

THE ROLE OF THE NEWFOUNDLAND MIDWIFE
IN TRADITIONAL HEALTH CARE, 1900 TO 1970

CENTRE FOR NEWFOUNDLAND STUDIES

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THE ROLE OF THE NEWFOUNDLAND MIDWIFE
IN TRADITIONAL HEALTH CARE, 1900 to 1970

by

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Abstract

This work examines empirically trained midwives in twentieth century Newfoundland. A history of efforts to train and licence these women, and discussion of the motivations of those who attempted to control and educate midwives is provided. Although most Newfoundland midwives ceased regular practice by 1965, there was never a systematic effort to eradicate the practice of midwifery by empirically trained women. Traditional obstetric care, the care women received during the prenatal period, labour and delivery and confinement is described in detail. Gestation, childbirth and the period of confinement that followed were regarded as uncertain, and at least potentially dangerous for both mother and child.

Traditional obstetric care was not marked by extreme intervention. Midwives dealt effectively with some complications, but had definite limitations, which they recognized. The relationship between midwives and health care professionals, and the impact of medical obstetrics on traditional care is discussed. Medicalization of childbirth occurred in Newfoundland because midwives and their clients wished this change, though many women regretted the loss of the personal care they received from friends and midwives in their own homes.

Most women did not rely on midwifery as their main source of income, but the occupation had a distinct folklife. Narratives told by midwives about their work reveal common attitudes towards childbirth, and the attributes of a good midwife. Patterns of selection and training of midwives are also discussed. The role of midwife is placed in the context of traditional healing practices, and the social organization of outport communities. The role of midwife was not connected with supernatural powers. Midwives were often drawn from upper and middle ranks of their communities, and the role conferred status and respect.

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debt to him, my gratitude or my love. My daughter Elizabeth taught me more about pregnancy and childbirth than I could possibly have learned otherwise. Her capacity for comic relief made my work easier, and her presence is a welcome reminder that there are more important things in life than academic research.

The many women who generously provided information about their lives and experiences in childbirth can never be thanked enough. In our conversations, I was amazed both by the depth of their knowledge of obstetric practices and the conditions in which they brought life to others. I dedicate this work to them, and the many other midwives of Newfoundland, known and unknown, who worked with such skill and commitment, with so little regard for material reward.

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Abbreviations used in this work:

CCFCS: Canadian Centre for Folk Culture Studies

CFMB: Canadian Folk Music Bulletin

DNE: Dictionary of Newfoundland English

JHA: Journal of the House of Assembly

PANL: Public Archives of Newfoundland and Labrador

Chapter I

Introduction

My great-grandmother was a midwife in the small pit village of Airdrie, Scotland. Among the many births she attended were the eleven confinements of her daughter-in-law, Janet Maxwell McIvor, the wife of a coal miner and my mother's mother. In 1929, the McIvor family immigrated to Canada to escape the dangerous, strife-torn coal fields which had already claimed the life of their oldest son. Growing up in the comfort of post-war Toronto, the life my mother spoke of in Scotland seemed very distant to me indeed. I began to study folklore partly in an attempt to bridge the gap between this past and myself.

For a folklore course taken in the 1970s at York University, I collected beliefs from my mother, Isabel McNaughton and her sister, Janet Young. Perhaps because of their relation to a midwife, many beliefs concerned childbirth. At the same time I joined a peer counselling collective concerned with all aspects of sexuality, especially birth control. This experience provided a basic understanding of reproductive physiology and some insight into the social problems of human fertility.

When my close friend Elizabeth Cunningham opted for home birth of her first child in 1980 I learned about high caesarian rates in North American hospitals and

growing discontent with medicalized childbirth. At this time, I moved to Newfoundland to begin graduate work in folklore and found myself in one of the few places in the developed world where medicalization of childbirth occurred within living memory, and with academic training suited to the study of oral history and folk medicine. This topic is an outgrowth of these personal influences.

This study concerns how childbirth was dealt with in twentieth century Newfoundland; the ways pregnancy, labour and delivery were perceived and managed; how midwives were chosen and regarded; the place of midwifery in the broader context of traditional healing; and the role of the midwife in her community. This is also the study of a dead occupation and health care system. In the discipline of folklore, the death of tradition has been lamented more frequently than documented, even though study of change is vital to our understanding of the forms, context and meaning of folklore. A major aim of this study is to explain why traditions which ensured that respected individuals successfully attended the vast majority of births for generations could vanish in a few decades with scarcely a ripple of regret.

The Context of This Work

It is useful to place this study in the context of the controversy surrounding traditional midwifery and the

medicalization of childbirth. My aim in reviewing this material is to examine gaps in knowledge and problems of approach which the discipline of folklore may be able to deal with. For two decades, discussion of the role of the empirically trained midwife in obstetric care has given rise to a heated and productive interdisciplinary debate, characterized by as much passion and polemic as the original, more pragmatic battle over medicalization of childbirth.

Western material on this topic has mainly interested historians, sociologists, and physicians. Doctors were among the first to examine the history of the medicalization of childbirth.¹ Among physicians and others strongly influenced by modern medicine there is a long established tradition of viewing medical history as a linear path to the modern scientific worldview. The "non-scientific" approach which women took to childbirth prior to medicalization is regarded in such works as laughable at best and more often dangerous.

In the 1970s, feminist scholars began to react against this portrait of the past. Although I sympathize

¹ See for example Theodore Cianfrani, A Short History of Obstetrics and Gynecology (Springfield, Illinois: Charles C. Thomas, 1960); Harvey Graham, Eternal Eve: The Mysteries of Birth and the Customs that Surround It (London: Hutchinson and Co. Ltd, 1960); Edward Shorter, A History of Women's Bodies (New York: Basic Books, Inc., 1982). Shorter, a historian, is heavily influenced by the medical worldview.

with their motivation, much early work on this topic is flawed by a romantic approach to women's culture. Some regard medicalization as a nefarious plot to wrest from women the right to control their reproductive lives. In such works, the midwife is often portrayed as "the victim of an elite, misogynous medical establishment."² On both sides writers make sweeping generalizations and pre-medicalized obstetrics is regarded as a homogeneous, unchanging unit.

Examination of these questions has now reached a more considered, less polemic stage. Researchers realize that understanding of midwifery, traditional obstetrics and medicalization can best be achieved by looking at specific times and places.³ Important work is being done in third world countries, and with ethnic minorities in

² This point is made by Judy Barrett Litoff in "Midwives and History," in The History of Women, Health, and Medicine in America, ed. Rima Apple (New York: Garland), forthcoming. For examples of this approach to medicalization see Barbara Ehrenreich and Deirdre English, Witches, Midwives and Nurses (Oyster Bay, New York: Glass Mountain Pamphlets, [1973]); Ann Oakley, "Wisewoman and Medicine Man: Changes in the Management of Childbirth," in The Rights and Wrongs of Women, eds. Juliet Mitchell and Ann Oakley (Harmondsworth: Penguin Books, 1976), pp.17-58.

³ See for example Eugene R. Declercq, "The Nature and Style of Practice of Immigrant Midwives in Early Twentieth Century Massachusetts," Journal of Social History, 19 (1985), 113-129; Mary Elizabeth Fiorenza, "Midwifery and the Law in Illinois and Wisconsin, 1877 to 1917" (M. A. Thesis, University of Wisconsin, 1985); Kathy Moggridge Kuusisto, "A Last Generation of Midwives: Midwifery in Twentieth Century Nova Scotia, Canada" (unpublished paper, University of Essex, 1978).

the United States who experienced medicalization of childbirth recently.⁴ Folklorists are now examining women's responses to current medical care as well.⁵ Such work is significant, but studies of non-European cultures and modern obstetric care are beyond the scope of the present work.

Many questions about the nature of midwifery and medicalization in Europe and Anglo-America remain unanswered. A number of good histories of medicalization of childbirth are now available.⁶ But research is

⁴ See for example Fran Leeper Buss, La Partera: Story of a Midwife (Ann Arbor: The University of Michigan Press, 1980); Molly C. Dougherty, "Southern Midwifery and Organized Health Care: Systems in Conflict," Medical Anthropology, 6 (1982), 113-126; Margarita Artschwager Kay, "Mexican, Mexican American, and Chicana Childbearing," in Twice a Minority, ed. M. Melville (St. Louis: The C. V. Mosby Co. 1980), pp.52-65; Sheila Kitzinger, "The Social Context of Birth: Some Comparisons Between Childbirth in Jamaica and Britain," in Ethnography of Fertility and Birth, ed. Carol P. McCormack (London: Academic Press, 1982), pp.181-203; Lois Paul, "Careers of Midwives in a Mayan Community," in Women in Ritual and Symbolic Roles, eds. Judith Hoch-Smith and Anita Spring (New York: Plenum Press, 1978), pp.129-149; Lois Paul and Benjamin D. Paul, "The Maya Midwife as Sacred Specialist: A Guatemalan Case," American Ethnologist, 2 (1974), 707-726.

