this apparent paradox by reiterating that birth plans are valid because they are not statements of intent or lists of prohibitions; they are not a 'matter of success or failure'. Rather they are:

An active process of preparation in which you are able to share decision-making about your body in which you are able to share decision-making about your body and retain your autonomy as a human being.

72 Ibid. p.10
73 A birth plan is a concise written statement of your wishes for childbirth and the days following birth, worked out beforehand in consultation with your midwife or doctor. Kitzinger Freedom and Choice in Childbirth (1987) p.150
74 S. Kitzinger The Experience of Childbirth (1978)
Kitzinger acknowledged that each labour and birth, whilst there is a common unfolding pattern, is essentially different. Her understanding and awareness of the subjective nature of childbirth informed her approach to childbirth education, which was constantly evolving in line with what she learned from the women who participated in her research. Nevertheless, always underpinning her work was the belief that engaging with the processes of pregnancy and birth – spiritually, emotionally and intellectually – equipped the expectant mother to face the realities of birth. In the Second Edition of *The Experience of Childbirth* (1978) she writes:

> Experiencing birth positively involves the conscious participation of the woman. She is no longer a passive, suffering instrument. She no longer hands over her body to doctor and nurses to deal with as they think best. She retains the power of self-direction, of self-control, of choice, of voluntary decision-making, and of active cooperation with doctor and nurse. This involves a certain degree of intelligence and knowledge of the processes of pregnancy and labour. She must have a mind which is not only relatively free of fear but also filled with pleasurable anticipation of labour.  

With this in mind, Kitzinger authored several books on pregnancy and childbirth packed full of information on the physiology of birth, as well as its emotional aspects. Simply telling pregnant women about birth could, argued Kitzinger, be far more beneficial than teaching them breathing exercises, or extolling to them the virtues of dimmed lighting, although these too had their place. *The Good Birth Guide*, first published in 1972, epitomised Kitzinger’s approach in this sense. The book, which Kitzinger described in 2005 as a kind of ‘restaurant guide, with recommendations for changes’, was based on

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76 Kitzinger *The experience of Childbirth* (1978) p.25
women's experiences of birth in hospitals across the UK. It was intended to provide practical information about the practices and procedures women were likely to encounter when they gave birth in hospital, covering everything from the décor and what the food was like, to whether pubic shaving, enemas and episiotomies were carried out routinely. For example, at Liverpool Maternity Hospital it was reported:

Most women not shaved. No enema if bowels emptied that day. Some women said they did not want continuous monitoring and found support from midwives. Large beanbags instead of pillows. Epidurals and acupuncture available. Gas and oxygen also offered. Partners encouraged to be present and can stay for forceps delivery. Midwives 'competent', 'friendly', 'understanding', helpful', 'considerate', though sometimes also described as 'quick', 'clinical'...

*The Good Birth Guide*, and its follow-up, written five years later and entitled *The New Good Birth Guide*, represented a new approach to birth education. The provision of honest, straightforward, research-based information was a rarity; hitherto, pedagogical approaches had almost exclusively dominated. Nevertheless, this approach was not entirely impartial. Kitzinger had very specific views about childbirth, developed from her study of primitive and traditional cultures and her observations of contemporary Western childbirth culture. Her attitude toward obstetrically directed birth – in particular the concept of Active Management of Labour [see Glossary of Terms] – is highly critical. She goes as far as to imply that technocratic birthing culture imposes certain procedures upon women as 'rites' – rather than medical necessities or in response to emergency

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situations – and that these rites have effectively replaced the traditional ceremonial procedures practiced by societies for millennia. Thus, with reference to the second (‘pushing’) stage of labour she writes:

Cheerleading in the second stage has a ceremonial quality. It may make everyone feel good, because there is a sense of all being in it together and at last getting somewhere. It can seem that if only the mother would push harder and longer the baby’s head would appear, so everyone present exhorts her to greater effort...she may be bullied, cajoled or threatened with forceps delivery if she does not try harder. When she holds her breath for a really long time, goes red in the face and gasps with effort, she is likely to be praised and told she is “doing it right now”. Dripping with sweat, eyes bulging, little blood vessels bursting in her cheeks and eyes, and falling back exhausted once each contraction is over, she struggles to obey the commands of her cheerleaders and tackles the second stage of labour as if it was a prize fight...Telling a woman to push, and encouraging her to work as hard as she can is no new obstetric intervention. It has been hallowed by time, and tends to be taken for granted as the only way of giving help in the second stage.79

Kitzinger’s approach was, ostensibly, to provide enough information for women to make up their own minds about what they want from their experience of childbirth and also to prepare them for what she considered to be the realities of childbirth, which, for those having their first babies, was an unfamiliar and often daunting prospect. However, despite the best of intentions and claims to the contrary, her work, like those before her, created an idealised picture of how birth should be by conjuring up the negative imagery of medicalised or ‘obstetrically directed birth’. Indeed, the common thread which links the ‘pioneers’ of natural childbirth together is not their cohesion to a particular set of

defining principles – as we have seen, their approaches to what might be termed natural childbirth differ considerably in form and substance. Rather, it is their shared suspicion of medical approaches to childbirth – indiscriminate use of analgesia and anaesthesia, forceps delivery, managed third stage, the dorsal lithotomy position, hospital birth, induction and the active management of labour – which binds them to one another.

Natural Childbirth, or Birth ‘Alternative’?

The concept of natural childbirth did not disappear in the 1970s. However, understanding of it did change; it had to. In 1969 an article in Midwives Chronicle and Nursing Notes calling for a change in the objectives of training and preparation for labour stated that the pioneering work of Grantly Dick-Read ‘set our footsteps along the wrong path’. ‘The greatest error’ it goes on to say, ‘has been emphasizing painless labour or natural childbirth… It is time we admitted that labour is a painful process and that this is not an abnormality nurtured in the mind’. Yet despite the shift in focus hastened by Leboyer, Odent, Kitzinger, et al, the issue of pain remained at the heart of debate about alternative approaches to childbirth. Moreover, the term ‘natural childbirth’ refused to go away, though by the 1980s understanding of it had changed considerably.

In May 1986 an article by journalist Polly Toynbee appeared in The Guardian newspaper that summed up contemporary debate on the subject of natural childbirth perfectly. The tone of the article could easily be gathered from the title:

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NATURAL CHILDBIRTH, A CHILD OF THE SIXTIES, WAS AND IS LARGELY A NUTTY FAD FROM A NOISY GROUP OF LENTIL-EATING EARTH GODDESSES.  

In a lengthy tirade against AIMS and other representatives of natural childbirth, Toynbee's hypercritical stance was more than evident. She claimed that mothers' and babies' safety was at risk from the 'natural fad' and that women were being discouraged from using safe and effective pain relieving drugs, such as epidural anaesthesia, by natural birth advocates who flagged-up the inherent risks of such with their 'scare stories'. She also criticised the way that women were apparently being made to feel unworthy if they did not want to 'experience' childbirth fully by opting for a natural, drug-free birth.

The natural birthers have succeeded in surrounding childbirth with a great deal of mystical claptrap, which induced guilt in many women. Did they have a "good" birth? Did they experience a special communing with nature itself (herself?). Did they seize back their bodies from the evil hands of doctors and salute their maternal ancestors in a celebration of the ultimate rite of womanliness? No, they were lying there Primally [sic] Screaming in Agony. Pointless, meaningless pain for which, like many "natural" but bad things, there is at last a cure.  

The response of AIMS was, unsurprisingly, to emphasise the inadequacies of the maternity services. In a article published in both The Guardian and in AIMS' own Quarterly Journal (where it appeared alongside excerpts from the Toynbee piece) AIMS chair Beverly Beech drew upon World Health Organisation statistics, which revealed that

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81 P. Toynbee The Guardian (12th May 1986)
82 Ibid.

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Britain ‘has one of the highest levels of technological interventions in birth in the whole of Western Europe’. Mothers’ and babies’ health and well being were being put at risk, she asserted, by the decline in ‘real’ midwifery, which had been replaced with what Beech described as ‘obstetric nursing’. Toynbee was missing the point, claimed Beech, in disclaiming natural childbirth as a ‘fad’ responsible for inducing in women feelings of ‘guilt’ and ‘failure’. Natural birth did have an important role to play in challenging contemporary attitudes to unnecessary and/or routine obstetric intervention and upholding the values of good midwifery practice. In this sense, natural childbirth in the 1980s, argued Beech, was about the vigorous ‘questioning of routine obstetric procedures’. Yet the response of many hospitals to the challenge of natural birth activism – which was to give the ‘illusion of supporting “natural childbirth” by changing the décor and buying expensive birthing chairs’ – was at best misguided, at worst, misleading. ‘The irony is’ Beech lamented, ‘that although many women expect to have natural, active birth, those who are required to give birth in consultant units (particularly the first-time mothers) will find that a natural birth is almost impossible to achieve’.

In her response Beech emphasised the way in which many UK hospitals in the 1980s adopted a position of ostensibly encouraging natural childbirth, only intervening ‘when necessary’. Nevertheless, she maintained, routine/unnecessary intervention remained higher in the UK than almost anywhere else in Western Europe and most mothers gave birth in units operating a system of ‘actively managed labour’.

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83 For details on the World Health Organisation (WHO) conference on “Appropriate technology for Birth” see: The Lancet (24th August 1985) pp436-437
observation was indeed accurate, why uphold the pretence? If it was nothing more than a ‘fad’ that appealed only to minority of pregnant women, why, by the mid-1980s, did it become necessary for some hospitals to appear to support the ideals of natural childbirth?

Paradoxically, technocratic childbirth culture, which, by its very definition excluded alternative childbirth philosophies, served also to foster them. Thus, during the early 1980s when there was an outcry against the way women were being treated whilst in the care of the maternity services, the natural childbirth lobby placed itself at the centre of furore. Throughout the 1970s, as we have seen, pioneers in the field of alternative childbirth techniques had been emphasising mothers’ (and the case of Leboyer, babies’) emotional and psychological wellbeing during labour and stressing the importance of the experience of giving birth upon both mother and child in the future. Criticism of contemporary technological obstetric care was the common thread that ran through the theories of this diverse group and was seized upon by those who had either themselves experienced negatively this system of maternity care, or those who felt instinctively that it was wrong. Mounting evidence of dissatisfaction from users of maternity services appeared to validate the claims made against the obstetric-led model of managed childbirth.86 Women’s sense of outrage about the way birth was conducted in hospitals was gathering momentum, especially as the discourse on natural childbirth widened [see Chapter Five, below]. Thus, by the early 1980s, with the situation reaching crisis point, the concept (or concepts) of natural childbirth appeared to provide a channel through which to express this dissatisfaction and campaign for change.

86 The extent of women’s dissatisfaction with maternity services will be discussed in the following chapter.
The tipping point – the point at which the campaign for birth alternatives could be said to have been at its most radical – arguably occurred in 1982. Yehudi Gordon, an obstetrician then based at the Royal Free Hospital in Hampstead, London, found himself at the centre of the controversy when an American woman booked under one of his colleagues, insisted on climbing off the bed in the second stage of labour and delivering in a squatting position. Gordon recalls:

The midwife sat in a corner and crossed her arms and said “That is dangerous practice, you are putting your baby at risk and I am not going to be involved with it”. The woman then informed the Ham & High [newspaper] – she was absolutely livid – she had said that there was another doctor in the hospital that is allowing that, and encouraging it!  

The doctor to whom the woman was referring was Gordon. Gordon had joined the Royal Free in 1978 and had been appalled by the conditions there: the impersonal routines and humiliating procedures, the systematised approach to care, and the risk-averse culture of the labour ward that robbed the experience of humanity. He remembers with dismay:

When a woman was in labour, she walked into the labour ward, she had an enema... And then she had a shave, a perineal shave, and then she had her waters broken if she was more than three centimetres dilated, and a clip put on the baby's head, to monitor the heart beat, and an I.V. drip, and then she was sort of attached to the bed... Almost everybody having their first baby had an episiotomy... I just thought it was horrific; terrible, terrible. Aggressive, dictatorial, chauvinistic, masochistic... It was sadistic, controlling, masculine – horrible; it just wasn’t acceptable really.  

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87 Yehudi Gordon, interviewed 10th May, 2005
88 Interview with Y. Gordon (10th May, 2005).
Gordon had been deeply influenced in his obstetric practice by the work of the wife of an old school friend, Janet Balaskas. Balaskas, a South African and a mother herself who was deeply committed to the principle of antenatal education, but who believed the system being offered by the NCT (not to mention the health authorities) was inadequate, had just published a book *New Life* (1979) based upon observations of birth in other cultures. Balaskas claimed in the book that giving birth lying upon one's back was a practice peculiar to Western cultures; in no other culture— not to mention other species in the animal kingdom—would the female choose to give birth lying down. The position most often adopted was upright: standing, squatting, kneeling, etc. Gordon had linked up with Balaskas in 1980 and began to combine her teachings, which were also based upon yoga practice during the antenatal period, with his practice at the Royal Free. Women who delivered under Yehudi Gordon were able to remain mobile during labour—a key aspect of Balaskas' philosophy of 'Active Birth'— and he also encouraged women to attempt delivery in upright positions. For a short period, he was able to work without attracting the attention of colleagues. However, this came to an abrupt halt in 1982.

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89 *Active Birth* was the title of Balaskas' second book, published in 1983. In it she outlined her philosophy of birth, which to a degree extended upon the work begun five decades earlier by Kathleen Vaughan. *Active Birth* advocated movement and the adoption of an upright position during the first stage of labour and, for giving birth, squatting, kneeling, all fours and any other 'naturally expulsive positions'. Practicing Active Birth required effort—Balaskas emphasised that active birth was the woman's own responsibility and involved preparation and the ability to locate a midwife or obstetrician willing to lend support to this method—but the benefits were, it was claimed, considerable. *Active Birth* did not make the claim that birth could be painless, however, Balaskas insisted that when women remained active, pain was more bearable and labour could be shorter; these claims were supported by independent research studies. Like Michel Odent, Balaskas placed emphasis upon the environment in which birth took place; she recommended the use of beanbags, low stools and water baths, all of which could be used as aids to the adoption of different positions. A birth partner was also crucial, and nudity was endorsed as a way of fostering bonding between mother and child. Music and dim lighting were suggested as a way of creating an intimate environment. Balaskas, who trained with the NCT as an antenatal teacher, set up the Active Birth Centre in London in 1981.
The day after the story broke, one of the senior obstetricians demanded Gordon explain what exactly had happened. Although Gordon did his best to reason that women were ‘desperately unhappy’ with the way their labours were being conducted, the consultant remained incredulous. To the consultants at the Royal Free, the NCT were nothing more than a bunch of troublemakers and the ideas they and other advocates of natural childbirth appeared to be promoting – the very ideas Gordon was attempting to put into practice – were ‘highly irregular’, if not down-right dangerous. At a meeting of the Obstetrics and Gynaecology department, he recalls how ‘they just looked at me and said “We are regressing to the dark ages. This is unsafe practice. Women are going to be injured and babies are going to die.”’90 The discussion ended there. Gordon was not at all surprised at not being re-appointed when his post came up for review. He moved on to set up his own successful private birth unit at the Garden Hospital in Hendon, North West London, offering women active, natural, birth.91

Yehudi Gordon’s experience illustrates the power the obstetric model of childbirth had over the way babies were born in England in the late-twentieth century. It demonstrates how terrified consultants were of trying out new ideas, so entrenched had the notion of safety become in obstetric practice. However, the obstetric profession got a wake-up call when, on a spring day some six months after the incident at the Royal Free, some 5,000 people rallied together to march across Hampstead Heath demanding that mothers be given the freedom to give birth by natural methods – and in any position they desired.92

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90 Yehudi Gordon, 2005
91 Yehudi Gordon still practices obstetrics today and has continued to develop his philosophy, authoring several successful books and delivering the babies of a number of well-known celebrities.
Many see the Hampstead Heath demonstration as a turning point. Certainly the conditions that led to the demonstration perpetuated the outrage, and it was the language of natural childbirth that was employed to voice the protest. However, what is really interesting is how the momentum of the cause of natural childbirth changed at this time, becoming more radical in response to the outrage of women, who had in turn themselves been enlightened, and in some respects, radicalised by the feminism of women's liberation.

The Influence of 'Women's Lib'.

The women's liberation movement of the 1970s had hastened reform in several areas of women's lives – marriage, work, family life, and so on – and the issue of women's health was high on the agenda throughout the decade. The publication of Our Bodies, Ourselves (1978) in the UK was, for example, was intended to raise awareness amongst women about issues that affected them and their health, such as mental health, sexuality, birth control, abortion, pregnancy and childbirth, and the menopause. Feminism brought to bear heavily upon the issue of pregnancy, birth and motherhood. Some radical feminists may have rejected what they regarded as the institution of motherhood, but the general tendency was, according to Pugh, 'to give a more positive status to the maternal role’ and also to ‘advance the idea of maternity free from male domination'.93 The Western system of maternity care was, for many feminists, a symbol of this male-domination. In the words of American feminist author, Adrienne Rich:

No more devastating image could be invented for the bondage of woman: sheeted, supine, drugged her wrists strapped down and her legs in stirrups, at the very moment

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93 M. Pugh, Women and the Women's Movement in Britain (2000) p.334
when she is bringing new life into the world. This ‘freedom from pain, like sexual
liberation, places a woman physically at men’s disposal, though still estranged from the
potentialities of her own body. While in no way altering her subjection, it can be
advertised as progressive development.94

Because it represented an alternative to a system that (according to feminist thought)
perpetuated women’s subjection, natural childbirth — although not a product of feminism
(Dick-Read and his theories received unbridled criticism from feminists in the 1970s)95 —
did provide a framework for those women who felt strongly about childbirth issues to
voice their views. Thus, whilst feminists such as Shulamith Firestone, an early theorist of
the contemporary women’s movement can be seen to have been sceptical of natural
childbirth, seeing it as ‘part of a reactionary counter-culture having little to do with the
liberation of women as a whole’, a convergence between the two is manifest.96 Roy
Porter briefly but keenly observes the connection between natural childbirth and
women’s liberation in his 1997 work exploring the historical relationship between
medicine and society, The Greatest Benefit to Mankind. Porter writes:

95 For example, Rich writes: ‘Dick Read’s work was path-breaking, and many of his observations are still
valuable. However, his attitude to women is essentially patriarchal: while in genuine awe of the female
capacity to produce new life, he writes of “the in-born dependence of woman” which finds its natural outlet
in her dependence on the doctor. He perceives the birth process as naturally “ecstatic”: “Biologically
motherhood is her desire”, he remarks; and at one point: “Varium et mutabile semper femina, but never
more so than in childbirth”. For him, childbirth is a woman’s glory, her purpose in life, her peak
experience. Remove fear, reinforce ecstasy, and childbirth can be “natural” — that is virtually without pain.
But the male obstetrician is still in control of the situation”. (pp.171-172)
Initially activists in the women’s movement were quite enthusiastic about the campaigns of male physicians who seemed to regard the preferences of women – as patients – over and above medical protocols and convenience...\(^{97}\)

With this in mind, Porter notes that the 1980s witnessed the revival of the tools of traditional midwifery – birth rooms and birth chairs ‘discarded centuries earlier’ – as well as a greater emphasis on mother-baby bonding and the importance of birth ‘supporters’. He adds, nevertheless, that ‘herein lurked a target for charges that this was another (albeit masked) mode of medical dominance’.\(^{98}\)

Natural childbirth, being a set of related though distinct concepts that emerged from within obstetrics, was of course a controversial choice as a device to be utilized in the perceived conflict of interests between doctors and women. One of the main criticisms hurled at natural childbirth was that it failed as means to engender real change because it placed too much responsibility upon women themselves, without challenging the fundamental structure of maternity care. Another criticism was that natural childbirth was an idealized construct that exerted too much pressure on women.\(^{99}\) Why should they feel they had failed if they needed drugs to help with the pain? Should they not benefit from technological advances intended to make birth easier and less painful? Despite such views, the anti-medical stance of the natural childbirth lobby did collude with the values of feminists. As Germaine Greer wrote in her polemic on *Sex and Destiny* (1984), ‘the woman who can get on with the business without interference is in better shape than the


\(^{98}\) Ibid.

one who has been taken over by the doctors, fighting to stay aware in theatres which exist to deliver drugs and surgical procedures, helpless in the stupid lithotomy position, befuddled, bamboozled and humiliated'. Even so, for many feminists, natural childbirth was not the answer to changing attitudes toward childbirth. Whilst the meaning of natural childbirth had shifted by the early-1980s, childbirth activists continued to idealise the 'experience' of giving birth. To a degree this was counter-productive: as more women asserted their right to 'experience' childbirth naturally, hospitals - in a bid to be seen to be responding to women's needs and expectations - made gestures toward providing an alternative childbirth 'experience', whilst all the while continuing to practice within the confines of obstetric orthodoxy.

Mainstream Maternity Care and Alternative Practices.

The unspoken position of many consultant units appeared to be to placate the noisy and demanding minority of women, whose expectations have been raised through exposure to the ideals of natural childbirth, but not to let it interfere with conventional labour ward protocol. Thus, Liu's labour ward practice textbook *Labour Ward Manual* (1985) advocates antenatal preparation 'within reason' and the support of 'the concepts and practices the woman expects'. "Flexibility in the attitude of staff is all important', states Liu, 'but it is an incitement against our training and values if we jeopardize the welfare of our charges by subscribing without comment to fashionable idiosyncrasies which we believe will put them at risk of possible medical hazard'. A medical model...
of maternity care influences Liu’s textbook; hence, it posits physical safety as the principal issue that ought concern labour ward staff. Nevertheless, what is most interesting about this book is the way in which it stresses the importance of acknowledging developments such as antenatal education and alternative birthing positions, whilst simultaneously issuing restrictions on their application on the labour ward. With reference to delivery room décor, for example, Liu states that the room should ‘not be totally stark and clinical’; preferably, it should be ‘homely’ and furnished with curtains, wall coverings, chairs, etc. However, ‘concession to this viewpoint must not jeopardize the need for a sterile environment’. Similarly, it is considered that ‘there is no reason why alternative postures of individual preference should not be allowed, provided there is no risk to the foetus or the mother’. 103

Lui also refers to alternative methods of pain management, specifically ‘psychological techniques’, and to antenatal instruction and its efficacy in the reduction of fear and anxiety. Labour ward staff should be aware of what type of antenatal education their patients have received and make efforts to ensure that they ‘derive full benefit’ from their preparation. However, it is added that ‘should psychological techniques prove inadequate, labour ward staff must exercise utmost tact to direct patients away from a sense of failure and guilt’ whilst at the same time introducing ‘a more appropriate form of analgesia’. 104 The feeling one gets from this is that alternative childbirth methods and techniques, whilst they should appear to be supported, should not, under any circumstances be seen to be replacing standard practice, under the assumption that they

103 Ibid. pp.2-5
104 Ibid. p.32
are unsafe and also ineffective. The following statement, which appears on the first page of *Labour Ward Manual*, sums up this attitude:

> Women who approach labour convinced that all things natural are beneficial may be disappointed. Nature is often cruel and capricious and has not endowed all women with the means to easy childbirth.\(^{105}\)

Nevertheless, as Greer asserted 'women continue to want to bear children; they may say that they want to experience childbirth. What they can mean by that when there is no telling whether they will be *allowed* to experience it, given the aggressiveness of childbirth management, or whether the experience will not simply consist of torture and terror, is not all clear'.\(^{106}\) The question of whether women were to be 'allowed' to give birth in the way they wanted is key here. It points to what feminists have described as the 'controlling power' of obstetrics, the dominance of the 'male-centred' medical model of childbirth in the West. The idea that women needed to be given permission to give birth naturally implied that preparing women for natural childbirth was, to be frank, a waste of time. It may even have been harmful, insofar as it raised women’s expectations about childbirth, generating negative emotions such as guilt and frustration. Moreover, if a woman did chose to assert her 'right' to give birth naturally, refusing obstetric help, it was implied that she would be responsible should anything 'go wrong'.

Essentially, even at a time when some hospitals were busy making superficial changes to labour ward practice, women were being given the message that natural birth was

\(^{105}\) ibid. pp.1-2

\(^{106}\) G. Greer *Sex and Destiny* (1984) p.11
painful and unsafe. Nonetheless, we must be careful not to take such statements at face value, or to assume that all maternity units that made steps toward implementing the principles of natural childbirth into practice were doing so merely in tokenism to an ideal.107 Perhaps the simple existence of an alternative to mainstream, orthodox obstetric-led maternity care was vital in ensuring issues other than the clinical aspects of maternity care remained on the agenda. Indeed, as the human aspects of obstetric care were being increasingly scrutinised, natural childbirth discourse can be seen to have lent itself to debate about how to improve human relations in maternity care.

For example, when the House of Commons Select Committee on the Social Services produced its Second Report on Perinatal and Neonatal Mortality (Session 1979-80) under the chairmanship of Labour MP Renee Short, it expressed concern that the maternity care system had become dehumanised.108 Interestingly, the terminology employed in the report’s recommendations colluded in some respects with that of natural

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107 Similarly we should be careful not to make the assumption that all obstetricians were against natural childbirth. The example of Yehudi Gordon shows this was not the case, but there were other notable obstetricians who questioned the supremacy of contemporary obstetric practice and were just as keen to see women given the opportunity to learn about the alternatives to mainstream care. Peter Huntingford of the London Hospital, a highly regarded consultant obstetrician in the 1970s and 1980s, went to great lengths to speak on behalf of pregnant women, emphasising their right to choose the kind of birth they had, even if they were giving birth within the confines of a hospital environment. Huntingford was a great believer in normal childbirth and was deeply concerned about the way the practice of obstetrics in recent decades had developed to the detriment of women’s psychological wellbeing and satisfaction. Huntingford, who in his own words ‘enjoyed being at the centre of trouble’, even went as far as appearing on BBC television, presenting a series on women’s rights during pregnancy and childbirth. He also authored a book on the subject to accompany the series entitled Birth Right, published in 1985. Huntingford’s work will be discussed further in Chapter Six [below].

108 The impetus for the ‘Short Report’ was the Social Service Committee’s concern that not enough was being done to prevent the death of babies during the ‘latter part of pregnancy and the earliest part of infancy’. There was mounting public concern at the time that babies were dying unnecessarily, or were being permanently damaged in some other way, around the time of birth and that perinatal mortality and morbidity was highest amongst the lowest social groups. The focus of the enquiry was, however, medical rather than social. The recommendations it made were, moreover, translated into policy that hastened the closure of smaller birth units and the greater concentration of birth in consultant-led hospital units rather than tackling the social basis of these inequalities.
childbirth discourse. Thus: more focus was needed upon the 'emotional needs' of parturient women and the fostering of 'a congenial and supportive atmosphere' in maternity units was considered of utmost importance.\textsuperscript{109} Also regarded as important was communication: it was recognised that 'women nowadays' were likely to be 'well informed' and therefore ought to be 'told about any procedure she is likely to encounter'.\textsuperscript{110} The antenatal class was suggested as the ideal medium for imparting this information. Reference was also made to the environment and décor on maternity wards, and it was also recommended that the practice of separating mother and baby after the birth be eradicated unless there were genuine medical reasons for doing so.\textsuperscript{111}

Still, the 'Short Report' – and maternity policy in the 1970s and 1980s in general – was still largely concerned with the physical safety, especially that of newborn babies.\textsuperscript{112} With the Short Committee recommending that 'an increased number of mothers should be delivered in large units...[and] home birth should be phased out further', a move that was justified if it ensured healthy babies, wholesale changes in patterns of maternity care along the line suggested by natural birth proponents did not – unsurprisingly – materialise at this time. If anything, the closure of smaller maternity homes and GP units and the virtual eradication of home birth threatened to stamp out alternative models of care

\textsuperscript{110} Ibid. p.92, para.290.
\textsuperscript{111} Ibid. pp.91-95
\textsuperscript{112} Government policy on maternity care at this time was pre-occupied with tackling persistently high rates of perinatal and neonatal mortality, and other medical problems with the neonate, such as low birth weight and physical and mental disability. Moreover, because these issues were identified as being unevenly distributed between the lower and the upper social classes, the aim of policy was also to address the apparent class bias in the maternity services. Following the publication of the Black Report on Inequalities in Health in 1980, the Conservative Government's concern with the effects of poverty on health, particularly that of newborn babies, resulted in a number of documents addressing maternal and child welfare.
altogether. Thus, even though natural birth had been promoted in the 1960s as being perfectly suited to birth in a hospital environment, the development of maternity policy in the 1970s and 1980s was such that the welfare of babies and the physical safety of mothers took precedence over 'emotional needs', meaning that any alternative practice that might endanger the unborn child was shunned. It goes without saying that freedom to explore alternative models of care was severely restricted under these conditions. Even so, the more high-tech birth became, the louder the outcry against it became. Even the NCT, which had spent the best part of the 1960s trying to woo the medical profession into accepting natural childbirth and incorporating it into practice, was slowly changing its stance, although it was far from the politically aware, campaigning organisation it was to become in the 1990s.

Although the establishment of a dialogue between policy makers and the NCT was still in its infancy in the early 1980s, its continued presence as an organisation purportedly committed to the needs of childbearing women was vital at a time when childbirth was becoming an increasingly political issue. Yet, how are we to explain the paradoxical fact that whilst concepts of natural childbirth were, in theory, providing women in the 1980s with an alternative to mainstream maternity care (not to mention a framework through which to express their wishes for more control over the experience), the same period was witness to 'a far more profound revolution in the technology of childbirth'? Indeed, according to an article from a midwifery journal in 1986, 'the same era that saw the acceptance of alternatives has also seen more and more so-called active management of

labour'. Perhaps the late Peter Huntingford, obstetrician and supporter of alternative childbirth practices, was correct in his assertion that some members of the obstetric profession had legitimised the practice of 'defensive medicine', intervening in order to prevent women making legal claims against them if something were to go wrong during labour or delivery. Certainly, a culture of fear pervaded maternity care in the 1980s: for example, more and more obstetricians were claiming that all babies presenting breech were to be delivered by caesarean, and it was generally accepted that no labour ought to last more than twelve hours. As we have seen, the backlash against the arrogance of obstetrics, which was embodied in mainstream practice, was swift and strong. Yet, at the same time as these alternatives were growing in influence, their impact on policy and practice remained minimal, amounting to little more than piecemeal changes that were lacking in substance.

In many ways, the persistence of a natural childbirth movement through the 1970s and 1980s attests to the need to have an alternative to mainstream maternity care; the response of policy makers and maternity care providers to the challenge it represented was by and large pragmatic, rather than defensive. Often the practicalities of implementing maternity policy and the considerations herein – not least the allocation of increasingly scarce resources, both financial and in terms of manpower and expertise – were paramount. The expectations of the 'users' of maternity service cannot be overlooked either: women having babies during this era expected a maternity bed, expected analgesia/anaesthesia, expected medical attention should it be warranted, and

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114 Ibid.
expected to give birth to a live, healthy infant. Or to put it another way, the concept of safety as a *norm* was entrenched in contemporary childbirth culture. It is hardly surprising that changes in the structure of NHS maternity care and concerns about an impending maternity 'crisis', precipitated by a shortage of qualified, experienced midwives, shifted the focus of policy makers away from the specific nature of the care offered to women.

Indeed, the RCOG, which maintained its overarching influence on maternity policy development, apparently took the view that models of care suggested by natural childbirth representatives such as Sheila Kitzinger (who was at this time advocating a return to home birth) threatened to overstretch midwives' already considerable responsibilities, compromising the safety of mothers and babies. In a letter submitted to *The Times* in the spring of 1980 chief obstetrician for the north east of England Mr. Albert Davis maintained that midwives would be unable to cope with the increased demands that would be placed upon them by a return to domiciliary delivery; an increase in home confinements was, he argued 'both misguided and retrograde'. The broader implication of this view was that the system of hospital maternity care was perfectly acceptable, given that to 'increase [midwives'] already fully extended capabilities...[was] both unfair to the midwife and harmful to her patients'.

It was a convincing argument: midwifery-staffing problems were indeed increasing and anything that would exacerbate the situation was not for consideration. However, the

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115 RCOG: C.5/2 (RCOG-RCM-CMB: Correspondence and papers Concerning Midwives, 1977-1979). Draft of letter to *The Times* from Albert Davis, FRCOG.
116 Ibid.

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RCOG’s motives are called into question when considering that the increased demand for midwives was, according to research carried out in the North West of England in the late 1970s, directly correlated with factors such as:

- The building of new hospitals with better facilities for patients but requiring more midwives to adequately cover the new geography, e.g. more single rooms, 4 bedded bays, etc.;
- The technological advances over the past few years in obstetrics, anaesthetics and paediatrics [which] have made great demands on the time and skill for the midwife;
- Changes in practice in obstetrics, paediatrics, etc., [which] have meant that most maternity hospitals deal mainly with acute obstetrics and paediatric patients needing more trained midwives to cope with the situation.117

Indeed, as an Occasional Paper on Midwifery Manpower undertaken by a researcher at the Chelsea College Nursing Education Research Unit pointed out to the RCOG in 1979:

In this modern age of accelerated labour for all patients and epidural anaesthesia for the majority, the ratio of staff per patient is insufficient. Each patient in labour is now [effectively] in intensive care...118

Midwifery training in the 1980s increasingly focused upon clinical experience of ‘complicated’ labour – the ratio of normal to complicated labours each pupil midwife was expected to have witnessed as part of her training in 1980 was ten to forty – and minimal time (just two hours) was devoted to ‘instruction on human relations and emotional

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118 RCOG/C/5/1: RCOG-CMB-RCM, S. Robinson Midwifery Manpower (Chelsea College Nursing Education Resource Centre, Occasional Paper No.4)
reactions associated with childbirth'. Unsurprisingly, there was very little scope to explore alternative practices. If anything, this emphasis upon the technological aspects of childbearing increased the mental stress that midwives had to cope with. ‘At times’, the author of the 1979 paper on Midwifery Manpower writes, ‘one midwife has two or three patients in her charge and if one reaches the second stage she can no longer supervise them all. At times patients who require constant monitoring are left alone with only a bell to summon help’.

The sense of frustration this situation created amongst midwives is palpable in the pages of contemporary midwifery journals. Midwives interviewed for this study recalled similar feelings: one midwife even shed tears when remembering her training and the anger she felt during this time. Midwife Caroline Flint remains convinced that the problems with recruiting new midwives that began in the late-1970s and continue to this day are inextricably linked to the technology-driven, obstetric-led childbirth culture that developed after the 1950s. The shortage of midwives that still exists now, she says, emerged because midwives found themselves unable to practice ‘true’ midwifery in this context. Whether this factor does indeed underpin the ‘midwifery crisis’ of the last three decades is a point for debate. Nevertheless, one cannot ignore the fact that according to a report published by the Central Midwives Board in 1978, only fifty

120 RCOG /C/5/1, S. Robinson Midwifery Manpower
121 Interview with C. Flint (30th April, 2006)
122 Ibid.
percent of midwives who qualified in any one year choose to continue to practice midwifery. 

Flint, whose ideas about childbirth were ridiculed by both her peers and her superiors (she was, and is, a great believer in the philosophy of Grantly Dick-Read, about whom she says: 'he was the first and last person to talk about what is going on in women’s minds') is convinced that vested interests ensured women did not have the opportunity to give birth naturally. Midwifery's scope for exploring alternative birth methods was severely limited in this climate; it is telling that neither obstetrics nor midwifery supported any policy for the wholesale adoption of these methods even in the face of mounting research evidence about the problems associated with common procedures such episiotomy, induction of labour and caesarean section. Even so, there were those, such as Flint, with alternative views about the way labour and delivery should be conducted.

The Association of Radical Midwives (ARM), established 1977, was a 'grass-roots' feminist organisation committed to 'restoring the role of the midwife for the benefit of childbearing women and their babies'. ARM, whose acronym was an allusion to the

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123 RCOG/C/5/1 Midwifery Staffing in North West England
124 C. Flint (Interviewed 30th April, 2006)
initials for 'artificial rupture of membranes' in obstetric terminology*, made the exploration of 'alternative patterns of care' one of its key objectives and, in the late 1970s, researched the idea of establishing its own alternative birth centre. The idea was eventually abandoned by ARM due to problems with securing funding; but the association also foresaw practical difficulties in functioning as 'alternative' within the NHS. It was decided instead that ARM would work to support midwifery, focusing on the sharing of ideas, skills and information with the aim of restoring confidence in midwifery as a profession in its own right. Nevertheless, ARM maintained its position on childbirth alternatives. Their quarterly journal Midwifery Matters had, by the mid-1980s, established itself as a forum for debate on women-centred, evidence-based midwifery care, ensuring that alternative methods of maternity care did not disappear from the midwifery agenda. Above all, ARM represented a challenge to medical hegemony in maternity care; as such it was tremendously important to those midwives who wanted to explore birth alternatives.

For, despite the apparent medical bias in labour ward practice, a few midwives were able to implement 'alternative patterns of care' into their practice by the mid-1980s. However, because such ideas were adopted in piecemeal fashion, and were often dependent upon an individual hospital's resources or its geographical location, not to mention the attitudes of the staff in charge, a midwife's experience in natural birth

* Artificial rupture of membranes translates as 'breaking the waters' in layman's terms. It is an invasive technique used to induce and/or augment labour. The Association of Radical Midwives adopted the initials ARM because of the 'obvious implications for getting things moving and stirring them up'. J. Spinks, (1982) p. 381

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techniques could vary considerably. Take the following quotation, from a midwife who trained at Kingston-Upon-Thames Hospital and qualified in 1982:

I hated my training as all the women had epidurals. They – the hospital – were a major training centre for doctors. All [the women] had monitors and were strapped to the bed, lay [sic] on their backs and all primips* [sic] had episiotomies. I was not offered a job upon qualifying and got a job at the West London hospital which was heavily into natural childbirth. My first delivery there was with Dr. Lee and my primip had an intact perineum. That was when I first started learning...\textsuperscript{127}

This midwife’s experiences with natural childbirth are particularly insightful, but others also referred to the culture of an individual unit as a barrier to the practice of alternative techniques. Some midwives spoke of having left midwifery because of the frustration they felt at the belligerent attitudes of other staff members, peers and superiors. A midwife who trained at Bristol and Sussex before working as midwife at Guy’s Hospital in London, and was actively involved with the founding of ARM, relocated to New Zealand in the mid-1980s. She has not since returned, and remains convinced that she would have been unable to practice midwifery according to her strongly held beliefs about natural childbirth had she remained in the UK.\textsuperscript{128}

It seems a lack of experience and confidence may have deterred some midwives from exploring alternative or natural childbirth techniques in the 1980s. The negative reaction from consultant units who were in the words of one midwife ‘dead against it’ must not be ignored. The notion of a geographical lottery lends itself well to understanding of the

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* Primipara – See Glossary of Terms
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\textsuperscript{127} Interviewed July 2005.
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\textsuperscript{128} Interviewed February 2006.
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situation, with some units actively encouraging a more natural approach to birth and others maintaining a more orthodox, interventionist position. Nevertheless, according to one midwife, only a minority of her colleagues developed an understanding of the process of natural childbirth and having the confidence to allow women to ‘just get on with it, just monitor and not interfere’, and these were ‘not usually found in consultant units’.129 Perhaps then, the environment of the consultant unit itself was at the root of the problem; this would explain why the natural birth lobby took up the issue of home birth more aggressively in the 1980s.

By the mid-1980s, people were beginning to question the now almost universal practice of giving birth in hospital. There were no statistics proving conclusively that birth in hospital was safer for mothers or their infants. Indeed, according to Birth Counts: Statistics on Pregnancy and Childbirth (2000) the government in the 1970s, 1980s and early 1990s were ‘reluctant to set norms and standards for any of its services’, hence there were ‘no agreed criteria for assessing the adequacy or otherwise of local services’.130 Nonetheless, the report of the Short Committee (1980) and its follow up report in 1984 continued to recommend 100 percent hospital delivery and the closure of small, isolated maternity homes and GP-run maternity units in the name of safety. What did this mean for the cause of natural childbirth?

Even though the concept of natural birth had been promoted in the 1960s as being perfectly compatible with birth in hospital, it had become increasingly clear to those on

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129 Interviewed July 2005.
both sides of the debate that this was misguided. Many natural birth advocates were now aligning themselves with the home birth lobby, supported by a growing body of literature. The publication in 1990 of Marjorie Tew’s *Safer Childbirth* appeared to vindicate what many had been claiming since the Cranbrook Committee and the Peel Report hastened the relocation of childbirth from home to hospital: that universal hospital delivery could no longer be justified on grounds of safety. The tide was indeed beginning to turn on medicalised childbirth culture; yet the challenge for supporters of natural childbirth had only just begun. Although no one could deny that there were problems with mainstream maternity care in England, as the controversy between the medical and natural models intensified, the question of whether the majority of childbearing women actually wanted the alternative offered by natural childbirth loomed large. Indeed, it was almost impossible to prove empirically; there were no official statistics, and what statistics did exist on type of delivery seemed to indicate a move toward greater incidence of obstetric intervention and operative delivery, concomitant with the almost universal shift to hospital birth. Consequently, it is hard to imagine where natural childbirth fitted in to this picture. With the safety of childbirth established, did women need this alternative? What was more, since understanding of the term had shifted since it was first popularised in the 1950s, did anyone even know what natural childbirth meant anymore?

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131 See: Chapter Six [below]


"Just learning to relax, deah, or trying to tell me something?"

Fig. 2: Cartoon and caption from Punch magazine, 1959.

The first thing to do if you're thinking of having a baby is to buy a do-it-yourself book. Of course reading isn't necessary nowadays: you can see it on television.

But a book is convenient and doesn't have to be left lying around like a T.V. set...¹

This cartoon, which appeared as part of an article in Punch magazine in 1959, tells us a lot about how new ideas about childbirth were being communicated in the second half of the twentieth century. From the 1950s on, books, television and other media were beginning to be employed to disseminate these ideas to childbearing women, their partners and the wider population. Some forty years hence, the volume of accessible information about pregnancy, labour, childbirth and motherhood had grown exponentially, and the development of discourse on natural childbirth was fundamental to

¹ M. Adams "Cradle to University: Do-it-yourself Motherhood" Punch (February 25 1959) p.276
this proliferation of instructive and informative media. When, by the late 1980s, the
notion of informed choice was beginning to influence all aspects of health care, the
implications of this were far-reaching, not least in the area of maternity care. Women
giving birth in the late 1980s and early 1990s were supposed to be educated, informed,
and assertive; they had high expectations of maternity care, having been told by the
childbirth ‘manuals’ that childbirth was the most significant experience of their lives.
The expanding market in antenatal instruction literature suggests that many women in the
late 1980s and early 1990s were more informed about labour and birth [and alternative
models thereof] than their own mothers and grandmothers. Yet alternative childbirth
practices remained peripheral, and were regarded by some as significant only to a
minority of women. The key to understanding why is located in the way natural
childbirth was perceived more generally which, of course, is inexorably linked to the way
in which the concept was communicated and disseminated.

Because understanding of the concept of natural childbirth shifted over time, and
because its meaning also changed in response to contemporaneous medical, social and
cultural factors, it is very difficult – not to mention misleading – to speak of natural
childbirth in terms of a homogenous movement. It is perhaps more helpful to consider it
in terms of a set of principles that have evolved since the early to mid-twentieth century
alongside – and in response to – the medicalisation of childbirth, and which have been
influential in providing women with a framework within which to articulate their
experiences of birth outside of medical parameters. As a counter-cultural force, this was
important, but whom did it benefit? Did women actually want natural childbirth, as the authors of books on the subject were telling us? And if they did, why did they?

So far we have looked at the origins of these principles, the ways they were promoted as methods to help women manage pain during labour and birth by voluntary organisations in the 1950s and 1960s, and the reception of these ideas by the medical profession and midwifery. We have seen that, following a brief flurry of interest in the principles of natural childbirth (particularly the aspects which emphasised antenatal education as a means to exercise control over childbearing women, once their status altered to that of hospital patient) mainstream maternity care became more, not less, medically defined. The result of this was that natural childbirth was marginalised. Yet, we have also observed how natural childbirth was, in the mid to late-1980s, beginning to be acknowledged as a viable – if radical – alternative within the mainstream model of care. Thus, tracing the idea of natural childbirth through the mediums by which it was communicated, then studying how perceptions and understanding of the idea were formed in response to this (and to external factors) is helpful, not least in addressing the related questions of what was meant and understood by the term natural childbirth, who wanted it and, ultimately, who obtained it.

Birth by the Book: The Expanding Market in Childbirth Literature.

As hinted to in the Punch cartoon, in the 1950s books were the main source of information for pregnant women on the subject of labour and birth. Such books are problematic as sources informing us what childbirth was actually like; they are,
nonetheless, an excellent way of finding out what women were told about childbirth, and this in itself is useful. Mechling's work on childrearing manuals in the early twentieth century is helpful in this respect, as it focuses our attention on the motives of those who wrote advice and information manuals, and the context in which they were written. Thus, according to Mechling:

Childrearing manuals are the consequents not of childrearing values, but of 
childrearing manual writing values... What we as historians want to understand and explain, therefore, are these "manual-writing values".\(^2\)

The same can also be said for antenatal advice and instruction literature.

Ann Oakley's work illustrates how manuals that ostensibly provided women with reassurance and guidance were actually complicit in the process of what she terms 'the medicalisation of pregnancy as natural'. Oakley argues that:

The authors of these books did not simply view pregnancy as a normal physiological function. To do that would have been to defeat their purpose, which was to provide information. What they did was a good deal more complex; essentially they constructed a schema of pregnancy that systematized what was taken to be the everyday experience of pregnant women. Thus systematized, this experience then came to be represented as technical-medical knowledge.\(^1\)

Oakley asserts that the function of this type of literature was to tell women what kind of condition pregnancy was, and to inform them as to how 'nature' decreed they conduct themselves. They also made the assumption that women were anxious about pregnancy

\(^2\) J. Mechling "Advice to Historians on Advice to Mothers" *Journal of Social History* 9 (1975) pp.44-63

and aimed to reassure them. Whether or not women were, on the whole, anxious about pregnancy and childbirth is, to an extent, inconsequential; the important point is that the authors of pregnancy manuals told women that they needed reassurance. Moreover, by positing themselves as the voice of authority on the subject, they inferred that the process of having a baby was too important to be left to ‘ordinary’ women.

The high maternal and neonatal mortality levels that persisted well into the twentieth century arguably justified such sentiments. *The Mothercraft Manual* (1933), for example, which reflected the ‘safe motherhood’ campaigns of the 1930s, stated emphatically:

> Is it not monstrous that the fate of a new generation should be left to the chances of unreasoning custom, impulse, fancy – joined with the suggestions of ignorant nurses, and prejudiced counsel of grandmothers? To tens of thousands that are killed, add hundreds of thousands that survive with feeble constitutions, and millions that grow up with constitutions not so strong as they should be; and you have some idea of the curse inflicted on their offspring by parents ignorant of the laws of life.4

The main focus of *The Mothercraft Manual* was the antenatal period and early motherhood; nothing is mentioned about birth other than in relation to antenatal care, the aim of which hopes ‘by prevention to avoid some of the most serious troubles connected with childbirth’.5 By chapter two, therefore, we move swiftly on to the baby’s ‘Layette’ and ‘Care of the Newborn’, leaving the business of childbirth to the imagination. Whilst *Mothercraft* reminds its readers not to heed old wives’ tales, which ‘should be scorned as

4 M. Liddiard *The Mothercraft Manual* (1933) p.1
5 Ibid. p.1
belonging to an ignorant past', young mothers would have had little other than these to go on as far as childbirth was concerned. The message being given to readers of the *Mothercraft Manual* – particularly educated, middle-class women, as it was this group at which such literature was being aimed – was that they had a responsibility to society, no less, to produce healthy infants and to avoid 'the curse inflicted on their offspring by parents ignorant of the laws of life'. Books of this type, written and endorsed by medical ‘experts’, were crucial in communicating a model of pregnancy and birth, and thus in shaping contemporary childbirth ‘culture’.

Therefore, the emphasis of antenatal advice and instruction literature in the 1930s was primarily health and hygiene during pregnancy and caring for the newborn infant. The notion of ‘self-help’ *during labour and birth* was unheard of in the 1930s; indeed most books and pamphlets failed to address the processes of labour and delivery completely. By the 1940s, birth was beginning to get a mention, but even as late as 1950 a popular pregnancy guide published in association with the *Sunday Express* newspaper limited discussion of the actual birth to just a few sentences under the heading ‘And now, the hospital!’:

> You will be placed on a trolley and rolled into the delivery room. Your period of waiting is over... In the delivery room, white with bright lights, you will be taken from the trolley to the delivery table. The nurses will be standing by with the doctor and with their

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6 Ibid. p.1  
7 Ibid. p.xvi. On page 2, of the *Mothercraft Manual* (1933), the author writes: ‘It is hoped that health and mothercraft will soon take a more prominent part in the education of our girls, especially in the schools for the upper and middle classes. The poorer child has often a better chance of learning about the baby by having to mother the younger members of the family than those brought up in the homes of the well-to-do’
gentle help and encouragement, aided by the science they have studied so long, your baby will be born!³

Again, as with earlier manuals on pregnancy and childbirth, the objective here appears to be to reassure women— in this case, that hospital was the safest place to give birth. The emphasis upon 'science', furthermore, served to impress upon the reader just how far technology had come. The technological triumphalism in which the above statement is steeped was perhaps typical of the 1950s, the decade that witnessed the Festival of Britain with its celebration of scientific and technological progress. Post war attitudes toward science and technology undoubtedly had a profound effect upon childbearing, as they did other areas of life, both domestic and industrial. Imbued with such notions of progress, the field of maternity care needed to be seen to be advancing, not regressing; encouraging women to give birth in hospital was a positive step toward the goal of progress.

Several other publications can be cited—the Family Doctor series of pamphlets, published by the BMA for example—which set out a specific model of childbirth which women were expected to follow in pursuit of such a goal. These particular books and pamphlets were aimed at a much wider readership than their predecessors in the nineteenth century or even those published in the 1930s, which were written mostly for the well-educated, middle-class or upper-class expectant mother. The establishment of the National Health Service in 1948 aimed to democratise maternity care and a similar pattern of democratisation can be traced in the pages of, for example, the Family Doctor

³ Mrs. Woodman The Sunday Express Baby Book (c.1950) p.42  The author, Mrs. Woodman, was Chairman of the Royal College of Nursing in the 1950s
guides. However, what also comes across in these guides – aside from their paternalistic nature – is the growing emphasis upon medical maternity care. The hospital is presented as the ideal place to give birth, (even though home births made up for a third of all confinements) and the medical professional (in this case the ‘family doctor’ or GP) the only reliable source of advice.

‘Nearly all American women have their babies in hospital and English women are beginning to follow this trend’ announced a Family Doctor Pamphlet entitled “You and Your Baby”. The desirability of hospital was presented in terms of its safety and it was stressed, in particular, that all ‘first babies should be born in hospital’. ‘The first time mother has not proved herself’ it was claimed, ‘until she has demonstrated her ability to have a normal delivery’. In this and other guide books, women from all levels of society were reassured that, in the hands of the experts, birth could be entirely ‘normal’; they were also told that it was an incredibly risky business and that social problems such as ‘unsuitable home conditions’ meant that ‘however much you believe that you and your family should be together in familiar surroundings for the happy event, you must put safety before sentiment and respect your doctors expert opinion’. We can see how this type of literature, which was ostensibly aimed at soothing worried expectant parents’ anxieties, were used to disseminate ideas, and thus were responsible for shaping birth trends. In Chapter One we saw how the assuaging of pregnant women’s fear and anxiety drove literature on alternative childbirth methods in the 1940s, 1950s and 1960s. Later, in Chapter Four, we noted how women’s dissatisfaction with conventional care during

9 The British Medical Association A Family Doctor Special “You and Your Baby” (c.1955) p.31
10 Ibid. p.33
childbirth prompted a new wave of literature on childbirth alternatives. Should we not, however, question whether women were anxious or dissatisfied, whether they really wanted all this advice, these ‘alternatives’?

**What Women Want.**

We do not need Oakley to remind us that nobody is really in a position to answer the question ‘what do women really want’, because, of course, women do not form a homogenous group.\(^\text{11}\) There are clues, however, that women of all social classes in the 1940s and 1950s were ill prepared for childbirth. Talking to, or reading the accounts of, women who had babies around this time, one is struck by how little they knew about birth. The evidence provided by the Mass Observation Archive directive on birth is especially revealing in this respect, and whilst generalisations are impossible given the subject matter, some fascinating conclusions may be drawn.\(^\text{12}\) For instance, even when a woman had a lot of younger siblings born in the family home, birth was not something that was discussed and the women’s own mothers generally told them next to nothing of their own births. Sometimes the silence was ominous, hiding traumatic experiences that were merely hinted at throughout the women’s childhood. In other cases birth was seen as not being all that relevant an issue to everyday life, or else so commonplace as not to warrant talking about; discussion of birth in and of itself was thus extraneous. When birth was discussed, it was sometimes in terms of the burdens such an event provoked, particularly for those who were less well-off or for whom pregnancy was an all too recurrent state. For example, some women recalled their own female relations’

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fretfulness when contemplating the arrival of their second or subsequent babies. The anticipation of agonising and/or protracted confinements (several women referred to the ‘pains’ that indicated the start of labour), and the physical challenge of recovering from childbirth whilst trying to meet the demands of a large family was carved into the memories of those women who reflected on what they had learned about childbirth from their own mothers, sisters, aunts or cousins.¹³

Even for those brought up in different social circumstances, birth was quite often simply something that happened; one woman recalled her own mother never having ‘grumbled about it’; subsequently the birth of her own child she describes as being painful but ‘ordinary’.¹⁴ Describing birth in terms such as ‘painful’ and ‘ordinary’ is telling. Certainly we might deduce from this that some pain during childbirth was expected and whilst clearly some women were anxious about this, others accepted it as an essential part of giving birth. In this sense, pain in childbirth was ‘natural’; indeed, in their recollections of childbirth, some women refer to having given birth ‘naturally, with no pain relief’.¹⁵ One woman, a GP from Edinburgh during the war years, remembered that

¹³ For example, one woman recalls how despite her mother’s difficult confinements and down-to-earth views on childbearing (She often scorned attempts to present pregnancy and childbirth in a romantic light. In the tenement blocks where she grew up women consoled each other when they became pregnant, rallied around with cast off baby clothes and helped each other when the cost of an extra mouth to feed proved beyond the families’ tiny income) she enjoyed her own experience of giving birth immensely. MOA: B.1215 (2/2/94)

¹⁴ MOA: A1223 (17/1/94)

¹⁵ Respondents to the Mass Observation directive on birth expressed this attitude, for example. It is also corroborated by an oral history study conducted by researchers from Queen Mary and Westfield College, London during 1991-1992. The purpose of the project was to investigate changes in childbirth in East London from the late 19th century to the late 20th century. Topics explored include: medical intervention (knowledge, practice, technology, facilities and care); women’s personal experiences of childbirth and the development of campaigns and women’s support networks. Interviewees include health professionals (doctors, midwives and health visitors); patients, statutory and voluntary organisations (National Childbirth Trust (NCT), Maternity Services Liaison Scheme). (British Library Sound Archive, QMWC: Changes in Childbirth, C.643)
in the districts she served 'it was thought rather feeble to need any anaesthetic for normal childbirth', whilst another doctor also practising during the war, this time in East Anglia referred to the 'tough country folk, solid with good hips' to whom she attended. 'These women were strong; childbirth just went on, year in, year out', she recalled.16 Was this stoic approach to pain particular to a certain type of women – perhaps rural, uneducated and more often than not working class?