⁵ See for example Robbie E. Davis-Floyd, "The Technological Model of Birth," Journal of American Folklore, 100 (1987), 479-495 and Carole H. Carpenter, "Tales Women Tell: The Function of Birth Experience Narratives," Canadian Folklore canadien, 7 (1985), 21-34.

⁶ See Jane B. Donegan, Women and Men Midwives: Medicine, Morality and Misogyny in Early America (London: Greenwood Press, 1978); Jean Donnison, Midwives and Medical Men: A History of Inter-Professional Rivalries and Women's Rights (New York: Schocken Books, 1977); Judith Walzer Leavitt, Brought to Bed: Childbearing in

severely hampered because women who could provide the most information died long before this topic was of interest to scholars, and documents containing first-hand accounts of childbirth are rare. Jane Donegan notes

the historian who attempts to depict accurately the actual strengths and limitations of the midwives' practice is faced with a paucity of primary sources. Rarely did the women leave written accounts of themselves or of their patients. A few in the seventeenth and eighteenth centuries wrote midwifery manuals. From these we can glimpse their methods. Even here, however, it is not easy to separate the ideal techniques from those that really were employed.⁷

Because of these problems, many studies of midwifery and medicalization in Europe and North America are like plays in which the main characters are conspicuously absent. We know what was said about obstetric practices in the midwifery manuals, often written by men, the controls Church and government officials wished to subject midwives to, and the opinions of medical doctors who were often in direct competition with midwives. But of the women giving and attending birth, their beliefs, practices and feelings we know almost nothing.

The discipline of folklore is suited to deal with

America 1750 to 1950 (New York: Oxford University Press, 1986); Judy Barrett Litoff, American Midwives: 1860 to the Present (London: Greenwood Press, 1978); Richard W. Wertz and Dorothy C. Wertz, Lying-In: A History of Childbirth in America (New York: The Free Press, 1977).

⁷ Donegan, pp.20-21.

some of these problems. Like anthropologists, folklorists try to avoid an ethnocentric approach which may lead researchers to dismiss beliefs and practices as irrational. In the last half of the twentieth century, there has also been a strong movement within the discipline to reject romantic approaches to the past upon which folklore studies was founded, so the concept of pre-medicalized childbirth as a golden age of women's culture is not tenable. It should therefore be possible for the folklorist to by-pass the joyous throng of parturient women on one side of this controversy and those dirty, hapless victims of superstition on the other, to create a more even-handed picture of childbirth, midwifery and medicalization.

Sources

The study of midwifery could not be undertaken from the perspective of folklore without detailed, first-hand information. In this regard, Newfoundland presents a unique opportunity. The province has had an interesting political history which deserves brief mention here because it greatly affected availability of health care. Newfoundland entered this century as a British dominion with an elected house of assembly, but in 1934 suffered economic collapse and was governed by a commission appointed by the British government from 1935 to 1949.

This period is known as Commission of Government. Newfoundland entered into Confederation with Canada in 1949, albeit with some reluctance. The economy has been based on primary resources; the fishery, logging and pulp and paper operations, some mining and a little farming. Until Confederation, much of the population was thinly scattered in small, isolated outports, many of which could only be reached by boat. The people are mainly English from the west counties and pre-famine Irish, with pockets of Scottish, French and Micmac Indian settlement.

Because of economic decline and geographic isolation, medicalization was slow to occur in Newfoundland and childbirth remained in the hands of empirically trained midwives until the 1940s in most areas, and into the 1960s in some. Women who experienced this change are therefore easy to find. Newfoundland is also a fortunate place for study because university students have been taking folklore courses and collecting and depositing interviews and term papers in the Memorial University of Newfoundland Folklore and Language Archive (MUNFLA) for more than twenty years.

This study is based on my fieldwork and data from student papers about pregnancy, childbirth and midwifery in MUNFLA from 1968 to 1986. Seventy-three accessions contribute to this latter source. These are mainly undergraduate student term papers. Many were located

using the annotated list of materials on women in MUNFLA compiled by Linda Kealey and Gillian Martin.⁸ Forty-one papers are based on personal interviews with thirty-seven midwives.⁹ Nine papers are based on interviews with a relative or relatives of deceased midwives, usually a daughter, though sometimes sons, daughters-in-law, or husbands. Twelve accessions are based on interviews with women who were clients of midwives. Some of these provide sketchy information, but there are two outstanding papers in this category.¹⁰ In four papers the collector acted as informant. The remaining seven were interviews with male informants not related to a midwife, or general discussions of women's lives or beliefs. The most recent acquisition is an autobiography of an empirically trained midwife.¹¹ This material covers most of the island of Newfoundland and part of coastal Labrador. (See Fig. 1).

The Newfoundland Folklore Survey Cards represent a vast, largely untapped source of information. There are

⁸ Linda Kealey and Gillian Martin, "Sources on Women in Newfoundland: The Memorial University of Newfoundland Folklore and Language Archive (MUNFLA)," Culture & Tradition, 8 (1984), 52-71.

⁹ Two midwives were interviewed by different student collectors. See footnote 19 below.

¹⁰ See 75-21 and 78-211. Both these lengthy papers are based upon interviews with a number of informants. 75-21 includes interviews with two midwives, but is included in the client category because it focused on childbirth from the client's point of view.

¹¹ 88-032.

an estimated 75,000 of these five-by-eight inch cards in MUNFLA, each containing a single item of folklore.¹² Only about half of these cards, to the end of 1973, are currently indexed. Sheer quantity makes unindexed cards inaccessible and most referred to here are currently indexed. The index category "Birth and Infancy" includes information on prenatal care and beliefs, christening and the churching of women, infant care, answers to the question "where do babies come from," divination techniques to determine family size and the sex of unborn children, and some information on obstetric practices, abortion and birth control. Prenatal beliefs are a major topic in this category.

The more detailed student papers provided much more information on midwifery and childbirth, and serve as the main source of archival information in this work. In

¹² "Folklore and Language Archive: Memorial University of Newfoundland, (MUNFLA)," CFMB, 20(1986), 40-42. Philip Hiscock, who is in charge of the day-to-day operation of MUNFLA, estimates that the number may be closer to 100,000.

Fig. 1 Map of Newfoundland showing sources of data.

addition to providing a geographic range and time-depth difficult for an individual to duplicate in fieldwork, many of these papers are about midwives who died before the present study was undertaken. A number of interviews were conducted by students who had special relationships with their informants: a relative, usually a grandchild; or someone the midwife delivered. These relationships helped to ensure good rapport.

Some trends in collecting bear mention. Women were able to collect the most detailed and valuable material. This is not to say that male collectors contributed no significant information. Men gathered good occupational narratives and data about fees and duties not associated with childbirth, but obstetric information is usually weak. Collectors do not always provide personal information about themselves, but married women seem to have collected better information than unmarried women, and unmarried males were at the greatest disadvantage.

There are cultural reasons for this. Historically, men were not part of childbirth. Several student collectors noted the presence of a male limited the type of information a woman would discuss, and I found this to be true in my own interviews. This problem is apparent in some interviews conducted by men. One midwife interrupted her description of a caesarian birth to ask a collector

"you're a married man and got a family, haven't you?"¹³
In another case, a collector's grandmother ended her discussion of post-natal care saying "...I can't tell you no more. Can't tell you the rest."¹⁴

Some women collectors gathered better information because they understood the physiology of childbirth. One outstanding student paper on midwifery was written by a nurse.¹⁵ Perhaps a male medical student or doctor could collect equally valuable data on these topics, but the student papers in MUNFLA reflect the disadvantage of male collectors. In spite of these problems, the student papers are a valuable source of information. Due to space limitations and stylistic considerations, it is impossible to credit each student by name in the text each time her or his work is referred to, though my debt to these other students is freely acknowledged.

The term papers in MUNFLA are uneven in quality. Some students conducted detailed interviews, while others were more cursory. The amount and type of preparation students were given for interviews in class, previous experience in collecting folklore, innate ability to conduct successful interviews and the amount of interest brought to the subject all influence the success of an

¹³ 76-481, MUNFLA transcript C2969, p.11.

¹⁴ 86-254, Ms p.68, from student tape transcript.

¹⁵ See 75-285.

interview. Rapport with the respondent, her willingness to be interviewed, capacity for recall and ability to articulate her past experiences also have significant bearing on the usefulness of any interview.

Students often omitted some of the information collected during interviews from their papers. For this reason, the transcripts of interviews were consulted when available, and sometimes the tapes themselves. Student papers tended to focus on the occupation of midwifery and the lives of individuals rather than obstetric care or belief systems. This may be because occupational details are easier to obtain, being less private and requiring less esoteric knowledge than obstetric information.

Few students approached this topic with opinions about the causes of medicalization of childbirth in Newfoundland.¹⁶ In fact, most were unaware of the concept of medicalization. As a result, women were seldom led to present midwifery or medicalization in accord with a collector's bias. Although many of these accounts are regrettably brief, almost all have the advantage of showing events from the informant's point of view without elaborate interpretation by the collector.

Virtually all papers left some questions unanswered. These lines of inquiry were taken up in my own fieldwork. Because many students were related to women they

¹⁶ See for example 82-326.

interviewed, some may have consciously omitted information which would present family members in an unfavorable light. It is also possible that interviewees suppressed information they regarded as confidential. In two papers, personal names and location of communities were suppressed to ensure confidentiality.¹⁷ These papers are more frank in discussion of the midwife's conflicts with clients and community members, but neither presents a picture of midwifery which is at odds with the bulk of this material.

These sources do not lend themselves to quantitative analysis. No attempt is made to provide a representative sample when collecting materials for MUNFLA, even when questionnaires are used. Some biographical and occupational data are tabulated in an appendix to this work. But, in keeping with the limitations of these sources, my aim is to provide a qualitative picture of traditional obstetric care and midwifery rather than a statistical survey.

Oral sources may be measured for reliability, the internal consistency of an individual's report, and for validity, the degree to which reports of events concur with other primary source materials.¹⁸ In the material

¹⁷ See 76-494; 79-405.

¹⁸ Alice Hoffman, "Reliability and Validity in Oral History," in Oral History: An Interdisciplinary Anthology, eds. David K. Dunaway and Willa K. Baum

examined here, the reliability of an individual was sometimes confirmed because she repeated her account to other collectors with only minor changes in wording.¹⁹ However, since many of the women interviewed in MUNFLA are now dead, internal reliability cannot always be established. Wherever possible I interviewed relatives and former clients of midwives previously interviewed by other student collectors to compensate for this. Documentary sources including government documents and publications and newspapers were also examined to confirm the validity of oral accounts, and these are referred to in Chapter Two. But anyone who has attempted such research in Newfoundland can attest to the paucity of such sources, and individual midwives were almost never mentioned by name. Oral sources often could only be checked against other oral sources.

How then can I justify my acceptance of the collections in MUNFLA as valid sources from which to begin to reconstruct the practice and occupation of midwifery in Newfoundland? Just as the internal consistencies of any one informant confirm her

(Nashville: American Association for State and Local History, 1984), pp.67-73.

¹⁹ Midwife Freida Guinchard was interviewed twice. See 76-104 and 84-332. Midwife Rhoda Maude Piercey was interviewed three times. See 76-142, 77-65 and 78-116. Nine of the women interviewed by me were previously interviewed by student collectors. These included midwives, clients and relatives of midwives.

reliability, so can similar practices, actions and experiences in the lives of women widely separated by time and distance be used to delineate the pattern of a tradition. Using a large body of oral sources such as this, it is possible to distinguish the typical aspects of the lives and work of these women from the anomalous. In spite of any flaws, these papers are a vast source of information and provided good preparation for fieldwork.

A list of manuscripts cited from MUNFLA appears in the bibliography of this work. These are cited in the text by accession number and manuscript page number (Ms p.). Survey cards are cited by card number (Msc). Tape recordings are prefaced with a "C," the MUNFLA designation for working copies, except in a few cases where tape numbers have yet to be assigned. If information comes from a transcript made in MUNFLA by professional transcribers this is indicated by "MUNFLA transcript." Some texts that I transcribed from tape recordings appear in this work. My conventions are similar to those of Edward Ives.²⁰ I do not include every hesitation the speaker makes, and all description is enclosed in brackets. No attempt is made to approximate the dialect of speakers. An ellipsis (...) indicates some

²⁰ Edward D. Ives, The Tape Recorded Interview: A Manual for Field Workers in Folklore and Oral History (Knoxville: University of Tennessee Press, 1984), pp.94-102.

text is omitted, usually to avoid confusion.

My fieldwork, conducted over five years, began in 1983 and ended in 1988 and consists of thirty-three interviews with thirty informants, accessioned under the number 88-281, tape numbers C11353 to C11385 (see Fig. 1 for geographic range). A complete list of interviews appears in the bibliography of this work, but a tape concordance is omitted to ensure informants' privacy. Valuable information was sometimes not taped, though some was recorded in subsequent interviews.

One important aim in my fieldwork was to check the validity of archival sources. Five interviews were with empirically trained midwives and two of these were previously interviewed by other students. An additional six interviews were with relatives of midwives, often those interviewed in the past by a student collector. Since existing interviews were mainly with midwives, I tried to balance the perspective by interviewing others involved in childbirth. Six interviews were with former clients of midwives, usually midwives for whom I had specific information from other sources; four interviews were with doctors who worked with midwives or had special knowledge about the medical history of Newfoundland; three with registered nurse-midwives; two with women who regularly assisted empirically trained midwives; and four were to gather historical information on education and

licensing of midwives, or church doctrines related to childbirth. Some of my best interviews were with the nine informants located through MUNFLA, perhaps because they were familiar with the interview situation and therefore more relaxed. The initial interview may also have stimulated memories and helped to order ideas and events, even if that interview took place years before.

With clues from the work of earlier student collectors, I set out in fieldwork to fill in blank spaces in my knowledge of midwifery and traditional obstetric care. For example, the archive contained only fragmentary descriptions of "dry labour," so I asked questions about this emic category. Some women had never heard the term, but others provided detailed, if contradictory descriptions. Some apparent gaps in student papers were however accurate reflections of the culture. MUNFLA contained very little information about supernatural practices among midwives, although these were known among midwives in Europe and the American South. In my fieldwork, I found that midwives in twentieth century Newfoundland had little recourse to the supernatural. From this discovery I developed ideas about the relation between Newfoundland midwives and the supernatural discussed in Chapter Five.

As a result of Newfoundland weather and road conditions and the dictates of my own reproductive

career, many interviews were conducted after large parts of this work were drafted. This proved useful because some issues only became apparent after I began to write, and I was able to incorporate these into fieldwork and revise ideas in light of information received. The ability to interview also progressed apace with my knowledge of Newfoundland culture and birth-related traditions. This is reflected in some later interviews.

During interviews, I explained to women that I was interested in learning about childbirth as they had experienced it. Since all were well aware of the dramatic changes in the circumstances of childbirth since World War II, they readily understood why this topic was of interest. I introduced myself as a student from Memorial, and explained that my degree was in folklore but what I was doing was "more like history." This made sense, given my interest in details of the lives of specific midwives. Many women are sensitive to the fact that some beliefs and practices about pregnancy and childbirth are now regarded as foolish by their daughters and health care professionals, so my emphasis on history was intended to allay initial fears that I might wish to focus on quaint or bizarre aspects of their experiences. However, armed with information from other student papers, I went into these interviews with a good knowledge of past attitudes and beliefs in Newfoundland. When these topics arose,

women were often surprised to find that I knew of them and was interested in learning without making value judgments. Because of this, many discussed their practices and attitudes quite openly.

I avoided discussing the design of my fieldwork with informants because I feared that women without professional training might be intimidated if they knew I was talking to doctors and nurses. This information might also have fostered the impression that I was only seeking expert or official information which they did not believe themselves to have. At the personal level, my fieldwork was remarkably uneventful. All interviews were conducted in an atmosphere of polite goodwill. I still maintain friendly acquaintance with several of these women, and could return to any of them in the future.

Overall, interviews varied greatly in the type and quality of information yielded. Occasionally I was disappointed to find a woman was not really interested in, or recalled little about her experiences with childbirth. Many times, however, I was deeply touched by the intimate insights these women shared with someone who was not only a stranger, but an outsider, "from away." My outsider status was not necessarily a disadvantage. Researchers working with Hispanic-American women have noticed that outsiders are more likely to collect information about private matters such as sexuality than

are collectors of the same ethnicity.²¹ While their situation is not precisely analogous to my own, there was certainly no fear that anything told to me would become part of the local gossip. My own experience of childbirth and motherhood enhanced rapport.

Interviews with midwives and midwives' assistants contain detailed information about obstetrics, and occupational narratives discussing typical circumstances and more dramatic moments of the work. Such narratives will be discussed in Chapter Four. But interviews with midwives also tend to give a close-up picture which obscured the role of midwives in the larger community. Interviews with clients helped to provide perspective and sometimes yielded data not readily gathered from some midwives, information regarding infant and maternal mortalities and critical comments for example. Ordinary women spoke more freely on these subjects.

Historical sources yielded the most negative comments about Newfoundland midwives and these are discussed in Chapter Two. Doctors interviewed were not especially negative about midwives, though they disparaged many of their practices. When materials in MUNFLA and my own fieldwork produced negative comments about midwives, they were included in the present study.

²¹ Sherna Gluck, "What's So Special about Women? Women's Oral History," in Oral History, p.237.