The experience of childbirth, and in particular the pain of giving birth, is of course subjective; it is influenced by a wide variety of factors, social and cultural, physical and emotional. Some women, it seems, expected birth to be painful and were fearful of the pain they might encounter; some perhaps felt birth was a normal, natural process and did not become anxious about the prospect of 'the agonies' as others might. There were those for whom labour and birth was long and arduous; and those whose labours were swift, their births easy. Some recovered quickly, unscarred by the experience; others bled for weeks afterwards, or were unable to breastfeed their babies. Some chose never to repeat the experience; others had large families. We cannot assume, therefore, as the authors of literature on natural childbirth may have done, that all women were terrified, or at least extremely anxious about giving birth. However, analysis of the historical sources that are available, suggests that a lack of knowledge about labour and birth was evident amongst some women, regardless of social class, in the middle decades of the twentieth century. It was in order to address this state of ignorance that authors such as Dick-Read began publishing antenatal instruction literature for a lay audience.

So what was women’s motivation for seeking out the advice contained within this type of literature? As we have seen, Dick-Read was moved to develop his philosophy of natural childbirth partly by his concerns for the future of civilisation and the ‘British race’. As discussed in Chapter One [above] Dick-Read believed, as did many others in the 1930s and 1940s, that the declining birth rate, which was evidently more pronounced amongst the middle classes, might prove disastrous in terms of national vigour. Encouraging women of the higher social orders to have more children was considered by those with leanings toward pronatalism and positive eugenics as the chief means ensuring that disaster of this sort be averted. Hence, as we have established, much of this type of literature was aimed principally at the educated, middle class expectant mother – a group seen as being unable (or unwilling) to cope with the rigours of painful and/or protracted labour and childbirth. Thus, with assumptions about attitudes to the pain of childbirth essentially providing the impetus for literature on natural childbirth, it was middle class women who were initially exposed to the principles of natural childbirth in the 1950s.17

What is left begging is the question of whether these women sought out literature on natural childbirth because it promised them a labour free of pain (or at least one where pain was significantly reduced as to be manageable), or whether there were other factors influencing them.

17 In her book The Politics of Birth (2005) Kitzinger writes: ‘The women who sought out NCT classes were, on the whole, comfortably off, middle class and white.’ (p.80). It is safe to say that a similar demographic were exposed to the principles of natural childbirth through antenatal advice literature. Certainly evidence contained in the Maternity in Great Britain survey (1948) suggests that social class, and other factors such as education, age and parity influenced whether women were aware of natural childbirth methods. Apparently, in general those who had ‘been trained by Dick-Read’s method’ were middle class, educated, first-time mothers in their mid to late-twenties.
Were it simply a case of eradicating pain, middle class women had other methods to which they could resort: chloroform was still being used by physicians in the 1940s, but by the middle of the decade other pharmacological approaches were being considered. Moreover, the Analgesia in Childbirth Bill (1949), coupled with the increased centralisation and hospitalisation of state health care more generally under the NHS, established the issue of pain relief during childbirth as significant to the political agenda.\(^\text{18}\) Although on the one hand, debate about pain relief demonstrates how important this issue was to childbearing women (Barnett notes how during the mid-1940s the Minister of Health received numerous letters from the public – mostly women – complaining about the poor provision of pain relief in childbirth, and asking if this was to be improved under the NHS), does it necessarily follow that it was women’s only, or even their main concern?\(^\text{19}\)

Coverage of the debate in the press certainly seems to suggest that the quest for painless childbirth underpinned growing public interest in the subject. Various newspapers and magazines, picking up on the mood in the 1950s, used terms such as ‘painless childbirth’ in articles referring to Dick-Read’s work, even though his method never claimed to promise an \textit{entirely} pain free labour or delivery.\(^\text{20}\) Even if the issue of pain was at the heart of Dick-Read’s approach (and later that of Lamaze) many women appeared to be drawn to other aspects of natural childbirth methods, in particular those which emphasised awareness and control. Thus, letters from mothers who had tried, or wished

\(^{19}\) Ibid p.86
\(^{20}\) W.T.L: PP/GDR/C.103-142 (Miscellaneous press cuttings)
to try Dick-Read's method attest not only to worries about coping with pain, but also to a
– perhaps even greater – fear of losing control, or of being unwillingly drugged into
unconsciousness.

It is worth speculating for a moment as to the source of these anxieties. Perhaps they
were the legacy of nineteenth and early twentieth century experiments with chloroform
and 'Twilight Sleep' as analgesic agents in obstetrics.21 These methods, whilst they had
proved successful for many mothers, for others represented a dangerous and unreliable
means to dealing with pain in childbirth. The image of the dreaded mask being forced
over a parturient woman's face, obliterating not only the pain of her contractions but also
the memory of what was supposed to be a profoundly beautiful and life-affirming
moment was one that natural birth proponents seized upon to make their case. The search
for alternative ways of coping with pain was certainly induced by misgivings about
pharmacological methods and perceptions of their negative side effects. Some women
were perhaps drawn to natural childbirth methods not only because they promised them

21 Twilight Sleep was a combination of the amnesiac scopolamine and morphine developed in Germany in
1914. When injected with the concoction, the labouring woman would fall into semi-consciousness and
upon waking, once the baby had been delivered, would have no recollection of what took place whilst she
was under the influence of the drug. Twilight Sleep was immensely popular as a method of obstetric
anaesthesia in America until the 1930s. Women in England (usually those of the middle or upper classes)
also used it, apparently with a degree of success, during the same period before it eventually fell into
disuse, having been replaced by other drugs, such as pethidine, which was introduced from Germany in
1939. As an anaesthetic agent for use during childbirth, Twilight Sleep was not without its problems.
These were often associated with dosage; the required dose varied from woman to woman; overdoses were
an inherent risk of the drug. Also, because women's inhibitions were lost under the influence of Twilight
Sleep, the risk of physical injury was significant. To avoid this delivery rooms were often padded and
women's arms strapped down. In addition, it is noted by Tina Cassidy in Birth: A History (2005), 'doctors
would bandage [women's] eyes with gauze and stuff oil-soaked wads of cotton in [their] ears, so [their]
own screaming would not wake [them]'. Such images blighted Twilight Sleep's image and as if that were
not enough, other risks included delayed respiratory function in newborns; and for mothers, stalled labour,
postpartum haemorrhage and the possibility that pain would still be experienced. See Margaret Sandlowski
for a detailed account of Twilight Sleep and other approaches to obstetric pain relief in the early twentieth
century.
that they would be able to cope with the pain of labour without the help of drugs, but also because such methods professed to afford them the benefit of full consciousness and, ergo, a degree of self-control.

But were such women also seeking some form of empowerment from the experience, as one might suppose? Mary Thomas addresses this question in her study of the letters sent by women to Dick-Read in the 1940s and 1950s, Post-war Mothers: Childbirth Letters to Grantly Dick-Read, 1946-1956 (1997). In her introduction, Thomas cites Sandelowski who, in her book Pain Pleasure and American Childbirth: From the Twilight Sleep to the Read Method, 1914-1960 (1984) stated emphatically that natural childbirth in the 1940s and 1950s was 'distinctly non-feminist, if not anti-feminist and pro-medical in the control of the childbirth arena. It is simply inaccurate to politicize the early natural childbirth movement by depicting women and physicians on two sides of the natural childbirth argument'.

The supportive and enthusiastic nature of the letters received by Dick-Read from mothers both in the UK and abroad question this statement. Yet, Thomas's analysis of these letters is critical of the notion that natural birth methods were an attempt to give power to childbearing women. Thus, she writes:

By romanticizing the virtues of natural childbirth Dick-Read contributed to the post-war rhetoric of society's expectations for women: motherhood...A consequence of the writings and teachings of Dick-Read was an added layer of pressure for women to be perfect mothers by delivering their infants pain-free, joyfully and consciously. This he defined as 'normal'.

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23 Ibid pp.17-18
Looking back at the letters mothers wrote in support of Dick-Read’s method, it is possible to observe how their views were shaped by their reading and understanding of his work; it is also possible to deduce how this in turn shaped their perception of notions such as ‘control’ and ‘power’. As Kitzinger has noted, ‘for Dick-Read ... the issue was a woman’s control over her own body rather than her control over what other people are doing to it’, hence, the empowerment these women were perhaps seeking was limited by the confines of what was essentially a paternalistic ideology. Nevertheless, by analysing Dick-Read’s mothers’ letters from a post-feminist perspective, one is perhaps in danger of belittling the values of those women for whom remaining in control of their own bodies was an important aspect of the experience of childbirth. Therefore, one must regard the term ‘empowerment’ cautiously in this case: it is entirely possible that women who were interested in natural childbirth did feel (or at least expected to feel) empowered by their experience, but not necessarily in the way that feminists of another generation might have supposed.

One thing that does emerge from studying women’s reactions to the work of Dick-Read and others whose ideas were communicated through the medium of childbirth literature, is that, for many, the idea of relaxing and staying in control, of helping oneself by being prepared for the events of labour was empowering in itself. Consider the attitude of several women who, when reflecting on the changes to childbirth since the 1940s and 1950s, pointed to the availability of information in the form of books, pamphlets, etc. for
present day pregnant women as a major improvement. Thus becoming educated about childbirth could be empowering, although this is not the same as saying that as an ideology, natural childbirth was understood as being empowering to women. Indeed, as is established in Chapter One [above], natural childbirth rhetoric in the 1940s and 1950s tended to bolster contemporary expectations for women – domesticity and motherhood – rather than challenge them.

Yet, in the 1950s, women who read literature on natural childbirth were being conditioned to believe that in celebrating birth and motherhood, a natural approach to birth was in their interests in a way that medical approaches were not. As a letter from a reader printed in Health For All, a magazine from the 1940s, stated: ‘medical science seems to be quite unable to take a sane and really helpful attitude toward birth’. Unnecessary treatment and too many interventions, argued the letter, had transformed normal birth into an ordeal. Similar concerns that their wellbeing, both emotional and physical, was being overlooked by medical science in the arena of childbirth were voiced by women in letters to magazines such as Nursery World, which printed a number of letters in support of Dick-Read’s principles in the late-1940s. Good Housekeeping magazine also claimed that: ‘in the interests both mother and child, the birth should be a

24 The oral history study on Changes in Childbirth conducted by researchers at Queen Mary and Westfield, for example, highlights how some women viewed the availability of information as one of the more positive changes that had occurred in childbirth since they had their own children. (British Library Sound Archive, QMWC: Changes in Childbirth, C.643) Similarly, oral history interviews conducted for this thesis also revealed how the increased availability of information on childbirth was seen as a positive development that benefited expectant mothers today. (Group interview with women at the Southgate Jewish Women’s Centre, 20th September 2006)

natural one. This is almost always preferred. One gets a sense here of how natural childbirth discourse was already beginning to generate an undercurrent of mistrust amongst women from certain sectors of society toward medical involvement in childbirth in the 1950s. Natural birth was, according to some women's magazines, what women wanted.

Interestingly the question of 'how could a man know' what they wanted preoccupied many newspaper editorials on natural childbirth and clearly, judging from the number of letters they claimed to receive on this very subject, it was also an issue that women felt the need to address. The Sunday Pictorial newspaper received a total of 983 letters in response to this very question in November 1946; in July 1948 the Pictorial's sister paper, the Daily Mirror, was sent 'hundreds' of letters responding to its journalist's claim that Dick-Read had proved childbirth could be painless. The letters received by both newspapers were, reportedly, overwhelmingly supportive of natural childbirth and although some questioned the validity of Dick-Read's theories, few were opposed to them. Even those who agreed with Dick-Read's principles, but nonetheless felt the need for some form of analgesic whilst giving birth, felt that the method had worth for childbearing women.

Newspapers and magazines, and women's magazine in particular, in making these claims for natural childbirth, and by printing letters in favour of these methods, gave the impression that women were supportive of them. Moreover, because quite often women

discovered natural childbirth by 'word of mouth' — a significant number of those who were aware of the concept recall having been given a copy of Dick-Read's book by a friend or neighbour — it may have been that the validation of other mothers served to allay any misgivings that might have arisen about the origins of the ideas themselves. Moreover, it is worth noting how several women refer to the ideas as 'fashionable' or 'modern' in the 1950s; the influence of their peers doubtless contributed to women's enthusiasm for this 'trend'.

It is no surprise, nor was it a coincidence, that Grantly Dick-Read vociferously acknowledged the support he received from the countless of mothers who helped legitimate the concept of natural childbirth in this way.

According to Oakley, traditionally 'women were involved in a continual process of educating one another'. She cites J. F. Browne's 1955 edition of Antenatal Care, which identifies how most patients' information about childbearing was 'acquired from conversations with relatives and friends, or from books and periodicals, or in these days even from the cinema and theatre'. One can draw parallels between the exchange of advice on childbearing that took the form of "the cartload of rubbish" represented by old-wives' tales' and its replacement by the advice contained within the new childbirth manuals. Those manuals that admonished conventional medical approaches to childbirth appealed to some women, despite their didacticism, because they spoke to them in a different language, providing practical advice and explained the processes of labour and birth in simple — though not condescending — terms.

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30 Ibid.
31 Ibid.
As the market in this type of literature expanded, those who were exposed to it (and who were sympathetic to the ideals it represented) subscribed to the idea that birth was something to be celebrated, rather than endured. An article in the April 1st 1959 edition of the *Daily Telegraph and Morning Post* claimed that '70 percent of the hundreds of women who wrote in reply to enquiry whether childbirth was a beautiful experience have stated categorically, even rather crossly, that having a baby was the happiest moment of their life'. An earlier article about the opening in London cinemas of two films focusing on natural birth prompted the letters: *The Most Wonderful Moment* and *The Case of Doctor Laurent*. It is, therefore, difficult to make generalisations based on them given that they were likely to have been written by women who already had an interest in these films and their subject matter. Nevertheless, they are an interesting example of the way in which mothers were apparently endorsing the rhetoric of natural childbirth.

One gets a similar impression from transcripts of a broadcast of the BBC Radio Four *Woman's Hour* programme from October 1957. The programme on this particular day was devoted to the reading of listeners' letters in response to an earlier broadcast of *Woman's Hour* during which a recording of the birth of a baby delivered by Dick-Read

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32 W.T.L: PP/GDR/C.120 (Misc. cuttings re natural childbirth) *Daily Telegraph and Morning Post* (1st April 1959

was played. Over 500 letters were received by the makers of the programme, according to the host, who went on to thank those who wrote in for 'telling of your own childbirth experiences so vividly...[giving] us a much broader picture of differing conditions and shared emotions'. Not all shared the sentiments of the woman who wrote:

I pushed with the mother, my heart beating wildly, and my tears flowed all over my ironing as the baby was born. A wonderful programme to make one realise that together with the atom bomb this frightening materialistic age has also produced individual kindness, humanity and beauty.³⁴

Yet negative comments were, in the most part, limited to the view that such things were not entirely suitable for broadcast on national radio (particularly at lunchtime) as one listener commented:

I worked from 6.30 am till 1.30 pm, come [sic.] home, get my dinner ready, turn radio on, and think I am going to listen to something interesting and then you broadcast that stuff. I looked at the radio with mouth and eyes open, I was shocked, and it made me feel sick, had to get up from the table, and leave my dinner.³⁵

The Woman's Hour letters on natural childbirth demonstrate how frank discussion about childbirth was a novelty for the media; some people were clearly shocked by it, whilst others welcomed it, and it was to this kind of controversy that the press was drawn in the 1950s. When a short clip from a film featuring Dick-Read delivering a baby using his method of natural childbirth was aired on BBC television in 1957, the ensuing furore focused largely upon what was 'decent' for public broadcast and opinion was divided as

³⁴ BBC Written Archive Centre (W.A.C.) Women's Hour Scripts: B/C LP.01.10.57
³⁵ BBC W.A.C. B/C LP.01.10.57
to whether showing the birth of a baby on television was at all helpful to expectant mothers, or anyone else for that matter. What seemed to have been lost in the publicity that surrounded what was, as it happens, the first showing of the birth of a baby on British television, was the essence of what the natural childbirth philosophy was meant to be about. Of course part of this philosophy was the encouraging of openness, debate and education on the subject of childbearing; however, this alone was not enough. For example, a great many of the letters received by the makers of the *Woman's Hour* programme on natural childbirth voiced concerns about the likelihood of providing "the possibility of such a childbirth to all those women who would like it."\(^{36}\)

 Whilst natural childbirth discourse was seemingly well established by the 1960s, understanding of the concept was such that many saw it as an option that although helpful, was 'not for everyone'. Thus, in spite of the apparently supportive attitude of certain areas of print and broadcast media (the *Woman's Hour* programme, for example, provided a regular forum for discussion about natural childbirth methods during the 1950s and early 1960s), the optimism of this 1954 review of the Third Edition of *Childbirth Without Fear* seemed a little misplaced:

Doctor Dick-Read's gospel of Natural Childbirth may prove...the 'new orthodoxy' for normal labour. Where here and there conservatism and self-interest rule rather than progress and concern for the patient, the testimony of mothers who from experience know the benefit of Dick-Read's teaching will soon prevail.\(^{37}\)

\(^{36}\) BBC WAC B/C LP.01.10.57

\(^{37}\) W.T.L: PP/GDR/C.128 (*Childbirth Without Fear* 3\textsuperscript{rd} Edition, reviews) *Medical Officer* (12\textsuperscript{th} November 1954)
As we have seen the ‘testimony of mothers’ was crucial in establishing the discourse of natural childbirth, but at this stage it had failed to have any significant impact whatsoever on the organisation of maternity services. Consequently, natural childbirth methods remained accessible in practice only to a minority of women who were able to secure attendance in labour by a midwife or doctor sympathetic to these ideas. It was, at this stage regarded as something of an idealist notion, and not at all something that childbearing women, on the whole, wanted.

Great Expectations?

That is not to say that natural childbirth discourse did not impact on many women’s expectations of childbirth, and in particular those expecting their first baby. By 1960, the NCT was relatively well established as an organisation dedicated to preparing women for childbirth, and information on natural childbirth was becoming more easily accessible in the form of books and magazines, or more formal antenatal education. For example, Maternity, a series of monthly magazines circulated during the early 1960s aimed at (judging from the letters page) the expectant wives of middle class professionals, attempted to convince its readers just how achievable natural birth could be. Maternity, purportedly following the experiences of a genuine expectant mother, served as a guide to assist women through each month of pregnancy in succession, pointing out the importance of preparation and relaxation along the way, providing ‘helpful’ advice such as: ‘During early mild contractions, try saying to yourself “They are pleasant, they are pleasant, they are nothing to fear”’. 38

38 Maternity “The Ninth Month!” (c.1960)
Maternity magazine, as with other publications, gave the impression that natural birth was something that was perfectly achievable and, remarkably, consistent with the growing trend for confinement in hospital. Provided expectant mothers prepared themselves sufficiently, and entered into labour with a positive disposition and a willingness to 'try it the natural way', there was no possibility of failure. As the happy mother whose exploits were documented in the pages of Maternity assured her readers, 'the kind of person you are will probably determine the kind of experience you have. There [is] nothing to fear, it was the finest thing that ever happened to me!' Yet what of those women for whom birth did not turn out the way they had been primed by the literature to expect? What if it was painful? What if complications arose, requiring surgical or other types of intervention? The implications of altering women's perceptions and expectations about birth were undeniably a concern, both of those who wrote on the subject of natural childbirth and the midwives (and doctors) who attended them.

In her recollections of birth for the Mass Observation Archive, one woman wrote:

[The 1950s and 1960s were] the era of natural childbirth and somehow I got the idea that there was no pain – if I didn't like what was happening to my body (and it felt much worse each time) then that was my wrong attitude so I always felt terribly guilty if I cried out, and not once would I accept any form of pain relief. I saw that as a weakness...

What this statement reveals is the extent to which expectations of the experience of giving birth were already being altered by the discourse of natural childbirth by the 1960s. And whilst many publications on the subject went to great lengths to urge women

39 Ibid.
40 MOA: A.2168 (18/7/94)
who wanted a natural birth that using pain relief during labour was not to be interpreted as failure, the discourse strived to alter perceptions of pain. Thus, whilst Erna Wright’s *The New Childbirth* (1964) appears to communicate the idea that some pain is inevitable during normal labour, expectant mothers were nonetheless assured that as long as they ‘remain in control’ by using ‘conscious controlled breathing’ the pain would never become overwhelming. Furthermore, in Wright’s work and that of others influenced by the theories of Dick-Read and Lamaze, the dreaded ‘pains’ to which women referred to prior to the 1950s, were redefined as ‘contractions’—an entirely normal part of labour and therefore not a cause for alarm. As such it was implied, with preparation, women were perfectly well equipped to deal with ‘contractions’ without recourse to pharmacological assistance in most circumstances.

However, on the issue of pain, literature on natural childbirth gave women conflicting messages. Although many authors, in a bid to avoid criticism that their methods engendered feelings of failure, included guidance on the use of drugs during labour, the message was often that with adequate preparation, support from birth attendants, and a little faith in ‘Nature’, such guidance would prove unnecessary. Indeed, admonishments against the use of pharmacological pain relief were common. Take the following advice from Nixon’s *Childbirth* (1955):

> [Drugs] can be used to help yourself out, but there is a very definite limit to the amount of any drug that can be given without harming both you and your baby. Is not your baby worth some effort? Give yourself up to a process that is inevitable. Nature is quite an old hand and knows her job pretty well. If something went wrong, that would be entirely

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41 E. Wright *The New Childbirth* (1964) p.18
the worry of your doctor or midwife. There would be nothing for you to do except give them your confidence. Otherwise let yourself work with Nature.\textsuperscript{42}

Nixon places all the responsibility for the utilization of pain relieving drugs upon the parturient woman; here the eschewing of drugs is portrayed in terms of the degree of effort she is willing to put into giving birth to her child. Yet, just a few pages later Nixon advises that ‘the administration of a drug to relieve the pain of uterine contractions is one which must be left to the discretion of the midwife or doctor’.\textsuperscript{43}

The contradictions inherent in Nixon's work in particular could be attributed to his position as an obstetrician. Nevertheless, they do tell us something about how natural childbirth discourse in the 1960s attempted to shape women's expectations of childbirth. As discussed in Chapter Two [above], those involved in promoting natural childbirth in the 1960s largely worked within the confines of conventional approaches to childbirth. The advice they gave was to be used in conjunction with that of midwives and doctors, and whilst it was aimed at raising women's awareness about their bodies during childbirth, it was not supposed to challenge medical orthodoxy or question medical authority to any significant extent. Hence, the women who subscribed to these ideas during pregnancy were given the impression that the necessary facilities for the practice of natural birth methods, including the support of a sympathetic and considerate staff, would be available to them. If something went wrong, if they were not able to have the kind of birth they desired, it necessarily followed that the fault lay with them for not

\textsuperscript{42} W.C.W. Nixon Childbirth (1955) p.73
\textsuperscript{43} Ibid. p.77
having prepared themselves enough, not having made enough of an effort, rather than with the maternity services.

An article in *Nursing Notes* from 1957 indicates how much of a problem this had already become, and how women, as well as midwives, were far from benefiting from all the advice that was being given. The article, on “Teaching and Training For Childbearing” noted how it was a midwife’s ‘duty to help mothers achieve their ambitions for an ideal birth, imparting a sense of achievement and satisfaction’. Whilst sympathetic to the idea that tension was ‘the arch enemy’ of the labouring woman, it argued that fear was not the only determining factor in the production of tension: frustration was an equally likely cause. The danger of replacing fear with frustration was regarded by the author as problematic in itself:

> The result of propaganda and the dissemination of knowledge [is that] women are coming to their labour with pre-conceived ideas. An ambition for a normal, natural birth is most desirable, but it must not become a fanatical zeal for either a painless birth or for a birth without drugs or instruments if either should prove advisable... We can help [women] to achieve their ambitions if reasonably possible, and if not, we can assure by our understanding that they are not left with a sense of failure... Present propaganda tends to focus too much on the actual birth to the detriment of the higher, more permanent aims of parenting. 45

Despite such warnings, the emphasis upon achieving the perfect birth ‘experience’ in natural childbirth discourse increased throughout the 1960s. By 1973, a small guidebook

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44 C. L. Beynon “Teaching and Training for Childbearing” in *Nursing Notes* (March 1957)
45 Ibid.
to childbirth, written by 'a mother experienced in natural birth and a physiotherapist who trained women for childbirth', claimed:

It is universally accepted that antenatal training and correct relaxation and breathing techniques give the woman a marked advantage. Many women nowadays find labour a tremendously exhilarating experience which they approach with enthusiasm.\textsuperscript{46}

The book went on to describe the routine procedures to be expected in hospital – enema, shave, foetal heart monitoring, episiotomy – and, staying true to the educational spirit of natural childbirth discourse, reassured its readers that 'should you be left alone when transition starts, ring the bell to let the nurse know that you are getting ready to push'.

The book is revealing, for it – albeit unwittingly – demonstrates the difficulty of reconciling the dichotomy between the \textit{reality} of having a baby in an NHS hospital and the \textit{ideal} expounded by those for whom education and preparation was key to a good birth experience.

Throughout the 1960s, a vocal minority of women had been expressing their disappointment with the maternity services in general and with their own treatment in particular. Natural childbirth discourse had gone a long way toward raising the consciousness of a middle class elite of women susceptible to propaganda of this type, hoping to experience birth consciously and with the minimum of discomfort, whilst at the same time fully-contributing to the process itself. However, clearly this same group felt let down by the maternity services and the medical profession, which had failed to adapt to their demands or live up to their expectations. The letters received by the NCT from mothers apparently testify to the growing discontent of women who objected to their

\textsuperscript{46} A. Clare & M. Thomas All About Childbirth: A 'Hale Instant Book' (1973) p.1
treatment whilst giving birth. By the 1970s, however, a new generation of women emerged whom, having initially bought into the ideals it represented, felt bitterly let down by the rhetoric of natural childbirth.

The American feminist author Adrienne Rich perhaps spoke for many women when she wrote in her book, Of Woman Born (1977):

I found myself suspicious of [Dick-Read’s] claims that giving birth was the ecstatic and exhilarating experience for women...Labour seemed to me something to be gotten through, the child - and the state of motherhood - being the mysterious and desired goal.

Rich pointed out that the term ‘experience’ can be interpreted in different ways and that, disconcertingly, many women she encountered in the years following the births of her own children appeared to place a premium upon the level of pain endured when speaking of their own natural birth ‘experience’. What Rich observed amongst her peer group of middle class American mothers was reflected in the English context: perceptions of pain had changed; pain itself had become part of the ‘experience’. Thus, natural childbirth advocates ceased to deny or play down the existence of pain. Rather, those working in the field of childbirth education in the 1970s represented the pain of parturition in positive terms [see Chapter Four, above].