But almost all interviews with clients, relatives and community members conducted by me and other students, produced a positive picture of midwives. Reasons for this are examined in subsequent chapters, but it should be noted that empirically trained midwives in Newfoundland were measured against a clearly articulated, widely shared occupational ideal. It is not surprising that this shaped the way these women were perceived. While taking this bias into account, I have no reason to believe that there was a dark underside of midwifery in Newfoundland which was concealed from my view. It is difficult to say to what degree midwives were liked as individuals within their communities, but clearly, the women who strove to conform to traditional standards for midwives were respected because of this.

The picture of Newfoundland culture which emerges here is basically in accord with the findings of ethnographers who have worked in Newfoundland. Anthropologists studying the medicalization of traditional health systems in other places also provide important parallels. Our current knowledge of the traditional obstetric care of Western peoples, the role played by folk healers in their communities and the relationship between natural and supernatural healing in traditional medicine is slight. Because of this, my work is a probe into uncharted territory. I hope future

scholars will examine the same archival sources and conduct fieldwork on related topics so that my findings may be tested against other, similar work.

Outline and Theoretical Basis of this Study

In this study, midwifery and traditional obstetric care is approached from a number of perspectives. I draw upon the health care systems approach of medical anthropology and theories of occupational folklife. This first chapter places this study in context of recent work on midwifery and folklore studies, and introduces the sources drawn upon and some concepts used. Chapter Two relies on oral and primary source documents to provide the historical context of midwifery in Newfoundland: government and private efforts to control and educate midwives, the motivations of those involved, and the impact of such efforts on the practice of midwifery. Chapter Three takes a health care systems approach, describing traditional obstetric care, underlying attitudes towards pregnancy and childbirth, and how medical obstetrics influenced midwifery. Using the approach of occupational folklife, Chapter Four discusses how women were selected and trained to become midwives, and attributes thought necessary to and concepts about the role. Chapter Five examines midwifery in the context of folk healing, and the role of midwives in communities.

Before turning to examination of this material, some terms deserve clarification. "Medicalization" may be defined as the process by which some aspect of culture come under the auspices of medical professionals. In this study, the term medicalization specifically refers to the transition from midwife-attended birth in the mother's home to doctor-attended birth in hospital.

"Health care system" is defined by Irwin Press as "a patterned, interrelated body of values and deliberate practices, governed by a single paradigm of the meaning, identification, prevention and treatment of sickness."²² With reference to childbirth, Brigitte Jordan defines an obstetric system as "a systematic configuration of birth practices which are mutually dependent and internally consistent:" beliefs and practices related to pregnancy and childbirth; attitudes toward biological processes; and expectations about behaviour of birth attendants and women giving birth.²³

Such definitions allow that more than one system may deal with the same aspects of health care within a society. For most of this century Newfoundland women made use of two health care systems in childbearing, referred

²² Irwin Press, "Problems in the Definition and Classification of Medical Systems," Social Science and Medicine, 14 (1980), p.47.

²³ Brigitte Jordan, Birth in Four Cultures (Montreal: Eden Press, 1983), p.34.

to here as the traditional obstetric system and the medical obstetric system. These were neither mutually exclusive nor necessarily at odds, points made in subsequent chapters.

The term health care system is not intended to imply homogeneity of belief or practice. In their examination of folk medicine in rural Greece, Richard and Eva Blum found

individuals are themselves inconsistent from one moment to the next in beliefs expressed, and there is clear evidence that families within the villages differ one from another over a range which varies from slight modifications in story themes, to ignorance of phenomena described by others, to outright and even heated denial of the conceptions implicit in the accounts put forth by their neighbours. For a few themes, beliefs or concepts there is fairly general agreement; for many there are areas of sizable difference in views; and for a few others there would seem to be intense disagreement over the substance of a belief and its entire set of implications, emotional and cultural. ²⁴

Similarly, each individual in Newfoundland, whether mother or birth attendant, developed a unique interpretation of the biological and cultural features of pregnancy and childbirth. Nevertheless, it is possible to see attitudes, beliefs and practices which delimit two distinct systems.

The term traditional obstetric system is not without

²⁴ Richard and Eva Blum, Health and Healing in Rural Greece: A Study of Three Communities (Stanford: Stanford University Press, 1965), p.173.

problems. It has been noted that the idea of tradition is open to wide interpretation.²⁵ In my work, traditional is not meant to refer to an unchanging corpus of received ideas and practices from the past. Rather, tradition is used to denote an ongoing way of viewing birth which allowed successive generations of women to creatively reinterpret childbirth using some ideas and practices from the past. Tradition also provided these women with attitudes which influenced their response to newer concepts from medical obstetrics. Given the remarkable fluidity with which women in Newfoundland approached obstetric beliefs and practices, it would be difficult to regard tradition in any other light.

Midwives in Newfoundland: A Brief Introduction

During the twentieth century, different types of midwives were active in Newfoundland. Neighbourhood women with little or no basic formal training, the major focus of this work, are referred to as "empirically trained midwives." The formally educated, government employed women who were also birth attendants are called "nurse-midwives." Women who successfully attended a birth in an emergency but did not assume the role of birth attendant are not considered to be midwives.

²⁵ See Richard Handler and Jocelyn Linnekin, "Tradition, Genuine or Spurious," Journal of American Folklore, 97 (1984), 273-290.

It is possible to discern some categories of empirically trained midwives. Occupational information is discussed in more detail in Chapter Four, and some features are summarized in the appendix to this work. Not all women can be placed in clear categories because the necessary data are sometimes lacking. Nevertheless, it is possible to see some divisions. Most evident and perhaps the most important is financial. The majority of midwives did not depend upon this work for a livelihood. Most discussed in this work were married and not widowed when they became midwives and were primarily supported by their husbands, though all ran households and many contributed to the family income by working in the fishery. Widows, especially those in urban areas, supported themselves through midwifery, but at least one woman who became a midwife after being widowed could not support herself through this work. She received public health training at the Grace Hospital after her husband died in the early 1950s. For midwifery, she was paid "just a couple of dollars. I was supposed to ask \$10, but in them days there wasn't much money, so lots of people wouldn't pay any at all," and she would not ask the fee suggested by the government.²⁶ This woman did not become a midwife until after her husband's death because he had objected, though she accompanied the local midwife to

²⁶ 88-281, C11378.

confinements. After she was widowed, she took up this work out of interest and altruism. Her brother-in-law helped support her because she raised his two children after her sister died in childbirth, which enabled her to serve as a midwife.²⁷

Most Newfoundland midwives derived little income from their work. In the outports in the early decades of this century many fishermen were supplied by a merchant who also bought their fish, and it was not uncommon to find little or no cash was left when debts to the merchant were settled.²⁸ Though information is scant, it seems that midwives were not paid in cash before the twentieth century. One collector was told of midwife Sophia Anstey,

the only payment Aunt Sophia received for borning a baby was a meal and that was only occasionally. Some of the few richer homes did give her fifty cents especially if she had to stay there for a night or two.²⁹

This midwife was active from 1885 to 1939. Other midwives also worked without pay as a rule, though, like Sophia, they were occasionally given money by a grateful family

²⁷ 88-281, C11378.

²⁸ For description and analysis of this system see Wilfred Wareham's discussion in Victor Butler, The Little Nord Easter: Reminiscences of a Placentia Bayman, ed. Wilfred Wareham (St. John's: Breakwater, 1980) pp.149-156.

²⁹ 77-345, Ms p.2.

with something to spare.³⁰ Early in this century payment in kind was common. Midwives were given fish, hay, bread, or quilts.³¹ But by the 1940s payment in kind was rare. One woman recalled that her grandmothers were always paid in kind for their midwifery, though the midwife she assisted in the 1930s to '50s was given ten dollars.³²

Formal training of midwives contributed to this change. Clara McGrath and Elizabeth Austin were not paid for their work until after being trained and licenced by the Department of Public Health and Welfare, though they took this training a decade apart.³³ During public health training, women were urged to charge ten dollars for their services.³⁴ Jean Lewis, who administrated midwives' training in the Department of Public Health from 1949 until 1961, said this was done because midwives, unlike district nurses, were not salaried by the government.³⁵

As cash became more common, midwives were paid more.

³⁰ See 76-351, Ms p.10; 77-328, Ms p.40; 78-199, Ms p.24; 79-695, Ms p.11.

³¹ See 73-160, Ms p.8; 75-285, Ms pp.34-35; 78-211, Ms p.103; 82-326, Ms p.11; 84-364, Ms p.9; 84-383, Ms p.3; 86-254, Ms p.24; 86-301, Ms p.18.

³² 88-282, C11371.

³³ Clara McGrath was trained in 1935 by Nurse Lillian Whiteside in St. John's. 81-328, Ms p.18. Elizabeth Austin attended a course at the Grace hospital in 1944. 84-383, Ms p.3.

³⁴ 88-281, C11378.

³⁵ 88-281, C11383.

For example, Elizabeth Wells was given two dollars when she began midwifery around 1935. Eventually this rose to five dollars and finally by 1965 she was paid ten. In some places these increases were client initiated. Rhoda Maude Piercey was given eight dollars when she began her work in 1954. She said "many mothers decided the work and the care involved was worth more so they gave me \$10.00 for ten days."³⁶ In other cases, increases in fees were initiated by the midwife. Elizabeth Austin raised her fee from ten dollars to twelve "when the family allowance came" after Confederation.³⁷ Dorcas Taylor's fee went from ten dollars to fifteen at that time, though it was not indicated who initiated the change.³⁸ However, like most midwives, neither required payment.

Midwives rarely made an effort to collect outstanding fees. One midwife, a widow, kept a ledger listing each birth she attended during the 1930s. She was paid from three to four dollars for her services, the amount being decided by the client. When families in the community received their "dole notes" (government food vouchers) an item of food was brought to her. She

³⁶ 76-142, Ms p.13.

³⁷ 84-383, Ms p.3.

³⁸ 76-255, Ms pp.14-15.

recorded its value until payment was complete.³⁹ This is the only known case where such care was taken, and even here responsibility to honour this agreement rested with the client. Some paid less than a dollar. A few midwives stoutly maintained they were always paid, but most admitted sometimes receiving nothing for their efforts.

Even if payment was always forthcoming, it would have been hard for many women to support themselves as midwives because they attended so few births. To illustrate this point I will assume the number of births each woman attended was the same in all years, though this was probably not the case. Calculating in this way, four midwives attended one birth or less in the average year, six between two and five a year, while another six presided at less than ten. Three other midwives attended fifteen or fewer births in the average year. One attended an average of twenty-eight per year, two others close to fifty, and one about sixty. Even this seems like a relatively light workload, but each confinement represented nine to ten days of care, aside from the time spent with the woman during labour.

The busier midwives might have supported themselves through this work, but even some of these did not. Susan

³⁹ Unfortunately, all but one relatively short ledger kept by this midwife have now disappeared. The midwife who succeeded this woman was married and did not continue this practice. Like most midwives, she was sometimes not paid for her work. 88-281, C11373; C11374.

Everleigh, who attended about twenty-eight births a year, had no regular fee; she took what her clients offered, and was often unpaid. Lenora (Nora) Ellsworth, who attended an average of fifty births a year, rarely received more than two dollars, and was usually paid nothing. Dorcas Taylor, who also averaged fifty confinements, may have supported herself through her work. This is not clear. Only two midwives discussed here, Lillian Wandling and Florence Thompson, are known to have supported themselves through their work. There were, however, many more such women, especially in St. John's prior to the 1940s.

The two occupational categories that emerge from this information are the neighbourhood midwife, who worked without regard for pay, and the midwife-entrepreneur who supported herself and her family on the proceeds of her work. These two types of midwives co-existed in some areas, notably St. John's, for decades, and do not represent an evolution in midwifery. Furthermore, this division does not reflect relative competence. Many neighbourhood midwives successfully attended hundreds of births and some took advantage of formal training as it became available. Women in both categories were regarded as useful allies by doctors.

Most of the midwives examined in this work were neighbourhood midwives. They worked within a limited

geographic area centered on their community of residence. In the outports, the range of a neighbourhood midwife could encompass several small communities, and many midwives travelled further in emergencies. In rural Newfoundland, economic circumstances and low population density more or less precluded midwifery as an occupation which would enable a woman to earn a living.

The other category, the midwife-entrepreneur was typically a widow who supported her family through midwifery, most commonly in St. John's. Because of this financial imperative, these midwives tended not to confine their work to a limited area. Lillian Wandling practiced in St. John's and nearby outports such as Portugal Cove, Torbay and Topsail though she often walked to these communities.⁴⁰ Population density in the St. John's area and her good reputation combined to enable her to earn a living, though she also laid out the dead and decorated cakes to supplement her income.⁴¹

Lillian Wandling was one of many such midwives in St. John's, and midwife-entrepreneurs were probably active in the city before training began. Some women who sought training when it was first available previously managed 1,000 to 2,500 deliveries and were unlikely to be

⁴⁰ 88-281, C11355; C11365.

⁴¹ The role of laying out the dead is examined in Chapter Five.

attending their neighbours on an informal basis.⁴² Although a few neighbourhood midwives attended hundreds of births in the course of their careers, the midwife-entrepreneur was probably more active.

Most women in St. John's who availed themselves of training intended to earn a living from the practice of midwifery. Women trained by the Midwives' Club, the first organization to offer such education, were working class and many were in financial need. Their teacher, Evelyn Cave Hiscock, stated they were "nearly all widows and then some are very sensitive of their educational drawbacks."⁴³ In St. John's, midwifery education was regarded as a means of providing women who might otherwise be a drain on community resources with the ability to support themselves and their dependents while filling a need for trained birth attendants. This was markedly different from attitudes toward the role in outport communities.

Florence Thompson is the only midwife-entrepreneur known to have lived in a smaller community. She lived in the paper mill town of Grand Falls. When her husband

⁴² Mary Southcott, "Address Given by Miss Southcott at the Quarterly Meeting of the Child Welfare Association Grenfell Hall, Monday, October, 24th, 1921," The Evening Telegram [St. John's], 9 December 1921, p.4; 88-281, C11359.

⁴³ Letter from Evelyn Cave Hiscock to Governor Alexander Harris, 1 June 1922, PANL GN 1/3a 1920, File 24.

died, she would have lost the right to occupy her company-owned house, but two doctors convinced her to seek public health training in midwifery in 1943. This provided her with a source of income and enabled her family to remain in the house.⁴⁴

But, unlike most Newfoundland midwives, Florence Thompson did not work without doctors. She prepared the woman, monitored labour and called a doctor when delivery approached. Only once in an emergency did she attend a birth without a doctor. Florence Thompson represents another category of midwife: the doctor's assistant. Most Newfoundland midwives were independent birth attendants, calling a doctor only if complications developed. Some midwives acted both as independent birth attendant and doctor's assistant, depending on the client's preference and the presence of complications. This situation of dual use existed first in St. John's and later in some outports, but choice of birth attendant remained the client's prerogative.

The midwife who was solely a doctor's assistant represents a decline in midwifery and a transitional step in medicalization. In some areas of North America, the doctor's assistant seems to have been pervasive before the role of midwife vanished completely. Kathy Kuusisto found six of the seven midwives she studied in Nova

⁴⁴ 88-281, C11354.

Scotia active between 1910 and 1940 fell into this category; only one worked alone extensively.⁴⁵ In Newfoundland, the midwife who acted only as doctor's assistant was not as common. Just three of the women studied here, Florence Thompson, Myrtle Atkinson and Eliza Jane Dawe, acted as doctor's assistants only.

The difference between Nova Scotian and Newfoundland midwives can be explained in part by availability of doctors. In Nova Scotia, the ratio of doctors to general population was 1:1146 in 1921 and 1:1152 in 1931.⁴⁶ In Newfoundland, the ratio was calculated at 1:2029 in 1911. By 1935 it had fallen to 1:4050.⁴⁷ In 1936 the government estimated that the ratio of doctors to population in Newfoundland, excluding St. John's and Conception Bay, was in fact 1:7000.⁴⁸ Of course, no doctor could actually serve that number of people, especially given the scattered population of Newfoundland. Sheer volume of work in such areas made independent midwives a necessity.

During Commission of Government, a concerted effort

⁴⁵ Kuusisto, p.19.

⁴⁶ Kuusisto, p.13.

⁴⁷ Nigel Rusted, It's Devil Deep Down There (St. John's: Faculty of Medicine, Occasional Papers in the History of Medicine, Number 5, 1985), p.4.

⁴⁸ "Annual Report of the Commission of Government for the Year 1936," Observer's Weekly [St. John's], 27 April 1937, p.3.

was made to provide doctors and district nurse-midwives to isolated areas of Newfoundland. Access to health care professionals was a necessary prerequisite to medicalization of childbirth, but the end of midwifery cannot be explained by access alone. In many parts of North America, traditional obstetric care ended largely because midwives were legislated out of existence. The next chapter examines how government officials, medical men and those concerned with public health approached the question of empirically trained midwives in Newfoundland.

Chapter II

The Midwife Question in Newfoundland

In 1918, Lillian Moody was twenty-one.¹ Married to Alfred Moody, who was a cook on the S. S. Florizel out of St. John's, Lillian was the mother of two children and pregnant with her third. The Moodys were planning to move their young family to his parents' home in England, when, on what would have been his last voyage, the Florizel sank and Alfred Moody was drowned. After Lillian's third child was born, her doctor, Cluny MacPherson, suggested she train as a midwife to provide her family with an income, and to help her overcome her grief. In the winter of 1921, Lillian attended the Midwives' Club; she appears in the lower left hand corner of the photograph of the class (see Fig. 6). She passed the exams set by the Midwives' Board in 1922.

Over the next twenty-five years, Lillian attended 1,500 confinements, 700 of these without a doctor. She worked with at least seven St. John's doctors and was

¹ Information about Lillian Wandling was collected in an interview with her 6 October 1984, and after her death in February of 1986 in an interview with her daughter, Lillian Adey, 9 May 1986. See 88-281, C 11355; C11365.