47 See, for example, those printed in the NCT magazine New Generation in the 1960s. The NCT claimed it received ‘hundreds’ of letters each month from women, many of them from women disappointed with their experience during childbirth. The NCT New Generation magazine, and prior to this the monthly Newsletter, printed a small sample of these each month.

48 A. Rich Of Woman Born (1977) p.175

49 Ibid. p.176
Kitzinger, writing in 1972, stated that ‘mothers who have imagined that their labours would be completely painless have suffered an unpleasant shock’. Nevertheless, she was convinced that the principle of educating women for childbirth was still of enormous value. She admonished her predecessors for their blasé attitude toward the pain of childbirth, stating emphatically that ‘we have a grave responsibility if a woman is trained for childbirth only to feel she has failed at the first pain’. Once natural birth advocates began to focus more upon the experience of giving birth, and less upon the management of pain, natural childbirth discourse ceased to function as it had before. No longer was it a merely prescriptive or pedagogical paradigm; rather it began providing women with a forum for discussion about their experiences. However, because natural childbirth discourse essentially rested upon an ideal – childbirth literature was indeed responsible for redefining the perfect birth experience – it effectively held up a mirror to the inadequacies of the maternity services and the medical/technological approach. Basically, it offered women an alternative to medicalised childbirth. Hence, what we do find happening during the 1970s, is a gradual shift in perceptions of what natural childbirth had been in the 1950s and 1960s – a technique that could be used by any woman for relaxation and to help herself cope with labour and birth – to a tool for expressing frustration and, in some cases anger, at obstetric procedures that many of those who subscribed to these ideas were coming to believe were unnecessary and, indeed, harmful.

50 S. Kitzinger The Experience of Childbirth (1972) p. 22
51 Ibid. p.22
Such views were formed thanks, in part, to the propaganda disseminated by contemporary natural birth advocates. However, as has already been demonstrated, voices of dissent, perhaps not against obstetric care per se, but rather about the so-called ‘system of childbirth’ and women’s treatment within it, were beginning to be heard not only from mothers, but even amongst those working within the NHS maternity service, such as midwives, GPs and even, remarkably, a handful of obstetricians. Yet, it appeared as though the childbirth debate was divided into two sides: those who were in favour of the medicalised, hospitalised, homogenous approach to childbirth, and those who agreed with the teachings of natural childbirth and the alternative they represented. Moreover, the perceived split was still couched in terms of gender; even though, as Susan Pitt’s research has shown, in practice the situation was rather more complex.52

The idea that childbirth alternatives were essentially a feminist issue gained currency in the 1970s (in spite of the scepticism of many feminists on the subject) due in part to the unbridled criticism of ‘male obstetrics’ that was by now intrinsic to natural birth rhetoric thanks to the contribution of protagonists such as Kitzinger. Though clearly not all women – not even the majority – regarded the natural alternative as an appropriate riposte to the medicalisation of childbirth, natural childbirth was increasingly offered up as the ‘other side’ of the childbirth debate. Of course, the impact of the women’s liberation movement of the 1970s and 1980s on perceptions of natural childbirth cannot be underestimated. As discussed in Chapter Four [above], natural birth discourse provided

52 See: S. Pitt “Midwifery and Medicine: Gendered Knowledge in the Practice of Delivery” in Marland and Rafferty Midwives, Society and Childbirth: Debates and Controversies in the Modern Period. (1997) pp. 218-231. Pitt’s research shows that although discourse on childbirth in the late twentieth century was ‘organised into oppositional concepts relating to gender’ [p.220], these networks overlap; they are not solid, separate categories, nor are they historically static. Based upon her study of oral history material from research into maternity provision in the Swansea area from the end of WWII to the mid-1970s, Pitt concludes that ‘arguments about the male takeover of childbirth need to be framed very carefully in terms of the gender of practice rather than the biological sex of the practitioner’ [p.230].
women with the means to engage with their experience of childbearing outside of male medical parameters. Its advocates strove to raise awareness and conquer ignorance, through books and other media, as well as formal antenatal education, empowering childbearing women by providing them with knowledge on all aspects of pregnancy, labour and birth. In the era of women's lib, such claims took on a new, perhaps more urgent character, particularly given the appalling birth experiences women were reportedly having in NHS hospitals during this period.53

This shift in perceptions of natural birth during the 1970s, from being a system of learned breathing and relaxation techniques, to being a weapon to be held aloft by liberated women in the fight against the male dominated, medicalised system of childbirth was reflected in the literature. Published in 1976, Danae Brook’s *Nature Birth* was, like many such books written by ‘real’ women (as opposed to medical professionals), inspired by personal experience and is unmistakably underpinned by the context of women’s liberation. Thus, it is worth quoting from *Nature Birth* at length in order to illustrate the extent to which understanding of the term ‘natural childbirth’ had changed by the mid-1970s, and why. Brook writes:

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53 Research carried out by the Kitzinger on behalf of the NCT, for example, indicated that women were hugely disappointed and, in some cases, traumatised by their experiences in giving birth in NIHS hospitals. The research, which was carried out from the mid to the late 1970s, explored women’s experiences of induction, caesarean section and epidural anaesthesia. The results of the research on induction in 1975 proved particularly controversial. It revealed that some women had been induced without their consent and that induction for ‘social reasons’ was endemic. The Department of Health was acutely aware of the furor that publication of the survey results could yield and vowed to ‘look into the whole subject of induction’. Nevertheless, it was maintained that ‘there does not seem to be any reason why inductions should not be undertaken for the social/convenience reasons of the mother’ and recommended the discussion with the RCOG, which was supportive of the current rate of induction, on the subject. The NCT studies were criticised for being unrepresentative; even so a BBC “Horizon” television programme picked up on the issue and David Owen, M.P. speaking on behalf of the Dept. of Health admitted that ‘in ensuring a safe birth, we have sometimes failed to adequately meet the emotional needs of both mother and baby’. (TNA. MIH 160/1088: Induction of Labour/Sheila Kitzinger/NCT)
I was in labour fourteen hours under the kind of medication which made me too woolly to deal with myself or anything that was going on. Too weak to stand up for my own rights, I'd forgotten I had any rights. I didn't care how my baby was born. I was put on an intravenous drip to speed up contractions and left alone for most of the labour; shovelled from bed to stretcher to delivery table at the most intense point of discomfort. I had a gas mask slapped on my face, although I summoned all remaining strength to push it away and was oblivious when my baby was born. I felt afterwards that I had lost the whole experience. A forceps delivery bruised his minute head, scissors cut into my vagina, but he was strong and healthy and, to my dazed but infatuated eyes, perfectly beautiful. For reasons never explained to me, I was not permitted to hold my son until hours later, when he was wheeled in to me bathed and cleanly wrapped in his first trappings of so-called civilization...

In what was clearly an exercise in catharsis, Brook chose to analyse her bad experience in terms of what it told her, and those who would read her book, about the state of contemporary childbirth culture in relation to women's emancipation. Crucially, Brook made a connection between natural childbirth and the empowerment of women, arguing that the two concepts were not, as some feminists had implied, incompatible. Thus, she continued:

Female emancipation has to go further and mean more than political, sexual or financial freedom. It has to embrace motherhood, which means we must reinterpret the role of mother so that those who see families as traps can see the ways to enjoy having children...If you are a normal, healthy woman, concerned with keeping yourself

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54 D. Brook *Naturebirth* (1976) p.9
normally healthy whilst you carry a child, it is much simpler to have your baby naturally
if you can, than to be dependent on men and machines.\textsuperscript{55}

Brook, mindful of the type of criticism aimed by feminists at concepts of natural
childbirth, advised women neither to feel guilty, or inadequate, nor to admonish
themselves for having failed should they ‘require help’. Her book, although it refers to
breathing techniques and relaxation as the means to cope with labour, was not really
about methodological approaches to birth. And whilst she was obviously suspicious of
the technocratic approach to birth, she was perhaps more concerned with the \textit{application}
of the technology to birth and what this symbolised in terms of gender inequality than
with the technology itself. Therefore, Brook advocated that ‘a woman should have the
right to choose the conditions in which she gives birth, and a right to information relevant
to making that choice’.\textsuperscript{56}

\textbf{The Discourse of ‘Birthrights’}.

Although a somewhat obscure work, \textit{Nature Birth} in many ways exemplifies the
uncomfortable relationship that developed during the 1970s between the values of
women’s liberation and those of natural childbirth. Whilst the two discourses may not
have reconciled their differences, and whilst feminists remained sceptical, critical even,
of the values represented by natural childbirth in the past, understanding of the concept

\textsuperscript{55} Ibid. p30
\textsuperscript{56} Ibid. p.30
was, without a doubt, forever altered by ‘women’s lib’. By the 1980s, with maternity care an established issue on the political agenda concepts of natural childbirth took on an even greater significance in the battle for childbearing women’s ‘birthrights’. The term, coined in the early 1980s is also the title of a book by former midwife and NCT antenatal teacher, Sally Inch, published in 1982. Also in 1982 a Birthrights Rally was organised, spearheaded by Kitzinger and others committed to ‘saving’ natural childbirth, in protest against women being forced to lie on their backs during childbirth. Not only had this position been shown by natural birth proponents to be ineffective and, in some cases, harmful, it was also regarded as a symbol of the subjugation of women and the controlling power of male obstetrics. The Birthrights Rally can therefore be seen as a significant point of conjuncture between the principles of natural childbirth and the women’s movement.57

On the 7th of March 1982, in response to the protest (which was in part prompted by the recent controversy at the Royal Free Hospital in London [see above]), the Sunday Times ran an article that suggested perceptions of natural childbirth had become inexorably bound with the issue of women’s rights.58 Thus, asserting ones’ right to a natural birth now meant asserting one’s ‘right to choose’ – not only to be ‘conscious’ at all stages of labour, and ‘in control’ of oneself in order to cope with the pain of contractions, but also to allow labour to begin spontaneously, to remain mobile and upright; to be accompanied by ones’ partner in the delivery room; to decline to be subjected to certain ‘routine’ procedures, such as shaving and enema; to opt for an unassisted ‘third stage’; to be able

to breastfeed immediately after delivery; to be free, ultimately, from the trappings of high tech, male dominated, hospital birth.

Essentially, the language of childbirth had subtly, but meaningfully, altered by the 1980s, partly in response to the values represented by the women’s movement. Thus, the discourse of natural childbirth changed to accommodate women’s expectations more generally in the 1980s. Kitzinger, in The Politics of Birth (2005) writes:

There is one word the meaning of which has changed dramatically. That is ‘control’. When psychoprophylaxis was in fashion it implied self-control on the part of the woman who successfully applied the pain-prevention techniques she had learned in pregnancy... Today ‘control’ is a vital element in ‘empowering’... it should mean that a woman is free to obtain the information she needs to make her own decisions, and to control the environment for birth, and everything that is done to her and her baby... the radical change in the meaning of the single word control is probably the biggest breakthrough that has been achieved in the language and thinking about birth.59

Alongside ‘control’, the term ‘choice’ – or more specifically ‘informed choice’ – made its way into the discourse and with it came the notion of ‘planning’ for labour, as one might plan for a long and arduous journey (which, many commentators insisted, was what childbirth in fact was). It is no coincidence that the idea to employ ‘birth plans’ – the physical manifestation of the notion of informed choice – arose in the early 1980s.

59 S. Kitzinger The Politics of Birth (2005) p.64
Linked ideologically to concepts of natural childbirth, being as they were based upon the values of preparedness for and knowledge of the processes of labour and birth, birth plans were like statements of intent for the 'perfect' or 'ideal' birth. Joanna Moorhead in her account of the first forty years of the NCT asserts that birth plans 'helped to rid birth of some of its quaint and by now entirely anachronistic, customs. Shaving the pubic hair, which many women objected to in their birth plans, was one.' Birth plans, Moorhead notes, 'reflected the issues of the day'; they are, historically speaking, an important source for understanding what issues were of concern to women. Thus, they have tended to be seen as evidence of the growing influence of the 'consumer' — in this case pregnant women — on maternity policy and practice. In compiling a birth plan, expectant mothers were encouraged to question routine procedures, and oppose the 'we know better' attitude of many doctors. Unsurprisingly, some obstetricians and midwives were certainly critical of them, arguing that women arrived on the labour ward armed with shopping lists of demands.

Those who chose to make a birth plan were labelled as 'difficult' or 'cranky': in his book Birth Right (1982) Peter Huntingford warns those who are considering using a birth plan that doing so may 'serve to label you, as far as the staff are concerned as 'one of

60 J. Moorhead New Generations: Forty Years of Birth in Britain (1996) p.70
61 See “Sample Birth Plan”: Appendix C
62 See: Chapter Six, below.
63 S. Inch Birthrights (1982) p.15
64 However, Kitzinger, who was influential in developing the concept of the birth plan [see, for example, her book Freedom and Choice in Childbirth: Making Pregnancy Decisions and Birth Plans (1987)] insists that making a birth plan was always meant to be about choosing different birth options, and should not resemble 'choosing cans of beans off the supermarket shelf'. It is good, she argues, to be resolute about one's wishes for birth, but not about what not to have (in terms of drugs and other interventions). Birth plans were supposed to be about 'exploring alternatives' according to Kitzinger; the aim was to establish a dialogue between women and caregivers, rather than cause confrontation. (S. Kitzinger, interviewed 8th April, 2005).
them' or as a trouble-maker'. 65 Huntingford, who was committed to the values expounded by natural childbirth enthusiasts, was nevertheless a realist: 'there is, and can be, no 'perfect', or even 'right' way to give birth’ he wrote. 66 However, as the birth plan showed, many women were being convinced that there was, or could be such a thing as the perfect birth. It was the discourse of natural childbirth, which as we have seen, was by now enmeshed with notions of women's empowerment and childbirth as 'experience', which gave women the impression that by refusing to be subjected to medical authority, the perfect birth was attainable. Thus, the birth plan functioned as something of a metaphorical battleground; through it the conceptual shift in understanding of the term natural childbirth that occurred in the early 1980s, and what this meant in terms of the wider debate about women and childbirth, is clearly discernible. It was all about having the freedom to choose alternatives, and, ultimately, about who 'controlled' childbirth: the medical establishment, or the 'consumers' of maternity care.

In 1981, the popular BBC television programme That’s Life, conducted its own independent survey of its viewers, the results of which were published by Pan Books with the title The British Way of Birth in 1982. That’s Life claimed to have received responses from 6,000 British women; it was, remarkably (so the authors claimed), the first time 'consumer response' to maternity services had been systematically assessed in this way. 67

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65 P. Huntingford Birth Right: The Parent’s Choice (1985) p.73
66 Ibid. p.72
67 C. Boyd & L. Sellers BBC TV “That’s Life!” Survey of the British Way of Birth (1982) The women who took part in the survey were from all parts of the UK, though by far the greater number were based in the South East of England. The average age of respondents was 27, with the oldest being 44. 10 percent of respondents listed their husband/partners occupation as 'professional', 26 percent as 'intermediate', 18 percent as skilled 'non-manual', and 28 percent as 'skilled manual'. There were considerably fewer respondents from the 'semi-skilled', 'unskilled' and 'unemployed' brackets (11 percent, 2 percent and 5 percent respectively). The majority (94 percent) gave their marital status as 'married'. For 38 percent of women, this was their first pregnancy. The majority had 'normal' labour (76 percent) and pain relief (85 percent) during labour and/or delivery. The most commonly used forms of pain relief were pethidine (50
The results of the survey, which provides unique insight into contemporary popular opinion about childbirth, suggested that ‘freedom of choice’ and ‘retaining control over the process’ were governing preoccupations of childbearing women in the UK, yet it was also revealed that ‘over and over again women are being denied real choice’.68 The architects of the survey understood that choice meant more than merely the stark choice between a ‘natural’ and ‘high-tech’ birth. They noted that every woman had ‘her own idea of a happy birth’ and that for some a ‘natural, drug-free birth is not the most important thing’.69 Having a pain-free birth was more important for some, and just as many women complained that the drugs they wanted were unavailable as complained about being given drugs against their wishes. Significantly, the ‘happiest’ descriptions of birth ‘came from women who were given the choice as to how and where they gave birth’.70

The authors claimed that ‘birth in a high-tech consultant/university hospital can be a personally rewarding experience...especially if the woman is knowledgeable and able to express her wishes forcefully’.71 Yet in quite what terms such wishes were to be expressed was uncertain, although several of the women surveyed mentioned ‘natural

percent) and gas and oxygen (27 percent) although respondents were divided on the effectiveness of their choice of pain relief. In terms of general medical help received, most women found it helpful and were kept informed as to what was happening during delivery. 72 percent of the new mothers questioned said they enjoyed the experience of giving birth to their baby.

68 Ibid. p.1
69 Ibid. pp.70-72
70 Ibid. pp.70-72
71 Ibid. pp.70-72 Interestingly negative responses to the experience of birth in hospital were mostly with regards to ‘routine procedures’ such as enemas, shaving, rupturing of membranes, electronic foetal monitoring and episiotomy when carried out ‘automatically with little regard to personal preference’. (p.78) Dissatisfaction was also expressed with staff shortages and shift changes and concerns voiced about proposed closures of isolated GP/midwife led units upon which women from rural areas in particular rely and ‘regard with affection’. (p.78)
childbirth’ in their responses, equating it with the rejection of pain relief. One woman said ‘I believe childbirth to be the most natural thing in the world and asked not to be given any drugs unless I really needed them in labour’. Another recalled how ‘natural childbirth began to prove unbearable for me, so I had an epidural’. Thus, even though the meaning of the term remained in many ways ambiguous, natural childbirth was increasingly being defined in opposition to almost everything that hospital birth (or medicalised birth, or ‘obstetric-led’ birth) symbolized. In some ways this perhaps represented something of a stark choice for women. Whilst it may have been fortuitous in some respects to have been perceived in absolutist terms as an alternative to mainstream maternity care (for example, by providing mothers with a framework to express their dissatisfaction with certain aspects of it), there was the danger that such an approach would alienate some women.

Richard Seel, editor of the NCT’s New Generation magazine in the mid-1980s, broached the lack of progress made in making natural childbirth mainstream in an article from the September 1983 edition arguing that, for some people the idea of ‘going back to nature’ implied the ‘denial of essential humanity’. The ‘natural’, for so long understood in opposition to the ‘cultural’, perhaps implied something ‘animalistic’: ‘animals give birth naturally – but human beings have the ability to transcend the purely animal...’

Seel also pointed out that ‘because of the basis of the ideologies involved, the natural childbirth debate is also a battle of the sexes; between those who accuse men of having ‘taken over’ the essentially female act of giving birth, and those who accuse women of

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72 R. Seel “It’s Only Natural?” New Generation Vol. 2 No. 3 (September 1983) p.9
irresponsibly urging their fellows to follow the faddish cults and disregard the advice of the experts’. The problem partly lay, argued Seel, in the tendency to present the debate in crude terms as an ideological struggle between those ‘female birth educators who know that natural childbirth is best’ and ‘male birth supervisors who know that natural childbirth is not best’. The gross over-simplification of what was in fact a hugely complex and multi-layered debate meant, ultimately, that the ‘naturalists’ as Naomi Wolf would later call supporters of natural birth, were marginalised and stereotyped. It was easy to attack and disregard such women (for they were always women) and to cast aside their ‘extreme’ beliefs as ‘cultish’ and irrelevant.

The stereotype of the natural birth enthusiast, who has been portrayed by journalists since the late-1970s as a middle-class, sandal wearing, lentil eating, Earth mother, was almost certainly a creation of the media. Since the broadcast of a Grantly Dick-Read birth on the BBC in 1957, several programmes dedicated to childbirth had appeared on British television. Some of these, such as the BBC’s sixteen part series Having a Baby (1977), were orthodox in their approach, focusing largely on the medical aspects of pregnancy and birth. Programmes of this nature gave expectant parents a distinct impression of what was ‘normal’; in the late 1970s, this was birth in hospital, with all the

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73 Ibid.
74 See N. Wolf Misconceptions: Truth, Lies and the Unexpected on the Journey to Motherhood (2001) pp.122-173. Gillian Tindall, in The Guardian newspaper, made reference to the NCT ‘cult’ in 1966, though this was by no means the first, or the last time such comments were made in reference to supporters of natural childbirth.
75 See, for example: P. Toynbee “Natural Childbirth, a child of the sixties, was and is largely a nutty fad from a noisy group of lentil-eating Earth Goddesses…” The Guardian (12th May 1986)
76 British Film Institute, London (B.F.I.) TX/BBC2: 24.03.77-28.07.77 Having a Baby: Part of the Parent and Child Series
incumbent routines and surgical paraphernalia one might expect. Natural childbirth was mentioned in the Having a Baby series: in episode seven on ‘Preparation for Labour and Delivery’ viewers are told that some hospital antenatal classes taught Dick-Read’s theories, or ‘conscious and controlled breathing’ techniques. The over-all impression one gets of this particular television series is, nevertheless, that the contemporary experience of birth is a straightforwardly medical one. Even the teacher at the hospital antenatal classes featured in the programme is shown as a somewhat stern, no-nonsense, matronly figure wearing a stiff white nurse’s hat and uniform.

Contrast this image with that of the depiction of an antenatal class ran by Sheila Kitzinger featured in a BBC Scotland production broadcast on BBC2 in 1981. Kitzinger, who is described by the narrator as ‘the red hot mama of maternalism’ is depicted working from a Jacobean four-poster bed as she talks about the importance of choice in childbirth. The couple who have chosen to attend her class are Jane and her husband, a lawyer, both based in the South East of England. They are portrayed as ‘a bit hippyish’ and are, we are told ‘totally absorbed by pregnancy and preparation’, in contrast to the two other couples featured on the programme of which one is prosperous and upper-middle class and the other working-class and living in council house. Both the other couples, although their social and economic situations differed widely, were, as far as the birth was concerned, happy to leave it all to the midwives and doctors, and expected to give birth in hospital. On the other hand, Jane and her husband hoped for a home birth and were shown practicing squatting and breathing everyday. The sequence filmed at

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77 For example, episode 8 of Having a Baby, which featured a film of a real birth, dealt with the situation as an overtly medical event.
their antenatal class was ‘deliberately chosen to make normal people curl up’, according to a review of the programme in the NCT journal *New Generation*. Jane, described as ‘another Kitzinger convert’, is shown in a room full of other women – all of them white and wearing floaty clothes or leotards – circling their hips in unison to the music. Jane is later shown practicing yoga and listening to ‘womb sounds’ on cassette player, whilst Kitzinger, whom the narrator says, ‘helped to establish the NCT’, waxes lyrical about the ‘vagina opening up like a flower’ as the baby is ‘eased through’.

The NCT were all too aware of the stereotype to which the programme pandered, and also of the effect this had on their image. In *New Generation* it is pointed out that the *Sunday Times* preview of the programme, which was part of the BBC’s four part series on life stages, *Four Seasons*, warned potential viewers that it was ‘not for the squeamish, or first time mums’. The NCT also bemoaned that the point of social class was ‘laboured’ by the programme makers. It argued that three very socially diverse couples were featured, the aim of which was to portray the ‘NCT type’ as being ‘somewhere in the middle’. They were depicted as ‘arty types’ and ‘cranks’ that were into yoga and had decorated the nursery to be womb-like for the baby. The message of course was that this natural childbirth business was only appropriate for a certain type of person; as the NCT were well aware, programme making of this nature could only serve to reinforce the stereotype. More worrying for the NCT, however, was the way in which the programme failed to contextualise the subject, driving home the point that choosing natural childbirth was somehow fatuous and unrealistic. Thus, it is stated in *New Generation*:

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78 B.F.I. TX/BBC Scotland *The Longest Journey* (Broadcast 13th August 1981)
Sheila Kitzinger’s description of a vagina opening up like a flower is beautiful and entirely appropriate to couples in her class who have already learned that birth can be enjoyable and who feel free to talk openly about such things. But imagine for a moment the reactions of some of your friends, or mothers, faced with it cold! 79

The programme made a mockery of Kitzinger’s teaching, particularly at the point when the three couples came to having their babies. The other two women seemed to have progressed calmly with their labours, and were, we were told, ‘happy to let the hospital machinery/medical staff take-over’. The implication of this was, of course, that these births were straightforward and ‘almost pain-free’. The ‘NCT lady’ on the other hand – she who had hoped for a home birth – ended up having a caesarean section following a prolonged and complicated labour. Apparently she had been asked not be filmed during the labour; she was, viewers were told, ‘in too much pain’. The NCT objected, it said, not because the necessity for a caesarean section reflected badly upon antenatal classes, but because of the implication made by the programme which was, essentially: ‘leave it the experts, who know what they are doing, and you will be fine; try to do it your own way at your peril’. Certainly, the sense of disenchantment and failure was palpable; the programme deliberately created the impression that the outcome for those women who did hope to have a natural birth will very likely be disappointment. 80

79 NCT New Generation Vol.1, No. 1 (March 1982)
80 It should not be assumed that the BBC was hostile to alternative approaches to childbirth, despite programming of the type described above. On the contrary, the BBC was, on the whole, fairly balanced in its treatment of the subject, airing television documentaries such as the 1982 film Birth Reborn about Michel Odent’s work at the Pithiviers clinic in France, and a documentary series presented by Peter Huntingford (Birth Right 1982). Furthermore, BBC Radio Four’s Woman’s Hour dedicated several programmes to discussion of natural childbirth from the mid-1940s onwards, inviting commentators from Dick-Read to Kitzinger, Nixon to Odent, to speak on the subject. (Transcripts at the BBC Written Archives
Natural birth was still seen as a something of a niche concept; just as in the 1950s and 1960s, it was perceived as something that was appropriate only for a certain 'type' of woman. The discourse of natural childbirth, for all the attempts to be universally relevant, to address the concerns of all childbearing women, tended to appeal to the middle class, the educated, the motivated and the assertive expectant mother. Television programmes, even those that presented natural childbirth in a positive light (for example a Channel Four documentary broadcast 1986, which openly tackled 'feelings and experiences' about birth) tended to feature mostly white, educated, comfortably off women. 81

It was a stereotype the NCT tried hard to disassociate itself from during the 1980s. The organisation at this stage began to expand its activities, beginning its 'metamorphosis from an organisation of childbirth educators and mainly middle class mothers to one that speaks for all women and families.' 82 The NCT, in aligning itself with the campaign for a return to home birth, which was gathering speed during the 1980s, and in pioneering other significant challenges to the mainstream medical model of care during labour – such as allowing fathers to remain with their partners throughout and to be present at delivery – certainly succeeded in widening their appeal. Even those who did not subscribe specifically to the NCT's philosophy found they could relate to the organisation. Some women, even those who doubted whether physical preparation was

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81 B.F.J: Channel Four Life's Cycle: Birth, A Film About Feelings and Experiences (Broadcast: 6th June 1986)
82 S. Kitzinger The Politics of Birth (2005) p.52
in any way useful or beneficial, found NCT classes an invaluable means of ‘making friends’ and creating support networks. There were also those who had never heard of the NCT, but whose childbirth experience was, nonetheless, positively ‘influenced by the NCT’ and its campaigns to improve birth.\(^\text{83}\)

The values of natural childbirth went beyond eschewing pain relief or practising birth positions and breathing techniques at NCT classes. Nevertheless, the tendency to portray natural childbirth in ‘faddish’ terms is evident in the essentially patronising attitude of some areas of the press to these issues since the 1970s, as exemplified by a series of articles in *The Guardian* serialising journalist Jane Walmsley’s diary of her NCT antenatal classes in 1977. The implication of the articles (which concluded with an account of the birth of her baby at a large teaching hospital, assisted by an epidural and forceps delivery) was that whilst NCT classes may have been of ‘some psychological advantage’, women were being encouraged by the NCT to endure ‘hours of pain’ even when ‘safe relief’ was at their disposal. Walmsley gave the impression, with her condescending commentary, that learning about natural childbirth at NCT classes was rather pointless and that those who declared themselves against drugs were, ultimately, deluded.