Fig. 2. Lillian Moody with her son Alfred, circa 1918. Courtesy of Lillian Adey.



considered a good midwife.² Lillian was able to work because her mother cared for the three children. She married again around 1929 but this childless marriage did not bring financial security and Lillian continued to work as a midwife. In the 1930s she was widowed for a second time. In 1947 Lillian married an American, Adam Wandling, and went to live in her husband's home in New Jersey. In 1952 she returned to St. John's to assist at the birth of her daughter's youngest child in the Grace Hospital. When she was widowed for the third time in 1962, she returned to St. John's again, where she died at the age of eighty-nine in 1986.

Irene Farwell was born in Eastport, Bonavista Bay in 1899.³ She was the daughter of Kenneth Farwell, the most successful farmer in the community. Before marrying, Irene worked as a shop clerk in St. John's (see Fig. 3). After returning to her home community she married Kenneth Bradley. Over the years, they lived in Eastport and nearby Sandringham. Irene bore eight children and occasionally helped at a birth in an emergency. She did

² Lillian Adey said that Dr. Jamieson kept a journal in which he referred to Lillian Wandling as "my favorite midwife." This journal has since been destroyed by his daughter.

³ Information on Irene Bradley is taken from 79-549, a paper based on an interview with the midwife by her granddaughter Debbie Hallett, my interviews with Irene's oldest daughter, Phyllis Crisby, in Eastport, Bonavista Bay, 11 to 13 July 1987, and a client, Nellie Powell of Sandy Cove, Bonavista Bay, 13 July 1987. See 88-281, C11375; C11376.



Fig. 3.

Irene Farwell, with her
father
Kenneth, on her nineteenth
birthday.

St. John's, 1918.
Courtesy of Phyllis Crisby.

Fig. 4.

Irene Bradley, holding
her oldest son,
Rayfield, with her
father Kenneth
Farwell, holding
her oldest daughter
Phyllis.

Eastport, Bonavista
Bay, 1924.
Courtesy of Phyllis Crisby.



not consider herself to be a midwife, but was interested in nursing:

I always enjoyed public life and community work, and at an early age I started visiting the sick and aged. My life ambition was always to be a nurse after I learned some things about obstetrics from my mother, who had also been a midwife. Then when I was old enough to understand what it was all about I read a book which my mother had about obstetrics and learned what I could from that. The more I studied it the more interested I became.⁴

The nearest doctor, Gerald Smith, was located in Terra Nova about eighty kilometres from Eastport. He approached Irene Bradley in the 1940s to act as midwife in Eastport. From that time until 1974 she attended 151 confinements, with no infections or mortalities.

These women lived very different lives. They are typical of two respective types of Newfoundland midwives: Lillian Wandling was a midwife-entrepreneur, supporting herself and her family through her work; Irene Bradley was a neighbourhood midwife who acted mainly out of charity. During their lives, customs and practices related to childbirth changed dramatically. This chapter considers "the midwife question" in Newfoundland. The social and political trends which affected midwifery and contributed to the end of its practice by untrained women are considered. The people who sought to alter the circumstances of childbirth and their motivations are

⁴ 79-549, Ms p.11.

discussed. The relation between midwives and infant and maternal mortality and the history of legislation to control and efforts to train midwives are also examined.

Childbirth and Reform in St. John's

The first attempts to change the circumstances of childbirth occurred in St. John's immediately after World War I and were closely linked with the child welfare movement. Issues addressed at this time included: where childbirth should take place, in the hospital or at home; who should attend women in childbirth, doctors or midwives; and the type of training and control midwives should be subject to. In her discussion of the midwife question of the early twentieth century in the United States, Frances Kobrin characterizes the two basic stances of those involved as the "professional approach" and the "public health approach."⁵ These categories apply equally to Newfoundland.

The professional approach was taken by some St. John's doctors who wished to replace midwife-attended delivery in the client's home with doctor-attended birth in a maternity hospital. The public health approach was taken by other doctors and registered nurses who acknowledged the necessity of midwives and sought to

⁵ Frances E. Kobrin, "The American Midwife Controversy: A Crisis of Professionalization," Bulletin of the History of Medicine, 40 (1966), pp.353-54.

train, supervise and secure government licences for women deemed suitable. These two groups disagreed about solutions to these questions, but were not in complete opposition. For example, Evelyn Cave Hiscock, who worked tirelessly to educate empirically trained midwives, firmly believed that such women should be replaced as soon as birth attendants with formal training became available. As a registered nurse-midwife, however, she did not agree with those doctors who felt themselves to be the only appropriate birth attendants.⁶ Neither is it possible to portray all doctors as villains who wished to monopolize childbirth and wrench control from the hands of women. Perhaps the strongest supporter of empirically trained midwives in St. John's was a male doctor, J. Sinclair Tait.

Those who favoured the public health approach were part of the post-war child welfare movement in St. John's which emerged when recruitment during the war revealed poor health throughout Newfoundland. Of a total of 12,523 men who applied to enlist by 1919, only 6,339 were accepted; the rest were rejected as unfit.⁷ Educated

⁶ The argument between Evelyn Cave Hiscock and the St. John's medical establishment on the question of nurse-midwives is alluded to in a 1925 letter from the office of the Colonial Secretary to Prime Minister W. S. Monroe. PANL GN 5/2, 371-A.

⁷ Joyce Nevitt, White Caps and Black Bands: Nursing in Newfoundland to 1934 (St. John's: Jespersen Press, 1978), p.119.

Newfoundlanders related the health of recruits to child welfare.⁸ Newfoundland was certainly not the first country to be shocked into attention to child welfare as a side effect of military recruitment. In the late nineteenth century, France and England made similar discoveries about the health of conscripts, leading to greater concern for child welfare, efforts to lower infant mortality rates and concern with quality of obstetric care.⁹

During World War I there was also a growing awareness in St. John's of the nascent child welfare movement in France, Britain and the United States, where social reformers and public health officials successfully reduced infant mortality rates mainly by providing better sanitation, a supply of pure milk, and education on hygiene and child care to the urban poor. Between 1900 and 1914, the British infant mortality rate fell thirty-

⁸ For example, Dr. R. A. Brehm, Medical Health Officer for St. John's, stated "in every enlightened country great attention has been paid during recent years to the saving of infant and child life, and this movement has received a great impetus on account of the terrible sacrifice of life during the war." JHA 1917 (St. John's: His Majesty's Printers, 1918), p.523.

⁹ See Linda Kealey's introduction to Suzann Buckley, "Ladies or Midwives? Efforts to Reduce Infant and Maternal Mortality," in Not an Unreasonable Claim: Women and Reform in Canada, 1880s to 1920s, ed. Linda Kealey (Toronto: The Women's Press, 1979), p.131.

three per cent from 156 per 1,000 live births to 105.¹⁰

The child welfare movement in St. John's was funded and controlled by the educated and elite; doctors, trained nurses, city councillors, and the wives of wealthy business men and factory owners. One of the strongest supporters of this movement was St. John's mayor Gilbert Gosling who donated his salary for three months in the summer of 1918 to bring a public health nurse from New York city to organize a visiting public health nurse system. In September of that year this nurse, J. Rogers, submitted her "Child Welfare Report" which recorded her impressions of St. John's. The comments she made about midwives will be discussed below. The public health nursing system she began was taken over by the Women's Patriotic Association, reorganized as the Child Welfare Association early in 1920. This organization provided the first training for midwives in Newfoundland.

The people who worked to alter the circumstances of childbirth were all health care professionals. There is no evidence that midwives themselves, or women who normally employed midwives sought to change the status quo. Even most of those concerned with child welfare showed little interest in midwifery. For example, after

¹⁰ Anthony S. Wohl, Endangered Lives: Public Health in Victorian England (Cambridge, Mass.: Harvard University Press, 1983), p.38.

the Child Welfare Association had provided formal training for midwives for two years, Mary Southcott, Nursing Superintendent at the General Hospital and president of the Child Welfare Association from its inception until 1933, stated in an address to the general membership "perhaps some of you do not know that in connection with Child Welfare we have a Midwives' Club."¹¹

The doctors who favoured the professional approach to childbirth were responding to the on-going struggle to determine who would oversee childbirth in other developed nations. This struggle tended to emerge where different types of birth attendants co-existed in adequate numbers to compete for work. In rural Newfoundland, where there was no profit motive and far fewer birth attendants, doctors regarded midwives as useful allies well into this century. However, competition between doctors and midwives occasionally occurred outside the capital. In Grand Falls, for example, in the 1940s, doctors grew annoyed with older midwives who refused to defer to them. This problem was solved by selecting a woman who was willing to work as a doctor's assistant, and sending her to the training course offered by the Department of

¹¹ Southcott, p 4. For information about Mary Southcott see Nevitt, pp.46-49.

Public Health and Welfare.¹² St. John's was the only place, however, where doctors actively sought to control midwives over a long period of time.

At the beginning of this century there were few provisions for childbirth outside of the home in St. John's. The General Hospital only dealt with very complicated births on an emergency basis. In 1894, the Salvation Army opened a home for unwed mothers, known as the Cook Street Rescue Home or the Anchorage, which provided free care, including medical attendance at delivery. A few private maternity hospitals operated in the city with mixed success. Dr. William Roberts attempted to open a maternity hospital in 1913 and again in 1922.¹³ Both these ventures failed for unknown reasons. Mary Southcott ran a more successful hospital for maternity and children's surgery beginning in 1916.¹⁴

For the majority of women, however, childbirth took place at home. Women engaged a doctor as a birth attendant if they wished, but a midwife was indispensable. Then, as now, a doctor would not stay with a woman through most of her labour, which might easily last twelve hours in a normal first birth. The midwife monitored labour and decided when to call a doctor if one

¹² 88-281, C11354; C11355.

¹³ Nevitt, p.146; p.265.

¹⁴ Nevitt, p.264.

had been engaged, or if labour was too long or complications developed. There were no nurse-midwives in private practice in St. John's. All midwives were empirically trained. State intervention in childbirth was non-existent until the 1930s; there were no laws to govern who could act as birth attendants; midwives were not licenced or certified and no provisions were made to provide formal training until the 1920s.

This system was tolerated by doctors because it saved a great deal of time, allowing them to take many maternity cases without limiting general practice. It was not uncommon for St. John's doctors have 200 to 300 maternity cases a year in the early decades of this century.¹⁵ Midwives therefore allowed doctors to maintain a substantially larger practice than would have been possible otherwise. They also provided concrete benefits from the client's point of view. In addition to moral support during labour, the midwife returned to the woman's house for nine to ten days after the delivery, caring for mother and child and doing their laundry. Many midwives also did some housework, though this was up to the individual. For all this work, a midwife received between five and ten dollars.¹⁶

¹⁵ 88-281, C11362.

¹⁶ In 1921, for example, a midwife who sued the husband of a client for eight dollars stated she was usually paid ten. "Midwives' Union," Evening Telegram

St. John's midwives were not simply doctor's assistants; they were birth attendants in their own right. Many clients and midwives felt that a physician was only necessary if complications developed. The midwife, therefore, often decided if a doctor would attend a birth and this generated resentment among some St. John's physicians. In 1918, Nurse Rogers wrote

among the poorer classes it is exceptional rather than usual to find a physician has attended the mother during confinement. The physicians themselves say they attend only about fifty per cent of the cases they are engaged for because the "so-called midwives" reach the patients first and assure them that they do not need a physician [her quotation marks].¹⁷

These doctors felt they were being usurped, and in many cases they probably were. A doctor was regarded as an unnecessary extravagance when labour proceeded normally and an experienced midwife was in attendance. The idea that midwives were stealing patients may, however, also have been the result of conflicting expectations. Many women engaged both a doctor and a midwife, but it was understood by both midwife and client that the doctor would only be called in an emergency. It is not clear whether doctors shared this expectation, but

[St. John's], 7 June 1921, p.8.

¹⁷ J. Rogers, "Child Welfare Report of Community Nurse Rogers," Daily News [St. John's], 14 September 1918, p.2.

communication between the male doctor and the pregnant patient was often poor.

Women were not encouraged to speak with their doctors. A doctor who was active from the 1920s on stated that he preferred his poorer patients because they were more likely to follow his advice, whereas "the wealthy ones kind of tried to be domineering and tell you what to do."¹⁸ Women were expected to regard doctors as unquestionable authorities, even though this could have tragic results. One woman lost a child at birth because the doctor, not her usual physician, waited too long before applying forceps. This woman always needed forceps and realized that the doctor was probably waiting longer than he should, but did not feel she could advise him in his work.¹⁹ Women who chose midwives over doctors may have done so in part to avoid the deference expected of them as patients.

In her report, Nurse Rogers also commented on midwifery in St. John's. As a public health nurse from New York City, she was part of a system which had subjected midwives to fairly strict regulation since 1907 and provided comprehensive, free education for

¹⁸ 88-281, C11362.

¹⁹ 88-281, C11364.

empirically trained midwives since 1911.²⁰ Perhaps because of this, Rogers was disconcerted by the situation in St. John's and felt that the "total absence of regulations regarding women who practice as midwives" was a cause of the high rate of infant mortality in the city (see Table 5).

While Rogers did not completely condemn St. John's midwives she was not overly enthusiastic about their work, stating

it is willingly granted that there are some women practicing midwifery who have been instructed by physicians and endeavor to carry out these instructions as far as their intelligence permits. These women, and others who could be instructed, warrant it would be worth while to instruct and license all women before permitting them to practice midwifery.²¹

This was apparently the first time that the idea of training and licensing midwives was raised publicly in St. John's. Rogers also had hard words for midwives she regarded as incompetent:

at present there are all too many engaged for obstetrical service who are grossly ignorant, personally untidy, even dirty in appearance, and their teachings and practices are altogether questionable and disgusting. Tiny babies are handled roughly because of lack of knowledge, and

²⁰ For details, see the autobiography of the founder of this system, S. Josephine Baker, Fighting for Life (New York: MacMillan Co., 1939) and Litoff, American Midwives, pp.51-53.

²¹ Rogers, p.2.

many mothers with their first babies actually think this is the way a child should be handled.²²

Rogers' report indicates that doctors were dissatisfied with the degree of control they had over childbirth and that many midwives were positively dangerous. Information about a St. John's midwife active in those years helps to balance this picture. Agnes Ebsary Horwood was born in 1880 on the South Side of St. John's harbour, where her family had lived for several generations.²³ Agnes was the oldest of three girls, and the daughter of midwife Jessie Bursey Ebsary, with whom she apprenticed. At the age of nineteen Agnes married Frank Horwood who worked in the office of a warehouse on the South Side and the couple took up residence near by. It is unclear how old Agnes Horwood was when she began to work with her mother, but by age thirty she practiced alone.

Agnes Horwood served women on the South Side east of St. Mary's Church and in the tiny community of Fort Amherst, which is nestled at the mouth of the harbour about two miles distant. Another midwife was active

²² Rogers, p.2.

²³ Information about Agnes Horwood is taken from her granddaughter Helen Porter's book, Below The Bridge: Memories of the South Side of St. John's ([St. John's]: Breakwater, 1979) and interviews with Helen Porter and Mary Norris, a former neighbour and client. See 88-281, C11360; C11364.

west of St. Mary's.²⁴ Agnes was sometimes distressed by the poverty of the women she helped, but never felt she could refuse.²⁵ She was not, of course, the only midwife available to women in her neighbourhood. Mary Norris, who lived near by, engaged Agnes for two of her nine confinements but relied on two other midwives for her other deliveries.

Although Agnes Horwood had no formal training in midwifery and was never licenced, she worked with a number of doctors who liked and trusted her. Cluny MacPherson was said to be "a great fan" and felt that she was born to be a midwife.²⁶ Mary Norris recalled that Dr. Andrew Carnell entrusted her to Agnes for treatment after the birth of her first child.²⁷ Mary remembered

²⁴ 88-281, C11360.

²⁵ 88-281, C11360.

²⁶ 88-281, C11360.

²⁷ Mrs. Norris was slow to recover from this delivery although she had no fever. An older neighbour suggested to Dr. Carnell that Mrs. Norris needed a douche, implying that some material must have been retained. Dr. Carnell agreed, and left this to Agnes Horwood. Material had been retained, and the midwife looked after Mary Norris until the discharge ended. The fact that the doctor would entrust such a task to the midwife indicates a high degree of trust, as serious infection might have resulted. 88-281, C11364.

Fig. 5. Agnes Horwood, standing, with her husband Frank. Their daughter, Amy Evelyn Fogwill is seated with her daughters, Helen (left) and Margaret (right).

Manuels, Conception Bay, 1940.
Courtesy of Helen Porter.



Agnes Horwood as "real sympathetic and real good to me."²⁸ Agnes Horwood gave up midwifery in the early 1930s at the age of fifty-five and died in 1941. She was a capable, intelligent and clean midwife.

This suggests that Nurse Rogers' picture of midwifery in St. John's was somewhat pessimistic. However, the dissatisfaction expressed by some doctors was real enough, and contributed greatly to the drive for a maternity hospital which began in 1919. This institution was to be run by the Salvation Army, and was related to that organization's concern for unwed mothers. The maternity hospital was also the result of demand for medicalized childbirth among some women in St. John's. By 1919 the Cook Street Rescue Home was being used by "respectable [married] people," and beds were booked six months in advance.²⁹

In conjunction with fund-raising for this maternity home a statement appeared in St. John's newspapers signed by doctors Thomas Anderson, Alexander Campbell, H. H. Cowperthwaite, J. G. Duncan, N. S. Fraser, J. MacDonald, H. M. Mosdell, Cluny MacPherson, W. H. Parsons, H. Rendell, William Roberts, and W. J. Scully. Fraser, MacPherson and Roberts attended women at the Cook Street

²⁸ 88-281, C11364.