The NCT itself responded to Walmsley’s account of its antenatal classes: Deirdre Mackay [see Chapter Two, above] criticised *The Guardian* for publishing what amounted to a ‘hatchet job’ on the NCT. Eileen Hutton, then president of the NCT, attempted to redress the balance by assuring readers that the organisation’s aim was to inform and

educate expectant parents and to encourage them to take responsibility for their own labour. Still, as an organisation that hoped to be seen to represent the needs of the consumer, the NCT remained much maligned and misunderstood, no more so than in the media. The struggle to be taken seriously – and to be seen as relevant – was one that the NCT continued well into the 1980s and in many ways it was successful: in the early 1990s, evidence given by the Trust was instrumental in the development of a significant new piece of maternity policy [see Chapter Six, below].

Published in 1993, the report of the Department of Health’s Expert Maternity Group, *Changing Childbirth* perhaps suggested that a sea change had occurred in attitudes towards non-medical models of childbirth. Yet was this really what happened? Even in 1992, as the NCT’s evidence was being considered by the Expert Maternity Group, the opinion that ‘ginger groups’ such as the NCT were irrelevant and unnecessary was still being voiced, often by those in the medical profession who were sceptical of the Trust’s approach to birth. Kitzinger asserts that the NCT underwent a metamorphosis from an organisation of childbirth educators and mainly middle-class mothers, to one that speaks for all women and families. But did this necessarily indicate that the childbirth alternatives discussed here were perceived any differently, or that they had moved from the periphery into mainstream childbirth culture? Perhaps natural childbirth, in the late

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84 From the private papers of Eileen Hutton, with kind permission. This comment was made by Ian Mansun, Director of Obstetrics and Gynaecology at Sharoe Green Hospital, Preston in June 1992, at a symposium by Lancaster Polytechnic (Dept. of Midwifery Studies) on ‘Care in Childbirth: Collaboration not Conflict’. The NCT representative at the symposium later complained of several delegates’ ‘NCT-bashing’ during the closing discussions; Eileen Hutton, who had been present at the meeting was referred to by Mr. Mansun as ‘the NCT lady’, perhaps exemplifying how little relations had in fact improved between the NCT and the medical establishment.

1980s, was an idea whose time had come. There were many individuals who would have liked to think so; in reality, the path to *Changing Childbirth* was far from straightforward.
TOWARD CHANGING CHILDBIRTH.

Now we expect childbirth to be safe, we aspire to natural childbirth without medical intervention and feel hard done by if we have so much as an episiotomy. The notion of what is normal in childbirth has shifted dramatically.¹


In the early 1990s, the Department of Health Expert Maternity Group published its review of contemporary maternity services in a White Paper entitled Changing Childbirth. The report acknowledged the ‘enormous improvements’ that had been made in maternity care, particularly in terms of safety, over the previous seventy years. Yet it was the words of former Senior Medical Officer for Maternity and Child Welfare to the Ministry of Health, the late Dame Janet Campbell, whose observations were made in the 1930s, that set the tone for Changing Childbirth. Thus, section 2.8 on Care in Labour opens with the following quote:

“It is easy in the hospital atmosphere of professional childbirth to forget how terrifying childbirth often is, especially to the inexperienced, young mother, and how the patient can be comforted and soothed by gentleness and consideration, and a little time spent explaining away anxiety and fear. A placid patient is so much more likely to have an

¹ K. Figes Life After Birth (1998) p.11
easy delivery than one who is frightened or over-strained that such attention is part of
good midwifery practice as well as of humane care." Dame Janet Campbell 1935.\(^2\)

The report continues:

While the care of women in labour may, in some ways, have changed a great deal in the
intervening 60 years, the sentiments expressed by Dame Janet Campbell are as relevant
today, when 99% of births occur in maternity units, as they were to the audience she
addressed all those years ago.\(^3\)

*Changing Childbirth* is a noteworthy document in terms of its acknowledgement of
alternative discourses of childbirth. It represented an official declaration that women had
a fundamental right to *choose* what kind of birth they had. No longer would childbirth be
dominated by professional self-interest; no longer would pregnancy be defined as a
pathological process, or disease; no longer would ‘safety’ be defined in narrow,
physiological terms, but would encompass too the emotional and psychological wellbeing
of mother and baby. Forthwith, stated *Changing Childbirth*, women giving birth under
the NHS should be given the opportunity to do so with confidence, to exercise control
over what happened in them labour. More thought was to be given to the environment in
which birth took place: it should be ‘supportive and comfortable’; women should be ‘free
to move about and adopt new positions’.\(^4\) More emphasis should also be given to
continuity of care for the express reason that the reassurance it provided ‘reduced the

para.2.8.1

\(^3\) Ibid, para.2.8.2

\(^4\) Ibid, para.2.8.7
need for pharmacological pain relief. Specific attention was, furthermore, paid to the value of childbirth education, the provision of unbiased information about labour and birth and the use of birth plans.

This document appeared, on the surface at least, to legitimise what advocates of natural childbirth had been saying for decades: that the medical model that had dominated childbirth culture for decades was fundamentally flawed, and, moreover, that this could in fact be to the detriment of mothers and their babies. *Changing Childbirth* not only concluded that 'a medical model of care should no longer drive the service', it also developed recommendations to improve maternity service provision that in some respects mirrored the principles more often associated with alternative approaches to childbirth. Nevertheless, whilst alternative models were to be worthy of consideration in this manner – as worthy at least as were other technological developments – it still seemed that they were not to be regarded as a more desirable 'replacement' for conventional medical procedures, but rather as one of a range of birthing options or 'choices'. Further, the adoption of *any* new technique should be subject to a rigorous process of research and audit, justifiable because of a 'long history of well-intentioned changes which are not backed-up with proper research-based evidence to support their introduction'. Thus, the authors of *Changing Childbirth* state:

5 Ibid, para.2.8.8
6 See ibid, para.2.8.3: 'Parent education groups should also give women the opportunity to discuss and learn about birth, and to explore the approaches that will be open to them'. Also para.2.8.4: It is important that the woman's plans and wishes about the birth of her baby are documented in her maternity notes. A birth plan may be used for this purpose, either incorporated in advance into the notes or supplied by the woman herself. Birth plans should not just be for women who have unusual requests. Birth is a unique experience for every woman, and if, unavoidably, the woman is cared for in labour by some whom she has not met, the birth plan will be particularly helpful.
Electronic foetal monitoring is just one example of the way in which technological developments have been adapted as common practice, without distinguishing whether they are really necessary or beneficial. This is also true of other practices such as water-birth, homoeopathy and aromatherapy...where women express a wish for a particular form of care, which has no proven benefit, this must be discussed with them openly and fairly.\(^7\)

Whilst Changing Childbirth argued that the benefits and disadvantages of any procedure ought to be discussed with women openly and without prejudice, so that women might make an informed choice about the type of care they received, it was clear that certain procedures remained 'alternative'. Hence, the reference to 'other techniques and procedures' – techniques and procedures that ought to be subjected to the same level of scrutiny as any clinical measure would (or should) be, but that remain distinctive nonetheless. Given this measured approach toward mainstream acceptance concepts of natural childbirth – which, as we have already established, were merely alluded to and not explicitly referred to in the report – what does Changing Childbirth actually tell us about their overall impact upon changes to maternity service policy?

Clearly attitudes had changed in the decade leading to the report’s publication, even though critics argued that the notion of choice in childbirth represented an agenda that was set – as so often had been the case in the past – by obstetricians rather than by

\(^7\) Changing Childbirth (1993) p.63 Para. 4.3.1
childbearing women.\(^8\) Even so, the inclusion of a representative of the NCT (Eileen Hutton, the then president of the Trust) in the Expert Maternity Group membership could be seen as a marked shift in attitudes toward the role of lay/voluntary organisations in maternity service planning. The NCT had been invited to give evidence to the Winterton Committee [see below] in 1991, and although this set a precedence in terms of the consideration of the views of consumer groups, representation in the form of membership of the Expert Maternity Group signified the centrality of these groups to future service planning.\(^9\)

This was an important shift; the NCT, after struggling for decades to have its voice heard had finally achieved its place in setting the policy agenda. Mary Newburn, head of policy and research at the NCT since the late 1980s, describes *Changing Childbirth* as ‘a really important tipping point’.\(^{10}\) Insofar as the values the NCT represented were being discussed at policy level, and not merely by NGOs or pressure groups, her statement is not too far-fetched. For whilst some consumer groups were critical of the ‘choice’ agenda, the period leading up to *Changing Childbirth* was one in which alternative approaches to intra-partum care were beginning to be considered seriously (if cautiously), both by medical professionals and policy makers, as relevant to the future of maternity care provision. The Expert Maternity Group responsible for *Changing Childbirth* was, for example, ‘impressed by the degree of flexibility expressed by some professionals

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\(^8\) See, for example B. Beech “Challenging the Illusion of Choice” *AIMS Quarterly Journal* Vol.15 No. 3 (Autumn 2003)

\(^9\) See APPENDIX IV: Membership of Expert Maternity Group

\(^{10}\) Mary Newburn (Interviewed 13\(^{th}\) March 2006)
involved in maternity care, particularly about care in labour. In many places, there was apparently enthusiasm for and genuine interest in different approaches, and midwives and doctors seemed keen to ensure that *the woman's experience matched her expectations*. 11

The 'Consumer' and Maternity Care.

What this demonstrates is that the views of consumers (ergo the views of users of the maternity services) were now considered at least as important as the views of the medical profession in developing policy. This was, of course, part of the growing trend in consumer driven health service development, itself a product of the Thatcherite policies of the 1980s. Was it, therefore, significant that the NCT was the key organisation chosen to represent women in this way, given its status as *the* recognisable face of the natural childbirth 'movement'? One should perhaps be cautious in attributing the NCT's inclusion on the Select Committee to official acceptance of the principles upheld – or more specifically those *perceived* to be embodied – by the Trust. If anything, the NCT's involvement in providing evidence for the Expert Maternity Group merely signified the growing influence of consumer groups on the policy development. The point was that organisations such as the NCT were adroit enough to capitalise on this trend for consumer driven policy to advance their own agenda. Thus, by the early 1990s, stimulated by the campaigns of consumer groups, alternative approaches to childbirth had begun to make an impact on the policy-making agenda in subtle, but significant ways. The question was why, and what did this imply?

11 *Changing Childbirth* (1993) p.29, para.2.8.5. My emphasis
The 1980s was a tumultuous decade in the history of maternity care in England. The increased use of obstetric technology – the so-called ‘childbirth revolution’ of the 1970s\(^ {12} \) – engendered a backlash which only gathered strength in the 1980s as ‘consumers’ of maternity care spoke out against their treatment. Bolstered by evidence of women’s dissatisfaction with maternity care consumer groups such as the NCT and AIMS waged specific campaigns against the arbitrary use of obstetric technology. Other groups were also formed, such as the Active Birth Movement founded by Janet Balaskas, which aimed to offer women alternative approaches to childbirth. And still smaller, although no less insignificant groups emerged, such as the Society to Support Home Confinements (SSHC), established in Durham in order to help women to obtain home birth (for which the NHS was legally bound to supply attendants).\(^ {13} \)

The Maternity Alliance (MA) was another important addition to the barrage of groups committed to improving childbirth for women by challenging the authority of the medical profession. Established in response to the publication of the Short Report in 1980 which, as we have seen, perpetuated the trend toward universal delivery in large consultant-led hospital units by advocating the further closure of small GP-led units and the phasing-out of home birth altogether, the MA was instrumental in the campaign to improve parents’ rights in relation to maternity care. In addition to publishing a bi-monthly magazine addressing issues of concern to pregnant women and new parents, the MA published a comprehensive guide to ‘maternity rights’ in 1984. The *Maternity Rights Handbook*


aimed to enlighten expectant and new parents about the options open to them around the
time of birth and included legal advice and advice on services, benefits, and employment,
as well as choices in childbirth. The MA stated its belief that the maternity service
should be organised to 'meet the requirements of women and their families'; it was
critical of what it called 'the mythology of pregnancy as an illness' and asserted that
parents had 'few rights in relation to care in pregnancy, childbirth and the post-natal
period'. 'All too often' claimed the authors of the Maternity Rights Handbook, 'there can
be frustrated expectations and unnecessary battles with bureaucracies'.

Rather than expounding a specific agenda, the MA set out to inform women of all the
options open to them. For example, for those hoping for a natural childbirth, 'without
unnecessary interventions' the Handbook has the following advice:

[Plan] ahead early in pregnancy, or even before you conceive. If you have a choice of
hospital, find out which one is most likely to offer you this kind of birth and ask to book
in there. Or you may chose a home delivery. Discuss your wishes with your GP and/or
the doctors and midwives at the hospital and ask them to write your preferences in your
medical notes. Parents have few clear rights in relation to childbirth but they can expect
reasonable consideration and respect for their wishes. Remember that a natural birth with
no interventions may not be possible or desirable if you have a very difficult labour or if
the baby has problems. Necessary interventions are welcomed. But if you wish to avoid
the unnecessary ones, the following information [on routine obstetric interventions] may
be helpful.

15 Ibid. p45
The approach of the MA to childbirth alternatives perhaps demonstrates that what was different about the consumer groups committed to improving childbirth in the 1980s was their non-prescriptive approach. Even Balaskas' Active Birth Movement, which advocated antenatal preparation for natural childbirth, was established not to promote a specific 'philosophy' of birth, but rather to provide women with options in labour and birth beyond the rigid approach of the obstetric model of care embodied by the 'Active Management of Labour'. The NCT, similarly, was now committed to improving birth for all women, not only those who had ambitions for a natural childbirth. Reflecting the change in the NCT's tactics in the 1980s, Eileen Hutton, president of the NCT in the 1980s and early 1990s, stated in 1992 that the NCT 'advocate flexibility and informed choice, not natural childbirth, whatever that may be.'

'Choosing' Natural Childbirth?

The notion of choice in childbirth came to the fore in the 1980s (alongside growing consumerist approaches to health care more generally). The virtual eradication of the domiciliary midwifery service, the increasing closure of small GP and midwife-led birth units (not to mention the dwindling numbers of GPs practising obstetrics) had resulted in the homogenization of maternity care. A major concern of consumer groups was that choice was being eradicated, and that the closure of small maternity units was further exacerbating the situation. The issue was also raised in the House of Commons in

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16 Eileen Hutton (private papers, with kind permission). Letter to organisers of the 'Care in Childbirth: Collaboration not Conflict' Symposium, Lancaster Polytechnic (3rd July 1992)
December 1986. With reference to the proposed closure of the Keynsham maternity unit in Bristol, M.P. Jack Aspinwall's comments were particularly revealing insofar as they demonstrated the extent to which contemporary policy was dictated by the needs of consumers of maternity care:

It is clear that the trend of both medical and public opinion is back to "low technology" childbirth wherever possible. The Paulton maternity unit in the Bath district health authority is flourishing, with demand rising. The Keynsham maternity unit mothers' support group has made it clear that more women do not want "high technology" births, and, furthermore, do not want to go to the Bristol maternity unit. To close Keynsham would be to reduce the choice for expectant mothers. Moreover, it will reduce obstetric skills for GPs and once these have been removed, it is doubtful whether they will be recovered. Above all, in the light of new research and 512 demands by mothers, it will be closing the door on what must be regarded as the way forward for maternity care. This is not the act of a responsible Health Service.

The level of consumer protest was in itself seen as evidence that women wanted more choice in terms of maternity care. However, relatively few studies were carried out in order to address this very important question. Still, the view that all births should take place in large hospitals on grounds of safety was vehemently opposed by organisations such as AIMS, the MA, and the NCT, mainly because it was seen to diminish women's

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autonomy. For the NCT, AIMS and other consumer groups in the 1980s, the key to increasing women's autonomy was information. An increasing number of women were actively seeking this information, many by joining organisations like the NCT, although the number of women they were able to reach was limited, partly because the channels of information were themselves controlled by the health authorities. Establishing a dialogue between maternity care providers and pregnant women was necessary to inform women of their 'choices'; in this sense groups who claimed to speak on their behalf played a vital role.

What these groups had in common was their concern about high levels of medical intervention and their strong suspicion as to the necessity and appropriateness of this. They also had a strong association with alternative approaches to childbirth and hence – despite the efforts of some to disassociate themselves from the term in the past – natural childbirth. Furthermore, they had not always advocated choice: their approach to childbirth was at times prescriptive, didactic, or uncompromising (or all three), as we have seen. However, the mid-1980s, the word choice was already becoming ubiquitous in debate surrounding childbirth. In part this was related to the issues that were now central to the debate – home birth, birth plans, active birth, and so on – as well as the fact that the range of options available for birth had widened. In terms of pain relief alone, most women in the 1980s had access to epidural anaesthesia, and other commonly used forms of analgesia such as pethidine and 'gas and air', and of course they had the option

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19 According to one antenatal teacher who has worked with the NCT for over thirty years, the health services often act as 'gatekeepers and the NHS tends to recommend to the NCT those women whom they think will “fit in”' (N. Smith, interviewed 28th February 2006)
of forgoing the above in favour of the breathing and relaxation techniques advocated by proponents of alternative approaches to birth. Therefore, organisations like the NCT functioned to provide information, to tell women about their options, and to liaise with maternity care providers to ensure they too were imparting unbiased information. The anti-medical stance became less of an issue; alternative approaches and natural childbirth were still emphasised, but the focus was more upon enabling women to exercise their 'autonomy' when it came to 'decision making'.

To this end, the NCT's 'collaboration not conflict' approach was as timely as it was to prove effective.20 In the past, the medical profession had been largely unreceptive to the NCT's attempts to establish a dialogue with them on issues relating to intra-partum care. By the late 1970s a great deal of resistance existed amongst the less-adaptable members of the profession; however, the NCT had always tried to build good relations with midwives, GPs and consultant obstetricians. The Trust presented its views, for example, at countless midwifery seminars and conferences, and, by the 1980s, regularly contributed to journals, such as the MIDIRS midwifery digest. In its efforts toward mainstream acceptability, the NCT also invited obstetricians, GPs and senior midwives to become members, and to serve on its committee. Perhaps due to the perception that the NCT's aims were diametrically opposed to all those in the medical profession other than 'a militant wing of midwives who support their movement', the Trust was adamant, as it had been in the past, that it had 'no wish to set itself up in direct opposition to the medical

20 "Care in Childbirth: Collaboration, not Conflict" was the title given to a symposium held by the NCT in conjunction with Lancashire Polytechnic (Dept. of Midwifery Studies) in June 1992.
profession – if indeed there is a consensus to oppose'. This approach continued into the 1980s, with the NCT making concerted efforts to maintain the support of influential bodies such as the RCM and the Health Visitors Association, as well as that of individual members of the medical profession. In addition, at local level, the NCT worked closely with the health authorities, providing information and ‘staying in touch’ with the issues that were affecting how women experienced the maternity services.

‘Research’ and ‘information’ were the key words for the NCT in the 1980s. For example, in the 1980s, the Trust published the findings of its surveys of new mothers on issues relating to the experience of childbirth, including, specifically, episiotomy and epidurals. The research efforts of the NCT were intended to establish the Trust as an organisation that represented the needs of all expectant parents, not just a minority of middle-class, educated and articulate women. Providing what they considered ‘unbiased’ information to pregnant women was another means of reinforcing the image of the NCT.

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21 Eileen Hutton in a letter written on behalf of Phillipa Micklethwait in response to comments made by a nurse based in Merseyside in a letter intended for publication in the journal Midwife, Health Visitor and Community Nurse made these comments on the subject of “Nature Versus Science”. The nurse, Mary Dixon, commented that the NCT (which, interestingly, she mistakenly referred to as the ‘Natural Childbirth Trust’) threatened to cause ‘considerable conflict within professional ranks’ because of its stance on natural childbirth and the role of ‘science’. Micklethwait suggest the following for the closing paragraph of the NCT’s response: ‘As for the “marriage between nature and science”, we feel that the aim for all concerned should be healthy mothers with uncomplicated pregnancies to experience birth that is spontaneous and “natural”, with medical intervention reserved for high risk cases and the small proportion of other cases where it is shown to be necessary’. (With kind permission of E. Hutton)

22 For example, the NCT worked closely with Tower Hamlets Health Authority on its Health Promotion programme during the 1980s and 1990s, providing weekend courses training staff from the maternity unit at the London Hospital in the provision of ‘parent education’ and advising on the development of antenatal classes. A number of sources relating to the Tower Hamlets Health Promotion programme specifically dealing with antenatal education are located in the Archives of the London Hospital, Mile End, London. See, for example, TH/HP/A/3/2: Parent Education reports (1987).

as indispensible to the future development of maternity policy – given that policy was (by the mid-1980s) increasingly being couched in terms of what women ‘wanted’. The idea of engaging with maternity service users (as represented by organisations such as the NCT) fitted in with the trend toward consumer-led health care that was emerging at this time.

Mary Newburn, head of policy and research at the NCT, who joined the Trust in the early 1980s, remembers this time as one in which ‘women’s experience took centre stage’. The NCT (and other voluntary organisations, such as AIMS) were actively involved in this process, for example by being involved in the Maternity Service Liaison Committees (MSLCs) set up in the mid-1980s as a forum for maternity service users and providers, as well as policy makers, to discuss local services and design future service provision.24 As the views of ‘users’ began increasingly to be seen as important to health policy development, lay organisations took on an ever-larger role. This was remarkable, given that in 1975, when the NCT carried out research on induction during labour that was roundly criticised by the Ministry of Health for being ‘problematic’ and ‘unrepresentative’ given the Trust’s tendency toward ‘membership from particular socio-economic groups’.25 How, therefore, did the NCT, a group criticised and dismissed on

24 The House of Commons Social Services Committee initially recommended the establishment of Maternity Service Committees and Regional Perinatal Working Parties in the it’s follow-up report to the Short Report (1984). However, uptake was disappointing, with only 63% of the 192 health district setting up MSLCs by 1984. Tew argues that where they had done so, ‘the committees were mostly dominated by obstetricians or other leading officials from the establishment, the lay representation being small and ineffective’. See: Tew Safer Childbirth (1998) p.213.

the premise that it represented only an articulate minority of childbearing women, manage to vie for a position at the forefront of maternity policy development?

According to Oakley’s assessment of the social context of contemporary maternity care:

One of the criticisms made by consumers in the 1970s was of the kind of communication that characterizes maternity-care encounters. It was said, and there was evidence to support this, that the typical encounter between pregnant women and obstetricians and/or midwives prevented many women from voicing their questions and anxieties. The spectre of the Guardian-reading, middle-class woman as the sole possessor of information-seeking qualities was laid to rest by Ann Cartwright’s survey of induction in 1979, which showed the only class difference to reside in the articulation of questions: working-class women had more unasked, and therefore unanswered, questions than their middle-class peers.26

If, as Oakley suggests, class differences resided in the articulation of questions about maternity care, the NCT’s approach — to provide information and establish dialogue — was an attempt to bridge to the gap in attitudes between social classes. Keen to move away from its middle-class roots, the NCT strove to re-establish itself up as a non-adversarial spokesperson for all expectant mothers. Yet the NCT were still firmly associated with the ‘alternative’, particularly amongst hospital labour ward staff.27

Moreover, their influence on policy, beyond the local advisory role afforded them via the MSLCs, was minimal in the early-1980s. MSLCs, were set up to advise decision makers

26 A. Oakley The Captured Womb (1984)
27 According to midwife Shelia Hunt, women who arrived on the labour ward with birth plans and so on were often labelled ‘eccentric, troublemakers, or NCT freaks’. See: S. Hunt “Autonomy, Accountability and Choice…” in Association of Radical Midwives Newsletter No. 36, (Spring 1988) pp.9-10
at a district health authority level; they did not have the power to allocate resources or implement policy changes. Nevertheless, with the choice paradigm increasingly setting the agenda for maternity policy, particularly by the late 1980s and early 1990s, the NCT seized its moment.

Historically, the NCT was not a pro-choice organisation (unlike AIMS, which had always campaigned from a pro-choice platform). As discussed in Chapter Two [above], it was established to promote a specific way of birth and, despite many changes in the organisation, it remained committed in its advocacy of non-medical approaches to the management of labour and childbirth. The shift in emphasis toward promoting choice in childbirth perhaps implied an acceptance on behalf of the NCT that the dialogue they sought could best be established by engaging with contemporary discourse on maternity care provision. Thus, the NCT, rather than shaping the maternity care agenda, changed its own stance in response to it. Or, as one veteran NCT teacher put it: ‘Issues have changed – maternity care has changed. NCT has responded to these changes rather than the other way round’. So who exactly was setting the maternity care agenda in the late 1980s and early 1990s? More to the point, what did this imply?

The Medical Profession and ‘Choice’.

29 N. Smith (Interviewed 28th February 2006)
One of the principal objectives of this thesis has been to discuss how concepts of natural childbirth, hitherto regarded as of interest only to a minority of middle-class mothers, began to impact upon mainstream maternity care by the closing decade of the twentieth century. The relationship between the medical profession and advocates of natural childbirth has been a key aspect of this discussion throughout. As the childbirth debate moved on to the issue of choice in the 1980s, this relationship grew in significance. A programme broadcast in 2007 on BBC Radio Four's *Woman's Hour* devoted to the recent history of childbirth culture in the west defined it in terms of a battle – 'The Battle for Birth'. The programme claimed that, by the late-1970s, 'women were demanding more choice'; 'the fight-back [against the medical profession] had begun' and 'mothers wanted natural births'.

Certainly, as suggested in the previous chapter, by the 1980s, it did appear that a backlash against high-tech, obstetric-led childbirth was underway. However, whether the battle lines were drawn quite so clearly between medical professionals on the one side and natural birth advocates (bolstered by the support of an increasing number of mothers) on the other is questionable.

A particular incongruity highlighted by the debate was that women could be regarded as both the beneficiaries of medical progress *and* the victims of medicalisation. This apparent paradox called for a re-evaluation of the relationship between the two sides of the debate. Another thorny issue was that of women in obstetrics: were female obstetricians more sympathetic to a more women-focused, choice-led approach to maternity care, or were they just as pre-occupied with the issue of safety, and hence as

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30 BBC Radio Four: *Woman's Hour* "The Battle For Birth" (Broadcast 7th April 2007)
risk-averse, as the majority of their male colleagues? Obstetrics was, of course, a male-dominated profession. Whilst the number of women entering the profession had increased steadily over the second half of the twentieth century, they were still in the minority. Obstetrician Wendy Savage recalls her training at the London Hospital Medical College in London's East End in the late 1950s, where she was one of just three women amongst fifty men. Female obstetricians thus had to work within the confines of a risk-averse, technology driven professional culture; personal views undoubtedly took second place and those who deviated from orthodox practice were regarded with suspicion, as the case of Wendy Savage illustrates.

Savage, who went on to hold a senior post in obstetrics at the London Hospital, became embroiled in a bitter legal battle, culminating in a costly public enquiry, following her suspension from medical practice in April 1985. Savage's suspension caused public outcry when it emerged that she had allegedly endangered mothers and babies in her care due her 'unorthodox approach' to labour and birth. Interestingly, the public – and the media – came out overwhelmingly in support of Savage. A support group was established, and on the 13th of July 1985 over 1000 people, including local GPs, Maternity Service Liaison workers, parents of babies delivered by Savage and representatives of women's health groups marched through Whitechapel to deliver a petition calling for her reinstatement. A unanimous vote by Tower Hamlets Health Authority eventually reinstated Savage to her position following a lengthy and bitter

enquiry; thus exonerated she took up her post at Mile End once again. The decision to absolve Savage had serious ‘implications for those who said she was [incompetent]’. It was they, not she, who had ‘their consciences to examine’. 33

The furore over Savage’s suspension brought into focus what she described as ‘the gulf between what women were seeking in obstetric care and what the medical profession wanted to provide’. 34 The widely different responses of the community and the medical establishment only served to underscore further this dichotomy. Thus, recalled Savage in her book *A Savage Enquiry* (1986):

> The doctors and health workers who worked in the Tower Hamlets Health District were willing to become publicly involved in my case because they knew, and liked, the kind of care I provided – and that I was competent... They and the women’s health organisations who were involved from the beginning of my suspension ensured that my case caught the attention of the media: my case was no longer the fight of the individual for her livelihood but a focus for a countrywide debate on the future of maternity services. 35

Refusing to be drawn into public discussion of the case, the medical elite recoiled from what some referred to as ‘trial by media’. 36 On the other hand individuals such as Beverly Beech (AIMS) and Sheila Kitzinger seized the opportunity to launch a media

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33 Ibid. p.173  
34 Ibid. p.71  
35 Ibid. p.67-68. Beech, Kitzinger and other representatives of consumer groups, including a group of women members of the Tower Hamlets MSLC, joined forces to establish the ‘Wendy Savage Support Group’ in May 1985. Using their connections in the media, members of the Support Group added to national media coverage of the issue. Kitzinger, for example, wrote about the campaign to reinstate Savage in an article in the *Sunday Times* (19th May 1985) entitled "Battle for the Birth Rights".  
campaign calling for Savage’s reinstatement and emphasising the degree of public support for the type of care she provided.

Media coverage of the case was, perhaps unsurprisingly, skewed in favour of Savage. Several newspapers championed Savage as the human face of obstetrics, pitting her against the seemingly out-dated, old-boys’ club that was the medical establishment. Indeed, her humanistic approach to obstetrics, which had been highlighted by the case, appeared progressive; in contrast orthodox obstetrics appeared staid, uncompromising and out of touch with the needs of mothers and babies. Savage, who had joined the London during Peter Huntingford’s time as Chair of Obstetrics and Gynaecology and was greatly influenced and inspired by his approach, had always worked hard to ‘offer women choice of services in childbirth’ and to ‘encourage midwives to regain their autonomy and take on home deliveries’.37 Her stance was one of non-intervention – unless intervention was called for – and her medical training convinced her that the contemporary practice of obstetrics was misguided: ‘it seemed to embrace everything that was wrong about the way women were treated by the health service’.38 This approach appeared in-step with contemporary discourse; moreover, the case only served to highlight how the indiscriminate use of birth technology was often misguided. The message conveyed was the opposite of that which her detractors, with their risk-averse approach, had hoped: intervening only when necessary, and not as matter of course, did not compromise safety.

37 W. Savage A Savage Enquiry (1986) p.22  
38 Ibid. p.20
Savage's approach was, nevertheless, at odds with that of most of her colleagues in obstetrics – something that came to light during the enquiry into her suspension. She was convinced, however, as were many of her supporters, that the real issue at stake was power. Offering choice to women, for example by giving them option to be cared for during pregnancy and labour by their GP or a community midwife, undermined the consultant obstetrician’s power to make decisions about ‘his’ patients. Ultimately this threatened to undermine obstetrics' role in setting the agenda for maternity service provision in general. The controversy exposed the obstetric profession to public scrutiny and indicated that the tide of public opinion was perhaps turning against what had been, up until now, largely unquestioning acceptance of the obstetric model of childbirth. However, the argument that childbirth in the mid-1980s was a relatively safe undertaking, and that obstetric progress had contributed to removing much of the risk associated with childbearing in the past held fast. Rather than undermining this assumption completely, the Savage affair engendered a re-appraisal of obstetric practice.

The gold standard of safety, in being employed as means of standardising practice, created culture of risk-aversity and professional protectionism within obstetrics. The problem was that clinical safety, although desirable, threatened to over-shadow the human aspect of maternity care provision. The Savage affair demonstrated that safety standards might not be compromised by offering women choice. However, an unfortunate side effect of the case may also have been to convince others – particularly women – in the obstetric profession that deviation from orthodox practice could be considered risk-taking. It was very difficult to ignore the fact that mothers expected birth
to be safe, above all else; the consequences for professionals, should anything go wrong, were manifest. The problem for obstetricians of course was that, now that the battle for safety had been won, women were demanding more.

The findings of a national survey on women’s feelings about maternity care conducted by a popular magazine for expectant parents and parents of young children published at the end of 1986 concluded that having a baby in Britain was apparently either ‘a marvellous experience or a sad disappointment’.\(^{39}\) What was striking about this was that, according to the results of the survey, sympathetic staff that supported and listened to women were vital in determining this. Women, it was claimed, wanted more information and more consultation; on this issue they were ‘united’. Those – around a third of respondents – who found the attitude of doctors and midwives unfriendly and unsympathetic felt they did not have the ‘kind of birth [they] wanted’.\(^{40}\) Thus the findings of the survey indicated that, above all, communication was key to a good birth experience. Most women had some kind of pain relief and criticisms of intra-partum care generally tended to be focused upon either a lack of prior discussion about pain relief, or the ‘routine’ procedures, such as shave and enema, that were regarded as unnecessary or those that limited women’s mobility during labour, such as Electronic Foetal Monitoring (EFM).\(^{41}\) In other words, what was being questioned was not obstetric practice per se, but the way it was being conducted and the way in which certain procedures were carried

\(^{39}\) *Parents* “Birth Survey” (November, 1986) pp.6-8

\(^{40}\) Ibid.

\(^{41}\) The survey results indicated that routines such as pubic shaving and administration of enema were falling out of favour in many maternity units by 1986, but that Electronic Foetal Monitoring was routine for most women in labour and was universal for first time mothers.
out routinely, based *a priori* assumptions of risk, without discussion or consideration of individual circumstances.

In the past, obstetrics had been able to act with impunity, arguing that such procedures were necessary and beyond reproach in the name of safety. However, as a discourse of questioning and criticising modern obstetric practice and idealising alternative approaches to birth developed, the safety argument ceased to function effectively as obstetrics' trump card. Moreover, given the progress made in maternity care over the course of twentieth century, more women were beginning to take an interest in natural childbirth *because*, rather than in spite of, the abundance of medical technology available to them. Thus, contemporary obstetric care provided a kind of 'safety net' for those women hoping to explore alternative ways of giving birth. This is an important point: even though the medical profession continued to emphasize safety as a priority, that the dangers once associated with childbearing seem to belong to a distant past arguably removed some of the anxiety women felt entering into childbirth, leaving them free to explore other aspects of the experience. Women still wanted assurance that medical back-up would be available to them 'in case something goes wrong', but they also wanted the kind of birth they read about in the childbirth manuals. As long as they were offered — or more to the point *were seen to be offered* — choice, then improvements were arguably being made.

Hence, one notices something of a compromise taking place from the middle of the 1980s with the some in the maternity professions appearing generally more sympathetic —
albeit reservedly - to alternative ideas. Furthermore, the organisation of maternity services appeared to be increasingly considerate of them, directing resources toward the improvement of maternity unit décor, for example, or the implementation of ‘birthing rooms’ where the labouring woman is ostensibly free to move around as she pleases and/or deliver in an up-right position. But were such improvements merely ‘skin deep’? Real choice arguably rested upon factors such as demographics, with alternatives more often than not being offered in some progressive units, mostly in large teaching hospitals in and around London (the London Hospital, for example) rather than in the north, or Scotland. Nevertheless, the issues were being addressed, for instance at the RCOG’s annual Consultant’s Conference in 1984, which was focused explicitly on alternative approaches to birth under the heading ‘Back to Nature: Less Intervention in Obstetrics’. Amongst the papers presented at the conference were findings of a study on the benefits of birth rooms versus labour ward by a consultant from Queen Charlotte’s Maternity Hospital. The study, although small and London-based, was not

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42 Tew mentions reforms of this type in her book *Safer Childbirth*. The Short Committee recommended such reforms in 1980, with the aim of ‘humanising obstetric care’. Tew suggests that ‘the humanising process may have been less in response to the committee’s recommendations than to pressure from consumers’ organisations’.

43 J. Robins “Has the birth revolution gone too far?” *Parents* (October, 1987)

44 Ibid. This author of this article pointed out that ‘Doctors in these areas argue that they see more high-risk women and women from poorer backgrounds. Such women may be less articulate and less able to make the system work for them’.

45 RCOG E2/2 Consultants’ Conference, 3rd – 6th December 1984 (Conference Programme)

46 RCOG E2/2 M. C. Chapman *Birth Room Vs. Labour Ward Study* (Conference Paper, December 1984). The benefits of the birth room over the labour ward were listed as: 1. Decreased admission-delivery interval; 2. Less analgesia; 3. More freedom of movement; 4. Less suturing required; 5. Increased ‘rooming-in’. The study explicitly did not set out assess the ‘safety’ of the birth room environment (it was claimed that the numbers were too small to do so effectively). However, one of the main aims of the study was to ascertain whether mothers found the birth room environment an acceptable one in which to give birth and whether there were any marked advantages for women who wished for such an environment. In both of these objectives the study reflected positively, although it was shown that there was no
insignificant, and the findings were, on the whole, positive. However, its presentation at the conference – indeed the conference itself – was likely to have been part of the more generalised attempt to humanise obstetrics [see above].

In 1980 the Second Report of the Social Services Committee on Perinatal and Neonatal Mortality hinted at the difficulty of humanising the system this, pointing out that good communication between health care professionals and patients was hampered not least by ‘attitudes of staff [which] are largely dictated by their view of the importance they assign to emotional support of the pregnant woman as opposed to the “medical” care they supply’. 47 The importance of the attitude of individual doctors and consultants cannot be over-looked here; nor can the intransigence of the contemporary system of obstetric care. As the experiences of obstetricians such as Wendy Savage, Yehudi Gordon and Peter Huntingford suggest, even when they were sympathetic to the emotional needs of women, practical problems engendered by the culture of hospital birth – imposition of routine, low staff to patient ratio, lack of resources, staff working on shift systems, lack of continuity of care, and so on – meant they were unable to extend the type of care they may have wanted to all their patients.

It seems that, in spite of the growing influence of consumer organisations, and of statutory bodies established to represent users’ interests (such as the lay Community Health Councils (CHCs) established in every health district in the UK in the 1970s to

difference in difficulty of labour nor in the method of feeding’ between those who delivered in the birth room and those who did so on the ward.

47 House of Commons Second Report from the Social Services Committee: Perinatal and Neonatal Mortality (HMSO, 1980)
counter the medical profession's dominance over the organisation of services) the
dichotomy between the interests of medical professionals and the needs of patients was
still very much evident. In 1987, the Community Health Council produced a damning
indictment of the state of the NHS maternity services entitled *Maternity Care In Crisis.*
The report indicated that whilst the birth rate was rising, spending on maternity care was
dwindling and resources were being scaled back. The shortage of midwives was a further
threat to services, and in particular 'the development of alternative and additional
community services'. A shortage in resources, not least of which was staffing
shortages, was endemic throughout the entire NHS. For the maternity services the
midwifery shortage, coupled with ongoing cost-cutting measures, often translated as little
or no choice being available for most women in where, or how, they gave birth.

The Childbirth Debate in the Late 1980s.

Even setting aside the crippling effect of resource and staffing shortages, there was
according to the *Maternity Care in Crisis* report a 'lack of agreement between users and
service providers about the role of the professional in childbirth [that] has made the
integration of hospital and community services difficult'. Simply put, the medical
profession and women who used the maternity services were speaking a different
language. Ultimately, both groups wanted the same thing: safe delivery of a live healthy
infant by a healthy mother. The big question was what means justified this end? Was it
enough to ensure that mothers and babies survived the experience in good physical

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48 Community Health Council \*Maternity Care in Crisis\* (1987)
49 Ibid.
health? Clearly it was not; the *Parents* survey of 1986, for instance, indicated that one third of women who participated in the survey were unhappy with their birth experience whilst more than half said they suffered from postnatal depression. The obstinacy of the obstetric profession, which hitherto had placed safety at the forefront of maternity policy, was doubtless tempered by evidence of women's dissatisfaction with many aspects of maternity care, including intra-partum care. However, pregnant women expected to be safe during childbirth and any changes in policy needed to take this into consideration. Therefore, although there was evidently a realisation amongst obstetricians that maternity care had to change, the question of how it were to change was more problematic.

One of the main obstacles to change for obstetricians was the aversion to risk that had permeated the contemporary practice of their profession, a vestige of the days when mothers and babies often died during childbirth. This risk-averse culture, which can partly be rooted within the wider context of a growing inability to accept risk in general in western society, was bolstered in more recent decades by the insidious growth of litigation. The custom of resorting to legal action in cases of perceived medical malpractice originated in the United States, before spreading to Britain in the 1980s bringing with it 'huge increases in [the] subscriptions required for medical defence insurance'. Tew asserts that 'of all specialists, obstetricians have been most often the object of litigation'. Is this due to the success of obstetric 'propaganda', which is responsible for raising expectations to 'an unrealistic level' as is sometimes claimed?

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50 *Parents* "Birth Survey" (November 1986).
51 M. Tew *Safer Childbirth* (1998) p.244
Possibly, given that whilst some litigants complain about unnecessary or harmful intervention, the majority of complaints upheld in court are most likely those pointing toward inadequate, late, or inappropriate intervention. It is hardly surprising that fear of litigation is given as one of the chief reasons for the rising incidence of caesarean section.\textsuperscript{52}

The possible threat of litigation since the 1980s undoubtedly exerted a degree of influence on behaviour in obstetric practice and, thus, on maternity care in general. This may go some way toward explaining why interventions such as Electric Foetal Monitoring were employed routinely and without question.\textsuperscript{53} Nevertheless, despite the defensive attitude of the medical profession with regards to the safety of mothers and babies, the indiscriminate use of technology in childbirth was coming under increasing scrutiny, not only from women’s groups or those interested in natural childbirth. In the spring of 1985, the European regional office of the World Health Organisation (WHO), and the WHO regional office of the Americas held a global conference on “Appropriate Technology for Birth”. The conference, which took place in Brazil, brought together representatives of midwifery, obstetrics, paediatrics, epidemiology, sociology, psychology, economics, health administration, and mothers. \textit{The Lancet}, which printed


\textsuperscript{53} Tew writes, for example: ‘Courts are impressed by the visible record of the reactions of the foetal heart and perhaps have not yet been told that the foetal distress inferred from the trace from and electronic monitor, a fertile indication for emergency caesarean sections, is all too often not borne out by the condition of the newborn infant. Nevertheless, since courts are likely to judge the absence of this trace as evidence of negligence, fear of litigation is given as justifying the continued use of this kind of monitoring’. Tew \textit{Safer Childbirth} (1998) pp.244-245
in full the recommendations of the conference, noted that they were ‘adopted unanimously’ by those in attendance, following ‘careful review of the knowledge of birth technology’.\footnote{“World Health Organisation: Appropriate Technology for Birth” \textit{The Lancet} (August 24\textsuperscript{th}, 1985) pp.436-437} It went on to state that ‘birth is a natural and normal process, but even “no risk pregnancies” can give rise to complications’. Accepting that intervention is sometimes required to obtain the best result, \textit{The Lancet} added that in order for the recommendations to be viable, a ‘thorough transformation of the structure of health services is required together with a modification of staff attitudes and the redistribution of human and physical resources’.\footnote{\textit{Ibid.}}

Notwithstanding \textit{The Lancet}'s somewhat measured reaction to the recommendations of the WHO, which was perhaps understandably pragmatic given the confines of the health services in England, the conference itself could be seen as a watershed in attitudes toward the technology of birth. The WHO's recommendations are indicative of this shift in attitudes away from obstetric orthodoxy:

- Countries with some of the lowest perinatal mortality rates in the world have caesarean sections rates of less than 10%. There is no justification for any region to have a rate higher than 10-15%.
- There is no evidence that caesarean section is required after a previous caesarean section birth. Vaginal deliveries after a caesarean should normally be encouraged wherever emergency surgical intervention is available.
- There is no evidence that routine foetal monitoring has a positive effect on the outcome of pregnancy. Electronic foetal monitoring should be carried out only
in carefully selected cases related to high perinatal mortality rates and where labour is induced. Research should investigate the selection of women who might benefit from foetal monitoring. Meanwhile, national health services should abstain from purchasing new equipment.

- There is no indication for shaving pubic hair or for an enema before delivery.
- It is not recommended that the pregnant woman be placed in the dorsal lithotomy position during labour and delivery. Walking should be encouraged during labour and each woman must freely decide which position to adopt during delivery.
- The perineum should be protected wherever possible. Systematic use of episiotomy it not justified.
- The induction of labour should be reserved for specific medical indications. No region should have rates of induced labour higher than 10%.
- During delivery, the routine administration of analgesic or anaesthetic drugs (not specifically required to correct or prevent any complication) should be avoided.
- Artificial rupture of membranes, as a routine process, is not justifiable.  

What the recommendations suggest is that the message propounded by advocates of alternative models of childbirth, or at the very least those suspicious of the obstetric orthodoxy – that the systematic, technocratic approach to maternity care was fundamentally wrong – was being more generally accepted. To explain the origins of these recommendations, Beverley Chalmers of the WHO European Regional Office for Maternal and Child Health, revisited the period leading up to the “Appropriate Technology in Birth” conference in the British Journal of Obstetrics and Gynaecology in  

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56 Reproduced in The Lancet (August 24th, 1985) p. 436
1992. Her account of that period shows how the questioning of obstetric technology developed (on a global basis) from the late 1970s, and the way in which this debate underpinned the WHO conference. Chalmers writes:

The United Nations declared 1979 as the International Year of the Child. At the Regional Committee for Europe in that year, concern was expressed over a number of issues including: the rapidly expanding technology applied to birth with its associated rising costs; the doubling or even tripling of the caesarean section rate which took place in the 1970s, [and] the question of whether this was associated with the increased electronic foetal heart rate monitoring; the increasing demands from women's groups to resume control over their birth experiences and the poorly understood inequities relating to perinatal mortality.\(^{57}\)

Chalmers goes on to say that there is no doubt that much deliberation, research and discussion went into the development of the WHO recommendations for appropriate technology for birth. However, she points to questions such as: how valid are these recommendations; how representative were the participants in conference and the research teams; and to what extent were the views expressed biased, given the possibility that individuals willing to participate in such meetings and activities would have an interest in 'changing the system'? Given that the participants representing the UK at the conference included AIMS chairman Beverly Beech and feminist author and critic of the modern obstetric model of childbirth Ann Oakley, Chalmers' suspicions about the biased nature of the deliberations are perhaps justified. Certainly the issue of bias did not pass

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\(^{57}\) B. Chalmers "WHO Appropriate Technology for Birth Revisited" *British Journal of Obstetrics and Gynaecology* 99 (September 1992) pp.709-710 [My emphasis]
unnoticed amongst obstetricians. In a letter to colleague, professor of obstetrics, S. L. Baron, complained:

As I suspected, the whole conference was slanted against the use of technology, and the only obstetrician I could identify was Roberto Caldeyro-Barcia who has a reasonable objection to technology in under-developed countries... 

That obstetricians were not well represented at a global conference on childbirth is of course in itself significant. It suggests, perhaps, that obstetric orthodoxy was being sidelined. Those representatives who did attend the conference, many of whom shunned technology in favour of a more natural approach to childbirth, included members of the midwifery profession keen to propound the discourse 'midwifery model' of childbirth, in opposition to the 'obstetric model' that had hitherto dominated. An example of the championing of the midwifery model of childbirth can be found in a paper given at the WHO conference on "Appropriate Technology for Birth" by Beverly Beech of AIMS. Beech, in an emotionally laden tirade against obstetric-led maternity care, declared:

Increasingly midwives are recognising that their role as with-woman has to be re-established. Those women who experience a normal childbirth find that they can give birth to their babies with little or no drugs, and that the pain of childbirth is not so overwhelming as it is when women suffer modern technological births. The image of normal childbirth as a process in which the woman has a dreadful, painful and potentially dangerous experience is false, but it is, nonetheless, deeply embedded in the obstetric mythology of normal birth experiences.

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58 RCOG B10/2/30 (WHO Inter-regional Conference on Appropriate Technology for Birth) Letter from S. L. Baron to R. W. Beard (18th February 1986)
The medical profession has been noted for its inability and reluctance to listen to what women have to say. Normal childbirth will only be re-established when women join together and support each other. Just as women need midwives so too do midwives need women and there is now evidence that in Europe, at least, midwives and women are beginning to support each other and press for the re-establishment of birth as normal process.\textsuperscript{59}

The midwifery model may have shared some common ground with the childbirth philosophy of those who were suspicious of or opposed to obstetric intervention and technology. Nevertheless, as this thesis argues, not all midwives advocated natural childbirth; as we have seen, in many cases modern midwifery and natural childbirth have appeared \textit{at least} as diametrically opposed in their values as have obstetrics and natural childbirth, perhaps at times even more so. Even so, as the childbirth debate developed to concentrate upon the issue of choice in childbirth in the 1980s, the profession was presented with a unique opportunity to redress the under-valuing of midwifery in previous decades. Given the recent history of midwifery in England, which, for example, suffered the near total decline of its domiciliary service as hospital birth became the established norm, it is hardly surprising that midwives joined the chorus of disapproval against medical domination of maternity care. Midwifery discourse in the 1980s reflected this, as can be seen in the archive of the 'Midwifery Digest' \textit{MIDIRS} (the Midwives Information and Resource Service). The number of articles included in

\textsuperscript{59} B. Lawrence Beech "Birth as a Normal Process: User Perspective" An AIMS Occasional Paper, presented to the WHO inter-regional conference on Appropriate Technology for Birth, Brazil (April 22-26\textsuperscript{th}, 1985)
MIDIRS which focused on issues such as choice of method and location of delivery, are evidence of the growing awareness of midwives of the significance of these matters, both for themselves as professionals and the women to whom they attended. But what exactly did the call for more choice in childbirth mean to midwives, particularly in relation to the place of birth?

The shift in the terms of the debate — away from safety and toward quality of care and emotional satisfaction — had once again made the option of home birth an attractive possibility for expectant mothers. Campbell and Macfarlane, in an essay examining debate on the place of birth, noted how the question of where a baby should be born was raised in the 1970s following the recommendations of the Peel Committee for universal hospital delivery in 1970. As discussed above, the Peel Report established safety as 'the only criteria by which places of delivery should be judged'. It also asserted 'without any supporting evidence, that a hospital delivery is safer for all women and their babies'. Campbell and Macfarlane demonstrate that, in spite of these recommendations, when it came to the question of where to give birth, safety was not necessarily the principal concern of women and the groups that sought to represent them. They write:

Many opinions expressed in the press and through the media at this time tended to suggest that a home delivery offered a more rewarding experience for parents, because the kind of care provided by community midwives and family doctors was more personal.

For example, writing in *The Times*, Margaret Allen describes her first delivery in hospital

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61 Ibid. p.218
as one in which she ‘felt physically, mentally and emotionally assaulted’, while her second birth was ‘simply a slightly untidy morning at home’.62

The debate on the place of birth was bolstered by the involvement of groups such as the Society to Support Home Confinements and of course the NCT, which had been focusing more and more upon these issues since forming its multidisciplinary Study Group on Home Confinements in 1976. Campbell and Macfarlane, whose extensive review of the evidence (or as they put it ‘lack of evidence’) to support policies of universal hospital delivery Where to be Born? was published in 1987, argue that evidence provided by surveys carried out into women’s experiences of home and hospital birth since the 1970s indicate that ‘at least eighty percent’ said they preferred giving birth at home. It was for this reason that the decline of domiciliary midwifery was, in the words of Jean Robinson writing in The Times in 1974, ‘so bitterly regretted’ by many.63

Whilst some within the midwifery profession may have indeed ‘regretted’ the decline of home birth, becoming actively involved in trying to offer women more choice in where they gave birth, many were more guarded in their approach. For example, a student midwife based at ‘a large London teaching hospital’, writing about her experiences in the professional journal Midwife, Health Visitor and Community Nurse in 1986, suggested that in order to address the issue of the ‘insidious diminution of the midwives role’ in consultant-led maternity units in large hospitals, midwifery training needed to be

62 Ibid. p.218
63 Cited in Ibid. p.219
completely over-hauled.\textsuperscript{64} This was especially important given the recent debate on the place of birth. The article pointed to a study by Robinson in 1976 which indicated that many newly qualified midwives lacked the confidence to attend home deliveries, with 'sixty percent responding that they felt "less than adequately prepared" to care for mothers during a home confinement'.\textsuperscript{65} This particular student of midwifery felt her own training lacking also, writing:

I feel that midwifery training could be broader based, encompassing some psychology, social sciences [and] philosophies which concern women and childbirth and holistic approaches to medicine...A holistic approach is more satisfying to for the midwife and her clients.\textsuperscript{66}

Reinstating domiciliary midwifery – if this student midwife’s experiences are anything to go by – was by no means a quick fix. And although the issue had been seized upon both by women’s groups and those advocating natural childbirth, home birth was still viewed with scepticism. Moreover, in spite of the claims of those keen to advance a return to home birth, for some, often expectant mothers themselves, safety was still a fundamental issue in deciding where to give birth. A study of 95 first time mothers carried out in Swansea in 1983 for instance, indicated that sixty-eight (72 percent) were

\textsuperscript{65} Ibid.
\textsuperscript{66} Ibid.
in favour of hospital birth and, more tellingly, that forty-three of these emphasized safety as a factor. The study indicated that:

The equipment, which some might regard as mechanising the birth, was regarded by these women as a source of comfort. It implied to them not unnecessary interference in the natural process of birth, as suggested by some advocates of natural childbirth, but rather security and safety.

Midwives, according to the folklore of traditional midwifery, have a duty to listen to the needs of women and to act in their best interests. The problem for midwifery was deciding whether the claims of those who supposedly spoke on behalf of women were representative. Bringing about change in the maternity services would undoubtedly benefit midwives; this in turn would benefit childbearing women – or so the argument went. However, the question of what women wanted from their maternity services formed the basis of the platform from which the movement to change childbirth spoke. Obviously, as the terms of the debate shifted in the late 1980s, this question grew in significance. In 1985 a study of women attending an antenatal clinic in Cambridge into whether women really ‘wanted’ natural childbirth indicated that seventy-three of the one hundred women questioned had seen television programmes featuring Michel Odent

68 Ibid p.405. Some of the women who took part in the study nevertheless thought that home birth was ‘far more natural’ and that only at home would you be at ‘ease in your own surroundings’ and less likely to have your baby ‘carried off to a room with lights’. Such women were likely to have been exposed to ideas about natural childbirth, or to have experienced negative aspects of hospital delivery in the past. It is surprising though that only two mothers who took part in the study mentioned medical aspects of hospital in negative terms or that choosing to give birth at home was a way of avoiding interventions. Indeed, most expected to have the same access to medical care at home as they would in hospital. That they thought this is interesting as it surely belies the idea that home birth could be equated with natural birth, particularly as at least one respondent indicated that she believed home birth to be ‘more natural’. Even though the debate on home birth had become enmeshed with the debate on natural childbirth, the two were not in fact historically inter-related. See, for example, Leap and Hunter’s study of midwifery in the inter-war period, The Midwives Tale (1993), cited in the Introduction to this thesis.
speaking on the subject of natural childbirth. These women displayed considerable interest in the subject and it is perhaps telling that most of their interest and knowledge of natural childbirth had arisen from having viewed these programmes. The authors of the study claimed that the results indicated 'a substantial number of women [were] positively interested in the concept of natural childbirth and would use such facilities if they were available'. The authors nevertheless felt it was important to stress that the research also indicated that perinatal and maternal mortality in those units where these 'facilities' were provided was no different to that in units with 'more interventional approaches'.

If studies like the one above tell us anything, it is surely that alternative ideas about childbirth were now influencing what women expected from maternity care. And when viewed against the backdrop of increasing membership of organisations such as the NCT – which swelled over this period from 8,000 to over 50,000 by 1997 – the shift in women's interest in aspects of natural childbirth is even more noticeable. Now birth was 'safe' expectant mothers, it seemed, felt able to explore different options. Certainly, if expanding NCT membership is anything to go by, childbearing women wanted more information – and, ergo, more choice – from their maternity care providers. This in turn was beginning to have a significant impact on maternity policy: by the late-1980s the idea

69 R. Griffiths and M.J. Hare "Do Women Really Want Natural Childbirth?" Midwives Chronicle and Nursing Notes (April 1985) pp.92-94
70 Ibid.
71 Ibid.
that the maternity services could be designed without consulting mothers, or their representatives, was already anathema.

By Women, for Women: Maternity Policy Development in the Early 1990s.

There are numerous sources that clearly demonstrate the impact of lay or alternative views on the maternity debate and, ultimately, on the development of maternity policy from the early 1990s onwards. The picture that emerges, as we have seen, is one of the questioning of obstetrics' hegemony over maternity policy, and the growing influence on debate of non-medical perspectives. For example, in 1990 a conference was held at the House of Commons, the aim of which was to investigate the issue of ‘Where to be Born?’ The seminar was organised by the Maternity Alliance, and was attended by representatives from various interested parties, including AIMS, the NCT, the RCOG, and the RCM, as well as those from the Patients Association, and the Association for General Practice in Maternity Care. MPs Sir David Price, Ann Widdecombe, and Audrey Wise were in attendance, listening on behalf of the Social Services Committee.

The outcome of the 1990 ‘Where to be Born’ conference directly challenged the view that the reduction in perinatal mortality was positively related to the concentrating of deliveries in consultant units. Indeed, a consensus of opinion emerged at the conference on the issue of place of birth. Almost no effort was made to defend universal hospitalisation as the only way to lower perinatal mortality, and most were in support of

increasing the availability of home delivery, or the expansion of small midwife/GP-led maternity units. The only dissenting voice came – unsurprisingly – from one of the RCOG representatives who apparently argued that without screening late in pregnancy to detect small for date foetuses, such care was inadequate and unsafe.73

Such claims could have appeared, in this context, out-dated and over-cautious. In her presentation at the ‘Where to be Born’ conference on behalf of the NCT Eileen Hutton alluded to the importance of feeling secure, of being listened to and ‘allowed’ to do certain things, like move around during labour. She accepted that many women do derive a sense of security from knowing ‘every imaginable aid is on hand’, but argued that security has other, equally valid forms. She claimed:

Many women believe that the tension which surrounds moving to an unfamiliar environment [like a large hospital] in labour is in itself enough to disturb the progress of labour. Vets believe it too. So do farmers. Why do so many hospital-based obstetricians have difficulty accepting it? I believe this has much to do with their problem-centred experience of obstetrics and their lack of experience of normal physiological labour. GP obstetricians and community-based midwives seem better able to view birth as a normal physiological event.74

Hutton also spoke of birth being a ‘family affair’, and stressed how the geographical location, the unfriendly atmosphere and the rigid routines of large hospital units combine

73 E. Hutton, private papers: Dr D. Jewel “In the Corridors of Power” Association for General Practitioners Newsletter (August 1990)
74 E. Hutton, private papers: E. Hutton’s paper as presented to Mr. Roger Freeman, Maternity Alliance Seminar, House of Commons, 12th March 1990.
to detract from this. Her paper, having been based upon women's experiences of birth in large and small units, fitted in well with, and supported, other evidence presented at the meeting.

The debate on place of birth provided a platform for groups such as the NCT to advance their agenda. This strategy was, by and large, successful. Eileen Hutton, who was president of the NCT from the mid-1980s, recalls how attitudes were changing at the time so that, by 1990, the active involvement of groups formerly regarded as 'alternative' in the policy making process was gradually increasing:

There were several changes at the time; we built up quite a reputation. We had far more members; breastfeeding counsellors, etc. When I first became president [in 1985], we were very good at talking about midwives and about obstetricians. I decided we needed to talk to them. I decided to go the RCM, and I found them very open, very keen to work with us, as became obvious through all these conference and so on. It would be interesting to know what their point of view was when they involved us all of these things. The obstetricians were slightly more reluctant. But I suppose that by this time—in the eighties—everybody wanted to be seen to be doing the right thing. I am not sure what prompted it, but there was great awareness to improve [services for] patients. The

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The NCT had been instrumental since the 1970s in waging a campaign to allow husbands or male partners into the delivery room. This campaign had been, on the whole, a huge success; most women wanted their partner by their side when they gave birth it seemed. Although in the early days, not everyone was keen (during its early years, the NCT itself even frowned upon father involvement), relatively few maternity units actively resisted the move in practice and by the 1980s the consensus seemed to be that involving fathers in the delivery of their babies was a good thing. More recently, however, the role of fathers in the birth room has been questioned; doubts have been expressed about whether the father is the most effective birth partner and the issue of the appropriateness of other relatives or friends assuming the role of 'birth supporter' is currently being debated. See: S. Kitzinger The Politics of Birth (2005) pp.165-169; H. Lewison Your Choices for Pregnancy and Childbirth (NCT, 1991) pp.76, 96-100, 103, 106, 133. See also: R. A. Bradley Husband Coached Childbirth (1996).
RCOG held a formal meeting twice a year, involving NCT and Beverly Beech and one or two patients. Amongst GPs, well there were always some who were very supportive, such as Luke Zander. Anaesthetists were funny, that’s a longer conversation. Later, it became much more rowdy, we got the feeling we were being much more involved in policy. We had more publications, more people running classes – it became much more normal, particularly as mothers themselves [were by now] challenging hospital settings.\textsuperscript{76}

Both the NCT and AIMS, alongside other groups (the Maternity Alliance and the Association of Radical Midwives, for example) wanted to be actively involved with advising on maternity policy. Whether the time had come for the principles for which they stood to finally be integrated into mainstream maternity care was debateable. Nonetheless, as we have seen from our study of natural childbirth discourse, growing sympathy to and interest in the ideas these groups represented was becoming evident. However, one must view the growing presence of voluntary/consumer groups within the context of a growing chorus of disapproval with contemporary maternity care, which was by now supported by an accumulating body of evidence disputing the obstetric model of childbirth. The publication of the first edition of Marjorie Tew’s book \textit{Safer Childbirth? A Critical History of Maternity Care} in 1990 perhaps best signified that the challenge to contemporary obstetric practice and the domination of singularly medical approaches to childbirth had reached a critical point. Tew was a research statistician based at the University of Nottingham Medical School when the first edition of \textit{Safer Childbirth} was published. It is worth noting that whilst she valued the support of alternative birth

\textsuperscript{76} E. Hutton (Interviewed 8\textsuperscript{th} November 2006)
advocates, such as Sheila Kitzinger, and groups such as the NCT and AIMS, her research was conducted independently of them. Rather, the claims made in Safer Childbirth were, according to Tew, based on ‘evidence found in the impartial statistical analyses of the actual results of care’. 77

Being neither a midwife, nor a doctor, nor an advocate of natural childbirth, and with her ‘personal experience of childbirth far behind’ her when she ‘she stumbled upon the subject in 1975’ Tew did not have a personal ‘axe to grind’ against the medical profession. Her book was not a treatise on maternity care; it was not a rhetoric-laden idealisation of childbirth. In fact it came about quite by accident, as Tew writes:

As a late re-entrant into academic life, I was teaching university students in the Department of Community Health in Nottingham University's Young Medical School how much they could find out about various diseases from the available official statistics. As part of these epidemiological exercises, I discovered to my complete surprise that the relevant routine statistics did not appear to support the widely accepted hypothesis that the increased hospitalisation of birth had caused the decline by then achieved in the mortality of mothers and babies. At first it hardly seemed possible that I could be right in questioning the justification for what the medical world and everyone else apparently believed, but my further researches only served to confirm my initial discovery. 78

78 Ibid. p.viii Tew's analysis considers the effect of over all improvements to the health of the population since 1900. She suggests that improving health over the generations, coupled with treatments developed in the twentieth century to cure certain types of pathology and to prevent others, reduced mortality of mothers and infants. It so happened, Tew argues, 'by chance that these first signs were immediately followed by powerful life-saving innovations in medical treatment. Popular opinion, medical and lay, was quick to give credit for the welcome improvements in maternal mortality to the new medical improvements and overlooked the possible contribution of improved maternal health and physique'. See: Tew Safer Childbirth? (1998) pp.33-36
Tew's pursuit of her subject was fraught at first and her experiences mirror those of others who questioned medical hegemony, from Kathleen Vaughan and Grantly Dick Read in the 1930s and 1940s, to Wendy Savage, Peter Huntingford and Yehudi Gordon in the 1980s. Her articles were rejected by medical journals, and her department in 1976 did not renew her contract of employment. Nonetheless, childbirth campaigners and those concerned with women's rights seized upon her findings, which appeared to vindicate their suspicions of the medical profession. Tew's book, which AIMS chairman Beverley Beech referred to in an interview in 2005 as being incredibly influential in proving that obstetricians were 'cooking the books' on the issue of safety, is all the more significant when placed within the context of growing disquiet about the legitimacy of the policy of universal hospital delivery.\textsuperscript{79} Once Tew revealed her findings, the medicalisation of childbirth was exposed to attack from those who had doubted both the integrity and necessity of routinized, obstetric-led, risk-averse maternity policy and practice.

Thus, the obstetric profession, which had hitherto exerted exclusive control over childbirth policy, found their hegemony challenged. In 1991, the House of Commons Select Committee on Health undertook to carry out a comprehensive inquiry into maternity services across the UK under the chairmanship of Conservative MP Nicholas Winterton. The report of the Committee, published in 1992, was commonly referred to as the 'Winterton Report'. However, it was Audrey Wise, MP for Preston since 1987 and member of the Health Select Committee, who was the real driving force behind it, and

\textsuperscript{79} Beverley Beech, interviewed 20\textsuperscript{th} April, 2005.
her well-informed approach to the issues helped steer its direction. According to Alison Macfarlane, Wise 'took the two volumes of *Effective Care in Pregnancy and Childbirth* [see below] into every hearing to check on what witnesses had said'.\(^8^0\) Wise's views on women's rights and her commitment to improving services for childbearing women, and her awareness of the issues, informed questioning and thoroughness contributed much to enquiry.

The Winterton Committee gathered together over 450 memoranda from organisations and individuals representing both maternity care providers and users in the UK. This body of evidence was collated with evidence from other countries, such as Sweden and Holland. Central to the enquiry were the views of consumers, and although professional bodies were of course well represented, according to Tew:

> For the first time in any such inquiry, paramount importance was given to organizing the maternity service so as to give precedence to the human needs of the service receivers over the professional interests of the service providers, wherever these [did] not happen to coincide.\(^8^1\)

Therefore, the views of organisations such as AIMS and the NCT were regarded, possibly for the first time, as constructive. According to Mary Newburn (NCT) 'women's experience took centre stage' during the Winterton enquiry.\(^8^2\) Whilst evidence from more 'traditional' sources – the RCOG was, for instance, well-represented – remained central to the enquiry, the active involvement of groups representing childbearing women


\(^8^1\) M. Tew *Safer Childbirth* (1998) p.214

\(^8^2\) Mary Newburn (Interviewed 13\(^{th}\) March 2006)
surely indicated that social, emotional and psychological needs could no longer be considered secondary to physical and medical needs when planning services.

In its evidence to the Committee, the NCT reiterated the centrality of 'experience' to the consideration of services for childbearing women, as well as its own expertise in speaking on behalf of the 'users' of the maternity services, stating:

The special expertise of the NCT is its longstanding experience of communicating with people of all ages about pregnancy, birth, and early parenthood, and about maternity care.

The NCT empathises with the needs and experiences of those who use the maternity services and seeks to represent them.\(^{83}\)

The focus here was communication, support and the provision of unbiased information. Unsurprisingly, the Trust took a definite anti-interventionist stance and their evidence was couched both in terms of the NCT's well-known philosophy of childbirth, as well as women's rights during pregnancy and childbirth. Nevertheless, the need for high standards of clinical excellence for all women was acknowledged by the NCT. For example, it was recommended that conscious attempts were made to limit medical interventions, ensuring that the use of procedures with known side effects is made on an individual rather than a routine basis, the point being that women should be well-informed about all aspects of their care, and that the available options and the implications of such ought to be discussed in advance of labour. This was particularly important when it came to pain relief. The NCT argued throughout that women should be treated with respect and offered support, empowered to ask questions about their

\(^{83}\) House of Commons Health Select Committee *Enquiry Into Maternity Services* Vol. 2 Minutes of Evidence: Memoranda Submitted by the National Childbirth Trust. (10\(^{th}\) July 1991) p.231
treatment, and made to feel confident in their own bodies' ability to give birth. They should, moreover, have access to 'the necessary privacy to facilitate relaxation, thus ensuring optimal progress of labour'. In addition, midwives should be 'able to spend time encouraging women in self-help techniques, thus reducing the need for pain relieving drugs and minimising the associated risks'.

Involvement in the Winterton committee undoubtedly provided the NCT with a platform for pushing their agenda. But by focusing on issues such as support and communication, the option of home birth, continuity of care and the relationship between pregnant women and midwives, and the advancing of the notion of 'normal' birth, the NCT avoided accusations of radicalism. Nonetheless, whilst it may have had something in common with that of the representatives of midwifery, and even GPs, the evidence provided by NCT noticeably contrasted with that provided by the RCOG. The memorandum submitted to the Committee by the RCOG focused mainly on safety and risk. Only women categorised as 'low risk' were to be 'referred back into the community system' as advocated by the NCT and other user representatives. The RCOG noted that they were, of course, aware of 'the trend amongst patient groups to seek less intervention in obstetrics, reduced rates of induction and increased choice in the place of delivery'. Even so, in the section relating to 'Intrapartum Care' the RCOG reiterated that its main priority was 'the safety of mother and baby'. In this respect, intrapartum care was 'of

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84 House of Commons Health Select Committee Enquiry Into Maternity Services Vol. 2 Minutes of Evidence: Supplementary Memoranda Submitted by the National Childbirth Trust (Intrapartum Care) p.257
85 Enquiry Into Maternity Services Vol. 2 Minutes of Evidence: Memoranda Submitted by the Royal College of Obstetricians and Gynaecologists (12 June 1991) p.140

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particular importance' due to the 'potential for mother and/or baby to be endangered during labour without warning'.

The RCOG position on safety is perhaps best summed up in the following statement:

The progressive decline in perinatal mortality (19.3 per 1000 births in 1975 to 8.3 in 1990) and maternal mortality (18.2 per 100,000 births in 1973-5 to 7.6 in 1985-87) attests to the success of the maternity services in providing a safe service. However, the RCOG agrees with the Select Committee on Social Services in their three enquiries into the maternity services that there are no grounds for complacency. New developments in technology, existing deficiencies which have not been made good, and changes in public expectations all contribute to the need to re-evaluate regularly the safety of maternity care, and in particular labour ward care.

The RCOG were, nevertheless, keen to be seen to be considerate of 'the wishes of mothers and their families'; these should, it stated 'play an increasingly important part in the management of labour', and the provision of information should be made to facilitate this. Yet, such information ought, in the view of the RCOG, to be monitored so that it is in line with accepted guidelines on safety. Thus, they recommended material published by the Health Education Council or antenatal education 'directed toward local procedures and practices in labour'. Similarly, the RCOG recognised the growing desire, amongst some expectant parents, for home delivery, and sensitivity towards the reasons for the growing interest in home birth was duly demonstrated in the memorandum. However,

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86 Ibid. p.142
87 Ibid. p.143
88 Ibid. p.144
the RCOG remained cautious, emphatically stating that ‘regardless [of] how normal the pregnancy may be, labour remains a potentially dangerous time and delivery in hospital is the only really safe option’. 89

Examination of transcripts of the minutes of evidence taken before the Health Select Committee show that this position was under attack; but did the focus on the essential ‘normality’ of childbirth threatened to render the RCOG’s position obsolete? The RCOG certainly seemed out of touch and over-cautious in the midst of this particular inquiry, with its focus on what women wanted from the maternity services. In their defence, the RCOG, doubtless aware of the implications, also alluded to the issue of choice in their evidence, stressing the importance of ‘informed choice’ and recognising that ‘a small number of women’ were requesting home delivery. 90 Even so, no indication was given that the RCOG was willing to support changes in policy or practice that might jeopardise safety. Whilst their memorandum alludes to the possibility of expanding provision of home birth, the issue that most concerned obstetricians was ostensibly making ‘home delivery as safe as possible’ by implementing systems that would ensure adequate support were available ‘to cope with any emergency that may arise during home delivery’. 91 Relinquishing control of the circumstances of delivery was clearly not part of their agenda.

89 Ibid. p.146; See: Chapter Four [above]
90 Ibid. p.146
91 Ibid. p.146
Recourse to the rhetoric of choice was perhaps the only option for obstetrics at this point. The self-assurance of the obstetric profession had been dented by years of campaigning on the part of those who had supported alternative birth practices, not to mention by criticism from groups supposedly representing the views of midwives and, of course, mothers, who had come to realise that the obstetric model of birth was flawed. The Winterton Report, once it was published in 1992, signified, once and for all, that maternity care needed to change. The Committee concluded:

On the basis of what we have heard, this committee must draw the conclusion that the policy of encouraging all women to give birth in hospital cannot be justified on the grounds of safety.\(^92\)

Even more revealing was the following statement, which served, quite plausibly, to validate what advocates of birth alternatives had been saying for decades:

We conclude that the hospital environment often deters women from asserting control over their own bodies and too often leaves them feeling that, in retrospect, they have not had the best labour and delivery they could have hoped for.\(^93\)

The Winterton Report was significant because it paved the way for future maternity service development: henceforth, it was promised, maternity care was to address the needs of childbearing women, not medical professionals. The NCT, predictably, concurred with most of the Committee’s recommendations. Others were less optimistic that real change could be implemented. Beverley Beech of AIMS recalls the period with

\(^{92}\) House of Commons Health Select Committee Enquiry into the Maternity Services: Government Response (Cm 2018, 1992) Para. 2.1

\(^{93}\) Ibid. Para. 2.1.15
bitterness, arguing that the notion of choice was conceived not by women, but by the medical profession in an attempt to pay 'lip-service' to the ideals maintained by consumer groups. Yet Winterton had been sympathetic to the needs of women as voiced by midwives and consumer groups. As a briefing of the National Association of Health Authorities and Trusts in the weeks following publication of the Health Select Committee Report demonstrated, the Committee hastened 'a shift in emphasis in maternity service policy which gives due weight to other criteria for success additional to the reduction of perinatal mortality'. It was suggested that 'by viewing maternity care in a more holistic way...much of the dissatisfaction with the present system could be overcome'. The question was, of course, whether such statements were mere rhetoric, or whether they in fact hastened genuine changes in practice and, more crucially, mainstream tolerance of alternative discourses.

Whether or not the changes proposed by the Health Select Committee would widely be implemented into practice rested upon a range of medical, social, economic and cultural issues. These issues were particularly complex and diverse; they included the individual attitudes of consultants, labour ward culture, allocation of resources, and the inequities of health care provision. In a supplementary memorandum submitted to the Winterton Committee in 1991 Dr. Geoffrey Marsh, a GP from Stockton-on-Tees perhaps best summed up why the reform of the maternity service was so vital at this time. There was,

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94 Beverley Beech (Interviewed 20th April, 2005)
according to Dr Marsh 'a continuing groundswell of maternal discontent with the over-
medicalising of the whole process'. He continued:

The mother must be involved in all decisions about her labour and birth...a birth plan is
essential; it will include attention to companionship (usually the father), methods of pain
relief, mobility in the first stage, choice of delivery, position, methods of bonding and
breastfeeding...''

Still, in spite of such awareness, attempts to implement a specific natural childbirth
paradigm into the mainstream were piecemeal at best, and units where alternative
approaches flourished in practice remained in the minority. So was mere lip service
being paid to an unattainable ideal? The response of the RCOG to the recommendations
of the Winterton Committee illustrates how the obstetric profession carefully trod a path
between acceptance of the recommendations in principle, and the upholding of orthodox
beliefs concerning safety. The introduction states:

The RCOG accepts the views of the committee on the need to enhance the emotional and
social components of care during pregnancy and childbirth and to provide choice in the
type of care available. However a major concern of the college is that some of the
recommendations might be interpreted as negative in relation to the technical and
scientific advances in obstetrics...for a significant number of women, the application of
science remains the only means by which they can achieve safe motherhood or a healthy
child.``

96 House of Commons Health Committee Maternity Services: Minutes of Evidence 15th May 1991
(supplementary memorandum submitted by Dr. G. Marsh) Para.273
97 RCOG:M.46/2 Complete Response of the RCOG to the Report of the House of Commons Health
Committee on Maternity Services (July 1992) p.4
Focusing upon technological advances and the 'application of science' as they saw it, obstetricians continued to categorise women in terms of risk. It is possible that the preoccupation with risk and reliance on the technology of birth, coupled with wider concerns (which were echoed throughout the NHS) with issues such as cost-cutting and resource shortages limited wider acceptance of more natural approaches to birth at this time. Whatever the reasons, the obstetric profession remained reluctant to significantly modify its views. Even so, the evidence does suggest that a semblance of middle ground was achieved. Maternity care was by no means revolutionised, yet, the mere existence of alternative discourses in the planning of policy was, to a degree, significant.

For the so-called 'users' of maternity services this was interpreted as a positive development: women were demanding their voice be heard, and alternative discourses provided a way for them to articulate their demands. Having said that, it should not be assumed that alternatives became mainstream, or that fewer epidurals were administered, caesarean section rates reduced, or that rates of home birth significantly increased. What we find, paradoxically, is that rates of surgical intervention, if anything, increased throughout the 1990s. Another problem raised by this issue was inequality: who, in reality, had choices, and who did not? The House of Commons Health Committee, reviewing maternity care since the publication of Changing Childbirth in 2002 referred to 'an illusion of choice' in contemporary maternity care. There was a danger, the authors of the report argued, that 'choice in the maternity services [was] really a choice for the

articulate middle classes.' The need for 'genuine and informed choice' was reiterated; however, according to the report the problem remained that for some women, 'making choices and participating in decisions was quite an alien concept'. Thus, providing 'options' for birth may have assuaged those who lobbied for the wider availability of birth alternatives, but ultimately it did little to empower women.

Interestingly, the rhetoric of choice has generated another facet of the debate: it is now argued with as much passion as that mustered by advocates of natural childbirth that women should be afforded the right to choose, for example, an elective caesarean section for 'non-medical' reasons. In 2006 Professor James Walker, an obstetrician based in the north of England, was quoted in *The Times* newspaper, stating:

> The choice agenda is interesting. Most see choice as preventing intervention, allowing women to have home birth if they want. But it should also allow women to choose Caesarean section if they want to. Why should choice be only available if we approve of the choice?  

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Striking a similar note, Maureen Treadwell, who in 2004 established the Birth Trauma Association to support women who felt traumatised by their experiences during childbirth, has spoken out on behalf of those women for whom caesarean section, or any other type of surgical or pain-relieving intervention during labour is the right 'choice'. 'Natural childbirth', she maintains, 'is a very good choice for women to whom natural childbirth is important'. She stresses that 'because some women feel very strongly about

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100 Professor James Walker, Department of Obstetrics, St James' University Hospital Leeds. Cited in "The National Birth Lottery" *The Times* (14th Jan. 2006)
natural childbirth, it does not mean that all women do'. According to Treadwell, whose views are based upon the letters and emails received by the BTA from women:

What seems to be important is how the individual woman feels about childbirth, what is important to her and the quality of information she receive; and where the choice is not always attainable, as natural childbirth may not be, there does need to be a thought through ‘plan B’. One piece of information that women don’t receive is that women can have very good experiences of caesarean section, natural birth and birth with epidurals – as well as bad experiences. What matters is the individual and all women are different. What research suggests is that the closer the real experience is to what the woman wanted and expected the happier she will be. Natural birth isn’t better than a caesarean birth or a birth with an epidural. Birth is best when the birth matches what the woman wanted, when she is listened to, respected and receives good emotional and clinical care.¹⁰¹

Treadwell’s position is an interesting one. The idea of a particular way of giving birth being somehow ‘better’ than other appealed to those on both sides of the debate; at the end of the day issues such as risk and cost take precedence. As caesarean section techniques improve to make the procedure safer and easier, it is harder for those pushing for more natural methods to justify their position. Couching the debate in terms of choice has, moreover, hindered their cause rather than helped it: a 1996 study, for instance, revealed that 31 percent of female obstetricians would prefer a caesarean birth.¹⁰² It may come as surprise that a significant proportion of female obstetricians, having weighed up the pros and cons of vaginal versus caesarean birth, would make the decision to undergo

¹⁰¹ Maureen Treadwell (Email interview, 10th March 2008)
¹⁰² Cited in “We Know the Reality of Childbirth” The Guardian (Friday 11th July 2008)
surgery. As a female obstetrician who gave birth to three babies by caesarean section commented to *The Guardian* in 2008: ‘if you’ve seen deliveries, you know the reality; maybe that’s why doctors have caesareans – they know it’s quite a risky time’.  

Recent NHS maternity statistics also suggest that over half of all women will have interventions ‘ranging from induction, to forceps, to an emergency caesarean.’ Thus, a significant number of women, *given the choice*, are deterred from even attempting a natural birth simply because, in spite of government pledges, the reality of birth in an NHS hospital will most likely preclude it.

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103 Ibid. My emphasis.
104 Ibid.
CONCLUSION

Must you squat in the woods with the wild things? Are you less of a woman if you decide you require obstetric help? If you have a caesarean, does it mean you have "failed"?1

The idealisation of childbirth by those publishing and broadcasting on the subject of natural childbirth contrasted starkly with the reality of birth in British hospitals since the 1950s. Such idealisation was, of course, a response to the medicalisation of childbirth, a plea to those practicing obstetrics and midwifery, as well as those in charge of planning maternity care to give consideration to the psychological and emotional sides of childbearing. It was also a reaction to the couching of safety in medical terms, and to the monopoly of the medical profession in the management of the pain of parturition. However, due to the way in which these ideas were disseminated amongst the lay population, the discourse of natural childbirth served to intensify the dissatisfaction and disillusionment of women with contemporary medical care during childbirth.

The portrayal of what birth could – or more to the point ‘should’ – be like, overshadowed the more subtle aspects of the natural childbirth advocates’ message, such as the importance of continual emotional support throughout labour and delivery. It is also possible that the focus on ideas such as training and preparation served to further undermine women’s confidence in their ability to give birth, leaving many feeling disappointed and that they had somehow ‘failed’. The effective dehumanising of maternity care during the technology explosion of the 1970s created

an adversarial situation between medicalised and natural, mainstream and alternative, and this also served to eclipse the real issues that concerned the majority of women. Thus we see the related issues of fear and pain — subjects that concerned early pioneers of natural childbirth — overshadowed by the issue of safety. The medical profession’s preoccupation with safety, which was employed as means to suppress theories of natural childbirth, was met with vehement opposition from groups advocating alternative approaches. These groups, affronted at the suggestion that natural childbirth was dangerous or retrograde, challenged obstetric orthodoxy and the view that childbirth belonged in hospital. Obstetricians continued to stress that childbirth was an inherently unsafe undertaking, yet, ironically, it was this very premise that generated interest in alternatives. A further irony was that it was only once childbirth had been declared safe that these alternatives began to flourish.

In focusing on the two apparently distinct, mutually antagonistic ideologies, both sides of the debate failed to see the validity of the other: the medical profession remained suspicious of the natural childbirth movement as they saw it, and vice versa. If this study tells us anything, it is surely that the histories of both sides of the debate are more closely related, more mutually dependent on one another, than hitherto supposed. Thorough investigation of the evolution of the concept of natural childbirth and the response to it reveals that its relationship to mainstream maternity care has always been complex, littered with paradoxes and inconsistencies overlooked by simplistic explanations. What is clear is that natural childbirth emerged in the 1930s and 1940s from within obstetrics a post-modern reaction against the march of scientific and technological approaches to birth, and in particular the pain of birth. These ideas, controversial from the outset, were disseminated amongst childbearing
women of the middle classes especially and, therefore, can be seen as part of wider cultural movement to encourage middle class women to become mothers at a time when the birth rate was slowing amongst this group. Despite the class bias, natural childbirth addressed the supposed concerns and anxieties of women, and for a time (in the 1950s and 1960s) it became fashionable to subscribe to these ideas. However, the concept of natural childbirth struggled to find a place to fit into contemporary maternity care; doctors and midwives who were enthusiastic about it soon found that implementing its methods into labour ward practice was difficult.

The NHS system of maternity care, built as it was upon the positivistic assumptions of medicalised childbirth culture, did not support the exploration of childbirth alternatives. Modernity's contribution to the founding principles of the NHS was profoundly felt through the NHS system it seems, particularly in maternity care. Thus, the desire to distance itself from childbirth's dark and dangerous past, and to deliver on its promise of high quality, universal health care, from cradle to grave, arguably led to the homogenisation of childbirth under the NHS. Alternative approaches were regarded as counter to these aims; they also threatened to divert already scarce resources away from them. Consequently, there was little funding available for research into the effectiveness of natural childbirth methods, let alone for the setting up of units such the one run by Michel Odent at Pithiviers in France. Later, severe resource shortages (endemic throughout the entire NHS system) restricted further exploration of alternative methods. The midwifery staffing shortage, which was at its most severe in the 1980s, was a particular impediment to the employment of techniques of natural childbirth, with their focus on one-on-one continuous care, on busy hospital wards.
The organisation of the maternity services in the UK since the late-1940s contrived to stifle the application of alternative methods and techniques to practice. Scepticism, along with professional self-interest ensured that natural childbirth remained on the periphery of childbirth culture in terms of practice and experience. Nevertheless, natural childbirth did make an important contribution to the establishment of the notion of antenatal preparation for childbirth, something Dick-Read, its self-proclaimed creator, advocated from the outset. Antenatal literature served as a means of disseminating information on natural childbirth, and the lay-teaching network established by the National Childbirth Trust served to promote new approaches to childbirth and also generated unique insight into women’s experience of childbirth. The NCT, founded to further the teachings of Grantly Dick-Read, is fundamental to the narrative of natural childbirth in Britain. Its position as mediator between natural childbirth enthusiasts and the medical profession places the NCT at the very heart of this analysis of the impact of childbirth alternatives on mainstream maternity care.

Other consumer organisations also played an important role in furthering the development of alternative discourse – a role that grew in significance in the 1980s, when Thatcherite notions of consumer choice dominated the political climate. The contribution of AIMS in particular has been noted here; organisations such as the Maternity Alliance were also highly influential in placing maternity at the top of political agenda. The NCT, however, played an especially important role in promulgating the value of natural childbirth; it did this largely through the dissemination of information on the processes of labour and birth. Antenatal education undoubtedly contributed toward the furthering of alternative discourses; the body of antenatal instruction literature analysed in this thesis illustrates this process.
It is argued here that literature promoting the idea of natural childbirth (and to a degree other media portrayals, such as film for example) was responsible for creating an 'ideal way of birth'. This collective body of literature – which varied in form and over time – provided expectant mothers with unbiased advice and information; it also served to impress upon them an image of how birth should be according to the author. Thus, we notice how the discourse on pain shifted subtly over time, the early emphasis being upon training women to disassociate themselves from pain through relaxation and breathing techniques, in an attempt to achieve a painless birth without the use of pharmacological pain relief. Later, women were told birth was painful, but the levels of pain experienced depended upon their interpretation of it; they were encouraged to reinterpret pain in positive terms, as a powerful and life affirming force, part of the experience of giving-birth.

Authors on the subject of childbirth alternatives sometimes employed literature as a means of furthering their own anti-interventionist agenda in much the same way as the medical profession used books and pamphlets to indoctrinate women into accepting, without question, the medical model of care. In this way, literature on childbirth helped to shaped expectations about childbirth. True, not all women giving birth in Britain were exposed to such literature; those that were, however, were likely to be educated and middle class. The important point here is that it is suggested that these were likely to have been the very women who vocally protested about the conditions of childbirth in contemporary British society.

In the late 1970s and early 1980s natural childbirth may have appeared at first glance to be a peripheral concern, relevant only to a handful of childbearing women.
However, this alternative discourse helped to expose the widening gulf between what women wanted from maternity care and what they were actually getting. Even so, there was one particular incongruity that was thrown into focus by the debate: the fact that women were at once seen to be the victims and the beneficiaries of medical advances in the field of maternity. This again is one of the inherent paradoxes of this narrative. It appears that the more obstetrics were seen to be achieving their goal of safer childbirth, the more their actions – not to mention their motives – were questioned. Furthermore, because the medical profession had always used natural childbirth's supposed disregard for the dangers of childbearing as a means of both criticising and dismissing it, the further ‘out of touch’, the more ‘insensitive to the needs of women’, it appeared.

Nevertheless, there was one particular branch of the medical profession which was seemingly favoured by supporters of natural approaches to birth, and which also stood to benefit from the changes advocated by them: midwifery. However, the study of midwifery's response to natural childbirth presented here demonstrates the profession's uneasy relationship with the concept. At times representatives of the profession dismissed natural childbirth as dangerous and retrograde, yet aspects of the concept always had something of a kinship with the values of midwifery. Midwifery's response to natural childbirth was surprising in many ways; the assumption that midwives would whole-heartedly embrace natural childbirth fails to consider how midwifery functioned as a profession, and also how such ideas might have been considered a threat to the traditional practice of midwifery. Whilst midwifery and natural childbirth may have had some shared values – not least the importance of continuous support and encouragement during in labour – a great many
midwives felt strongly that natural childbirth had no place in modern maternity care. There were, of course, those that were sympathetic but due to various constraints (the shortage of qualified midwives, hospital policies, the pressures of shift work, etc.) felt unable to offer it to women in their care. Thus, the response of midwifery to natural childbirth was mixed on the whole.

The intricacies of the relationship between the medical profession as a whole and alternative approaches to childbirth in twentieth century Britain are revealing, telling us as much about the way contemporary maternity care evolved over this period. Assuming that an obstetric ‘take-over’ of childbirth and a concomitant decline in the status of midwives defined British childbirth culture in the twentieth century, the response of these two professional groups in particular to theories of natural childbirth is revealing, serving a lens through which to view, and subsequently question, accepted narratives of the medicalisation of childbirth. In this respect then this thesis represents a unique approach to the recent history of childbirth, challenging oft held assumptions about the attitudes of medical professionals to unorthodox theories and shedding light upon the inherent complexities of the debate.

The study of professional reactions presented here demonstrates how professional self-interest on the part of both obstetrics and midwifery, affected wider acceptance of natural childbirth principles. However, quite aside from this, many in the maternity medical profession were simply skeptical about the implementation of unproven, alternative ideas into practice. By the 1970s it appeared that obstetric/medical dominance of maternity care was absolute and that the influence of alternative approaches to childbirth had reached their nadir: even midwifery discourse seemed to
have altered in line with medical orthodoxy. However, the paradoxical relationship between the medicalisation of childbirth and the development of antenatal education and preparation for childbirth — a concept, it is established here, that was rooted in the alternative discourse of natural childbirth — queries the idea that medical take-over of childbirth was absolute.

That the notion of preparing for birth was actively encouraged by the health authorities in the 1970s and 1980s shows that an outlet still existed for the discussion of childbirth in non-clinical terms, an outlet that enthusiasts of non-medical approaches to birth were able to employ to disseminate their views. Having said that, by the 1970s, a process of diversification had taken place in the understanding of the term 'natural childbirth', which was itself related to the increase in the technology of childbirth. Childbirth discourse reflected this shift in meaning, and in particular the work of Leboyer, Odent and Kitzinger is indicative of a more radicalised, reactionary approach to the subject of birth during a period of intense technological drive in maternity care, not to mention external factors, such as feminism and the women's liberation movement. The nature of the debate thus changed considerably by the mid-1980s, with the focus now upon on women’s experience of childbirth, a reflection of both the idealisation of childbirth in alternative discourse and dissatisfaction with mainstream maternity care.

Criticism of contemporary technological obstetric care linked the various strands of natural childbirth discourse during this period; as the discourse widened, women’s sense of outrage about the way birth was being conducted in British hospitals gathered momentum. Moreover, the conceptual gap between the ideal promulgated
through the discourse of natural childbirth and the reality of birth in British hospitals grew ever wider. Nonetheless, the poor treatment of women in mainstream maternity care (for which there was mounting evidence in the 1980s) meant that technocratic childbirth culture – which, by its very definition excluded alternative childbirth practices – also served to foster them. By the 1970s, a growing number of women were vocalising their dissatisfaction with maternity care, particularly when their experience failed to live up to their expectations. This had a two-fold and apparently paradoxical effect, fuelling the second wave of interest in alternative childbirth methods, whilst at the same time alienating the majority of women for whom natural childbirth was an eccentric ideology, relevant only to ‘trendy’ parents. The media played upon both of these conflicting images, especially in the 1980s, by which time perceptions of natural childbirth had become inextricably bound with the issue of women’s rights.

Ultimately, the language of childbirth itself had changed. The word ‘control’, for example, evolved in the discourse, implying something quite different – something more akin to notions of empowerment – from that which it meant in the writings of Dick-Read. And it was the related concepts of control and choice that would figure highly in the policy development of the 1990s. Natural childbirth was still seen, in many respects, as an issue relevant only to a vocal minority: as late as the 1992 the NCT was still referred to as a ‘fringe’ interest group. Nevertheless, it is possible to interpret, in the significance of the terms choice and control, the impact of natural childbirth discourse on maternity policy in the early 1990s. Insidiously, by means of an evolving discourse, alternative models of childbirth combined with wider social
movements to undermine medical hegemony over the development of maternity policy.

It has been argued here that the existence of alternative discourses was fundamental to the shifting in attitudes towards childbirth. Whilst practice, and indeed policy, may have appeared unresponsive to these ideas on the surface, the very existence of what may be regarded as a subculture of natural childbirth alongside mainstream childbirth culture is evidence both of the disillusionment with obstetric-led birth and the pervasiveness of alternative discourses dating back to the 1940s. Thus, natural childbirth emerges as a concept that served both to express and foster disillusionment with technocratic childbirth culture, as well as to give voice to women’s dissatisfaction. The idealisation of childbirth that was a feature of alternative discourse was significant in this sense; experiencing a perfect – and perfectly natural – birth grew more and more desirable at exactly the same time that the likelihood of achieving it dwindled.

This thesis began by exploring the origins of the idea of natural childbirth. It has been established that this idea, rather than fading away as childbirth became ever more defined in medical terms, evolved and continued to contribute to the childbirth debate. It allowed for the questioning of routine procedures, and attempted to give childbearing women a voice, both to articulate their feelings about childbirth and to make sense of the experience. It served to reassure that birth is a normal, social event, rather than a pathological or medical one. It enabled the challenging of some of the worst excesses of obstetric practices and championed the values of traditional midwifery. It educated and informed women about the processes of labour and birth.
and answered their anxieties and concerns in ways that have not diminished their autonomy. Given these not insignificant contributions, understanding of the history of this idea is vital, revealing the complex interplay of factors that have helped to shape twentieth century childbirth culture in Britain. In broader terms, natural childbirth represented a challenge to modernity. Even when the terms of the debate shifted in response to social and cultural change, the fundamental anti-modern foundation of the idea remained: the desire to re-engage with some kind of primal instinct. It was this sense of disaffection with modernity – which, if anything, intensified over time – that provided the impetus for the development of concepts of natural childbirth.

This study, it is hoped, opens up a new and hitherto little explored aspect of the history of childbirth in twentieth century England. It represents a comprehensive analysis of the theory of natural childbirth, its origins and the subsequent development of ‘alternative discourses’, the promotion and dissemination of natural childbirth methods and principles by voluntary lay organisations, the response of the obstetric profession and midwifery to these ideas and practices, and, ultimately, their impact upon the childbirth debate and maternity policy. However, despite the best of intentions, it is simply impossible to cover all the aspects of the history of natural childbirth one would have liked in a study of this scale. Hence, the opportunity remains for further research into the concepts and issues raised here.

For instance, attitudes amongst English women toward natural childbirth are touched upon throughout this thesis. Efforts were made here to establish how understanding of (and attitudes toward) the concept developed amongst childbearing women during
the period studied. However, there is much scope to develop this further. Given time, and the opportunity to carry out a fuller and more wide-ranging oral history study of women's views and how these changed over time and in response to factors such as social class, or geographical location, a fascinating and revealing research project could result. Similarly, the history of the NCT, whilst it forms an important part of the narrative presented here, is worthy of a discrete and more detailed historical study. For although the NCT is integral to the history of natural childbirth, its history can be considered from a range of perspectives, for example in terms of its contribution to the history of women's activism and voluntarism in the twentieth century. It is anticipated that the archives of the NCT (to which, until very recently, access was considerably limited due to lack of organisation) will now be made available to researchers, making a thorough historical investigation of the origins and later development of the Trust a possibility. Such studies could contribute further to the growing understanding amongst historians of the issues relating to women and childbirth in England in the twentieth century. This thesis, it is hoped, is a step in that direction.
APPENDIX I
Conduct of NCT Antenatal Classes

Notice to NCT Area Organizers, 1957.

For those running “authentic Dick-Read classes” the following instructions are issued by Mrs. Dick-Read who is running the model class for our association. They must be carried out if the mention of this method is made.

1. The dignity of the conduct of classes must be maintained. Teachers should be neither familiar or in any way bossy. Quiet companionship is the keynote.

2. In this teaching the classes have always been run strictly on the harem fashion, no men have a place there. If they are interested doctors they should be invited to attend after the relaxation and exercises but only on invitation in order to answer question, or at the lectures for labour. The reason for this rule is that there are many women who, in the presence of a man, find themselves unable to maintain a natural state of relaxation and then the atmosphere of the class loses its benefit. Also, for religious reasons women dislike being seen partly dressed by strange men whether they are medically qualified of not.

3. There should be no smoking during class because we must maintain an air of efficiency and scrupulous cleanliness – we are teaching women hygiene and how to breathe well and smoking is not in keeping with healthy pregnancy also it is obnoxious to some people especially when they are pregnant.

4. Teachers of this method should bear in mind that there should always be great respect for the placenta and also remember that childbirth is considered a Divine thing deserving nothing but the greatest seriousness. Bantering and talking are deplored during class. Remember that the women are rehearsing for labour and that whispered conversations, chattering and laughter are not conducive to a state of mental and physical relaxation.

5. You who are teaching this method are in the position of diplomats in it, for people from other countries will, directly you consider that your class and atmosphere is right [?], be sent on a tour of instruction. Therefore it is extremely important that high standards are maintained because remember just because this method is not recognised by those in control in England does not mean that other countries have not the greatest respect for it. Therefore until our college is founded the burden of demonstration will fall upon you.

6. Teacher should always see that the class-room is in impeccable condition and that our clothes are neat and attractive for our aim is to teach women that pregnancy is a time of added beauty and attraction.

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APPENDIX II

Membership and Structure of the National Childbirth Trust

The graph below shows how the NCT was organized from the late 1950s and throughout the 1960s.

**Membership & structure**

NCT 'Headquarters' was based in London, where the Trust had acquired office premises in 1961. Monthly 'committee meetings' and Annual General Meetings were held at HQ (prior to the move to offices in central London, the private homes of founder members or other volunteers served this purpose). Committees were made up of elected NCT members, mostly from around the London area. Two committees functioned alongside each other after 1958: a 'Main [Policy] Committee' and a 'Working Committee'. As membership of the NCT expanded throughout the UK, local 'Branches' were established to co-ordinate activities. Branches were run by 'Area Organisers (AOs), assisted by voluntary ' Helpers'; AOs regularly reported to HQ and attended meetings there every two months. A Branches Council was established to co-ordinate regional activities, and 'Area Organiser Correspondents' were named whose responsibility it was to keep Helpers informed of events and issues both at local and HQ level. Local activities were also reported in quarterly newsletters published by HQ under the heading 'Regional News'; newsletters were circulated amongst members and functioned as a way of keeping NCT volunteers informed and up-to-date with events and changes to the Trust.
Members’ responsibilities

Area Organisers (who also worked on a voluntary basis) were responsible for gathering information, attending conferences, running antenatal classes, organizing coffee mornings, showing films about natural childbirth, distributing leaflets, and so on. They would also have kept a small library of books that they loaned out to women interested in natural childbirth. They made themselves available to pregnant women (who quite often heard about them through word of mouth) and invited them into their homes to chat informally about childbirth issues. NCT antenatal classes run along more formal lines sometimes developed from these ‘informal’ gatherings, becoming more regular as the Branch became more well established. AOs and local Helpers made efforts to build good relations with local doctors and midwives, writing letters, inviting them to film showings or to speak at meetings, and in some instances volunteering to run antenatal classes in local clinics. The role of regional Helpers in public relations was invaluable to the Trust: they would often take it upon themselves to write articles for local newspapers and volunteer to speak to local women’s organisations. In order to co-ordinate local activities, AOs and Helpers would meet formally on a monthly basis, as well as holding regular ‘at-homes’ to discuss local issues. Helpers were also responsible for organizing fund-raising activities such as picnics and fetes, and it was their job to recruit local women to the NCT as well as to provide antenatal classes under the guidance of the local Branch.

Antenatal teaching

Antenatal classes for pregnant women were also provided at NCT HQ in central London. HQ was also the location for teaching seminars, which were held every six months or so in order to provide volunteers with guidelines for running NCT antenatal classes. In the 1950s and 1960s there was no official NCT training for antenatal teachers. AOs and local Helpers often had no qualifications for teaching other than a keen interest in and informed understanding of the principles of natural childbirth. By the middle of the 1960s, the Trust was taking steps to work out a standard of essential qualifications in order that the lay teacher may become accredited. Weekend seminars were held, both at HQ and around the country, as were monthly tutorials in Helpers’ homes. However, for many years local facilities for antenatal training were considered either inadequate or non-existent. Plans were eventually put into place to devise a diploma course in order to train qualified antenatal teachers and in the 1980s, the NCT began offering specialist training in the form of its Diploma in Antenatal Teaching, accredited by the University of Luton.

Finance and funding

Although many NCT teachers continued to teach on a voluntary basis, it was decided in the 1960s that members who conducted classes in their homes could do so on their own terms, with the NCT claiming a small percentage of the fees received as a contribution to general expenses. Lack of funds was an ongoing problem for the NCT, even after it gained charitable status in 1959. The majority of the Trust’s funding came from annual subscriptions (although non-payment of fees was an issue), followed by donations from individuals and organisations, or funds raised by members. Class and seminar fees, monies raised by film showings, sales of books, records and leaflets also contributed to the Trust’s upkeep. Rent for premises and publication and distributions costs took up the majority of the Trust’s outgoings.
APPENDIX III

Birth Plans

The two sample birth plans below are taken from Sheila Kitzinger *Pregnancy Day by Day* (1990, p.81). They were intended to provide examples of how a birth plan might look.

Thank you for the information you provided in the antenatal clinic and the classes at Central Hospital. I have found this very helpful, and after discussion with the midwives I should like to record my wishes about the birth, as they have suggested. They are:

That the support person I've chosen to be with me, my sister, shall be with me at all times, including if I need an assisted delivery. She has been to some of the classes with me, and has three children herself.

I should like to be able to go into labour spontaneously and not be induced, as that was very unpleasant last time.

I understand that it is routine procedure to use the external electronic monitor for 20 minutes upon admission, and I am happy for that to be done, but do not want scalp electrodes on the baby.

If I need drugs for pain relief, I should prefer an epidural to pethidine, with as low an anaesthetic as possible, so that I still have feeling in my legs and am aware of contractions. I'd like to let it wear off for the second stage, as I hope to be able to push the baby out myself.

If everything goes well, on the other hand, and I don't need pain relief, I should prefer to walk around and to give birth standing up.

I'm grateful for all the help and encouragement you can give me.

Signed: Lucy Roberts

Signed: Lucy Roberts
I'm looking forward to coming into St Stephen's to have my baby. I have thought carefully about what I would like during childbirth and have had help in thinking things through from my doctor. We have agreed that:

My partner, Douglas, and a woman friend of mine, Katy, who has attended childbirth classes with me will be my companions during labour.

I shall ask for pain killing drugs if I feel I need them, but should prefer them not to be offered to me otherwise.

I should like to move around and have a bean-bag and mat from the physiotherapy department on the floor for both the first and second stages of labour if everything is proceeding normally.

With this in mind, I do not wish to have an internal fetal monitor or anything which involves strapping me down.

I hope to manage without an episiotomy and to give birth with an intact perineum if possible, and should welcome help to achieve this. If the baby is in good condition at birth, the airways will not be sucked out.

Since I am going to breastfeed, I do not wish the baby to be given any formula milk.

I shall have 24-hour rooming-in and should like to do everything for the baby myself.

I shall appreciate all the help and encouragement you can give me to achieve the kind of birth for which I am hoping.

Signed: Janet Morley
NCT guidelines for making birth plans were given in the NCT publication *Your Choices for Pregnancy and Childbirth* by Helen Lewison (1991, pp.125-130). An extensive 'check list of choices' advising pregnant women of the factors they might like to consider when compiling their birth plan is given as follows:

**CHECK LIST OF CHOICES FOR BIRTH PLAN**

<table>
<thead>
<tr>
<th>Choice</th>
</tr>
</thead>
<tbody>
<tr>
<td>To be treated with respect and dignity at all times</td>
</tr>
<tr>
<td>To have every procedure explained to you</td>
</tr>
<tr>
<td>To be able to change your mind</td>
</tr>
<tr>
<td>Having more than one labour companion</td>
</tr>
<tr>
<td>Routine inductions: whether partner there from beginning</td>
</tr>
<tr>
<td>Induction, elective Caesarean section or spontaneous labour and delivery for a diabetic mother</td>
</tr>
<tr>
<td>Routine admission procedures</td>
</tr>
<tr>
<td>The right to return home if in early labour and waters unbroken or broken</td>
</tr>
<tr>
<td>Routine artificial rupture of membranes early in the first stage</td>
</tr>
<tr>
<td>Food and drink during labour</td>
</tr>
<tr>
<td>Wearing own clothes for labour</td>
</tr>
<tr>
<td>Using own equipment for labour, including music</td>
</tr>
<tr>
<td>Positions for first and second stages of labour</td>
</tr>
<tr>
<td>Positions for vaginal examinations</td>
</tr>
<tr>
<td>Routine acceleration, such as artificial rupture of membranes and Syntocinon drip</td>
</tr>
<tr>
<td>Management of breech labour</td>
</tr>
<tr>
<td>Management of twin or super-twin labour</td>
</tr>
<tr>
<td>Birthing pool: wish to use hospital's or bring in portable one</td>
</tr>
<tr>
<td>Routine offering of artificial pain relief</td>
</tr>
<tr>
<td>Availability of epidural anaesthesia for pain relief and Caesarean section and availability of suitably skilled anaesthetist</td>
</tr>
<tr>
<td>Availability/acceptability of TENS machines and/or midwives trained in the their use</td>
</tr>
<tr>
<td>Policy towards alternative methods of pain relief such as homoeopathic remedies, Bach flower remedies, acupuncture, self-hypnosis</td>
</tr>
<tr>
<td>Time-limits for first, second and third stages of labour</td>
</tr>
<tr>
<td>Management of second stage: whether woman allowed to await urge to push before being expected to push; whether epidural allowed to wear off after 8cm</td>
</tr>
<tr>
<td>Care of perineum during delivery; routine episiotomy and policy re tearing, especially in primigravidae</td>
</tr>
<tr>
<td>Availability of spinal block for emergency Caesarean</td>
</tr>
<tr>
<td>Positions for delivery</td>
</tr>
<tr>
<td>Management of third stage: whether midwives trained in and confident about physiological management if woman chooses not to have managed third stage</td>
</tr>
<tr>
<td>Management of baby immediately after delivery: sucking out of mucus; Leboyer-type delivery; whether handed to mother immediately; midwife/mother/father to determine sex of baby; mother/father to cut cord; help with first breastfeed in delivery room; vitamin K injection/drops</td>
</tr>
<tr>
<td>Availability of suitably skilled midwife/doctor to sew tear of episiotomy</td>
</tr>
<tr>
<td>The stay in hospital: how long' whether/not to have stay in bad for six hours after normal delivery; availability of amenity room; support for breastfeeding; policy re extra fluids for breastfed baby; breastfeeding if baby in special care; rooming-in; visiting; privacy</td>
</tr>
</tbody>
</table>
APPENDIX IV
Membership of the 1993 Expert Maternity Group

Chairman

Baroness Cumberlege, Parliamentary Under Secretary of State for Health

Membership

Mary Anderson, Senior Consultant Obstetrician and Gynaecologist, Lewisham Hospital, London

Simon Court, Consultant Paediatrician, Queen Elizabeth Hospital, Gateshead

Peter Farmer, Management Consultant, Ernst and Young

Eileen Hutton, President, national Childbirth Trust

Liz Lightfoot, Journalist

Lesley Page, Professor of Midwifery, Queen Charlotte’s College of Health and Science, Thames Valley University

Kulbir Randhawa, Co-ordinator/counsellor, Asian Family Counselling Service

Pat Troop, Chief Executive, Cambridge Health Authority and Cambridgeshire FHSA

Gavin Young, General Practitioner, Temple Sowerby, Penrith, Cumbria

Secretariat (Department of Health)

Jane McKessack, Secretary to the Expert Maternity Group

Kate Jackson, Midwifery Development Consultant, Nursing Officer

John Modle, Senior Medical Officer

Joanne Shipton

Martin Houghton
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