²⁹ "S.A. Project," Daily News [St. John's], 14 March 1919, p.3.

Rescue Home. This statement cited poor living conditions and the questionable obstetric care provided by midwives as major hazards to infant and maternal health.³⁰ In stressing the problems associated with living conditions, these doctors showed sympathy with the public health movement.

With reference to obstetric care, it was lamented that no trained obstetric nurses were available to women in their homes. Of empirically trained midwives it was said, "there are now practicing in the city and throughout the country, women who pose as midwives, who have had neither the experience nor the training essential to the due performance of their most important tasks." The maternity hospital was promoted as a place where training would be available to midwives from all parts of Newfoundland.³¹ Such training would indeed become a reality, but not until Commission of Government. H. M. Mosdell became Secretary of Public Health in the Department of Public Health and Welfare

³⁰ Living conditions were certainly a problem in the city at the time. St. John's has had a public water supply since the 1860s, but in 1915 there were about 2,000 houses in the city with neither water nor sewer connections. By all reports, the city centre was the site of an appalling slum, and 369 houses then occupied were deemed absolutely unfit for human habitation by the city's inspector. Armine N. Gosling, William Gilbert Gosling: A Tribute (New York: The Guild, [1935?]), p.90.

³¹ "Lend a Hand: They Know the Need, They Approve the Remedy..." (Advertisement) The Daily News [St. John's], 6 March 1919, p.2.

during Commission of Government and was probably instrumental in establishing that programme.³²

Although this advertisement is critical of empirically trained midwives, two of the doctors who signed it, Roberts and MacPherson, are known to have provided training for women who acted as independent midwives in their home communities.³² Of all these doctors, only MacPherson was strongly committed to the public health approach to the midwife question. His name may appear in this statement because of his close association with the Salvation Army Rescue Home rather than his attitudes towards midwives.

The fact that unwed mothers were to be cared for in the proposed maternity home and the denominational nature of the institution generated the most controversy during the establishment of the Grace Maternity Hospital.³³ Quality of obstetric care was not an important issue to the general public, although it remained part of the doctors' campaign for this institution. For example at a

³² Secretary was the senior civil service position in a department during Commission of Government.

³² Roberts provided training for at least two outport midwives. 76-255, Ms p.5; 88-281, C11358. As noted in the opening of this chapter, Cluny MacPherson encouraged Lillian Wandling to become a midwife.

³³ See, for example T. B. Darby, "The S. A. Maternity Home," Daily News [St. John's], 11 March 1919, p.5; "Outport Writer's Views," Daily News [St. John's], 13 March 1919, p.2.

fund-raising meeting in March of 1919, William Roberts stated that the maternity home was needed because

lack of skilled attendance is a positive danger to patients. Midwives, no doubt do their best, but they have no proper training. Everything cannot be done at once, but the proposed home affords the possibility of placing within the reach of women in all parts of the Island a skilled maternity nurse.³⁴

Not all St. John's doctors were as moderate. At the same time, Alexander Campbell spoke more strongly:

Dr. Campbell said we have no idea of the conditions under which the majority of children here are born but it was in their interest [that] the doctors were backing the movement. Medical ethics prevented the discussion of such a subject as maternity in public, and he had no desire to harrow the finer feelings of those present with tales of conditions surrounding many births, but in the name of the profession he asked all to support the project. For the sake of the children the institution is needed.³⁵

Campbell was one of the most persistent critics of midwives in Newfoundland. Richard Squires, who would be Prime Minister when legislation to control midwives was first considered, also spoke on this issue. He indicated an awareness of Nurse Rogers' report and felt that, were midwives to be trained at the maternity hospital, "the whole Dominion would benefit and many deaths be prevented

³⁴ "S.A. Project," p.3.

³⁵ "S.A. Project," p.3.

through such training."³⁶ In this opinion he was probably influenced by his close friend, Alexander Campbell.

The Grace Maternity Hospital opened in December 1923, and in 1929 a three year maternity nursing course was established there. Although most of the graduates of this programme spent their careers in hospitals working under the supervision of doctors, they were provided comprehensive training in midwifery. Minnie Taite, who was among the first graduates in 1931, was responsible for eighty-five deliveries during her training. She worked at the Cook Street Rescue Home after graduating where she frequently attended deliveries without a doctor.³⁷ However, as noted above, the promised course for empirically trained midwives was not established.

In spite of the advent of the Grace, most women in the city continued to give birth at home. In 1931 for example, only 332 out of a total of 1,169 births took place in institutions, including the home for unwed mothers, the Grace Hospital, and some private maternity hospitals. In the same year, however, two-thirds of all women giving birth in the city were attended by doctors.³⁸

³⁶ "S.A. Project," p.3.

³⁷ 88-281, C11377.

³⁸ Child Welfare Association Annual Report, 1931 (St. John's: The Evening Telegram Ltd, 1932), p.9.

During the considerable debate which surrounded the establishment of the Grace Hospital, J. Sinclair Tait was the only doctor to assert this institution was unnecessary. In November of 1919 he said

there was no desire for a Maternity home in St. John's. The private Maternity Hospitals already here were not availed of. What was more necessary was the schooling of mothers as to how to feed their children.³⁹

It was not unusual for doctors and government officials to blame midwives for high rates of infant mortality, but Tait considered the causes of infant mortality in Newfoundland carefully and believed that there was little evidence to support this assertion.⁴⁰ The actual causes of infant and maternal mortality are worth considering briefly because midwifery was regarded as a leading cause of these deaths.⁴¹

The assumption that medicalization of childbirth would lead to better obstetric care is questionable. Although the empirically trained midwife would not

³⁹ "Social Welfare Congress: Yesterday's Sessions," Daily News [St. John's], 18 November 1919, p.3.

⁴⁰ See J. S. Tait, "Infantile Feeding: A Paper Read by Dr. Tait at the Child Welfare Exhibit on Tuesday," Daily News [St. John's], 23 August 1917, p.5 and "Lecture Delivered by Dr. J. Sinclair Tait...On Infant Health and Welfare," Daily News, [St. John's], 15 July 1918, pp.2-3.

⁴¹ Because little attention was given to prenatal or post-natal care until well into this century, this discussion will focus on labour and delivery, and general levels of health and sanitation.

compare well with the modern obstetrician, it does not necessarily follow that medical doctors of the early twentieth century were always better birth attendants. Due to poor practical training and undue intervention, many general practitioners at the beginning of this century posed at least as great a risk to childbearing women as did empirically trained midwives.⁴² In Newfoundland, J. Sinclair Tait asserted that midwives were not worse birth attendants than doctors, stating

while it is highly advantageous that medical care and assistance should be provided [to women in labour] yet when we take into consideration the large proportion of our population living in remote and isolated parts, where no doctor is available, it is astonishing to find that the mortality among mothers per capita is not greater than where medical assistance is always at hand.⁴³

Maternal mortality, calculated per 1,000 live births, was high in Newfoundland compared to rates in other countries

⁴² In Britain such midwives supervised by medical officers on charity cases showed a low rate of maternal mortality, often half the estimated national average. Donnison, p.93. After the Midwives Act of 1902 was passed in Britain empirically trained midwives declined. In the next thirty years general death rates fell by one third and infant mortality rates halved. But from 1928 on the maternal mortality rate climbed, and was lower among low income groups than the affluent. Donnison, p.187. For discussion of this see Jane Lewis, The Politics of Motherhood: Child and Maternal Welfare in England, 1900-1939 (London: Croom Helm, 1980), pp.35-41. For information about the relative safety of midwives in childbirth in the United States see Baker, p.114; Litoff, American Midwives, pp.111-112; Declercq, p.124; and Kobrin, pp.355-356.

⁴³ Tait, "On Infant Health and Welfare," p.2.

(see Table 1). While causes of death during labour will be considered in Chapter Three, deaths caused by puerperal septicemia (infection following childbirth) will be considered here as statistics on maternal mortality indicate some relation between this problem and midwifery.

Details of causes of maternal mortality are available for a twenty-one year period prior to Commission of Government only (see Tables 2 and 3). Puerperal septicemia may be caused by the birth attendant if he or she is unclean, but there are other causes, especially if the place of birth is unsanitary or if a long interval elapses between the time the amniotic sac breaks and the child is delivered.

Initially, puerperal septicemia accounted for a high number of maternal deaths in Newfoundland. But, unlike many European cities and early maternity hospitals, there were no recorded epidemics of puerperal infection in St. John's. Nurse Rogers admitted this when she wrote

the majority of these women have no knowledge whatever of even the primary principles of aseptic treatment demanded on such occasions, although there is in the city a surprisingly low percentage of puerperal infection...⁴⁴

Outside the city, it is rare to find more than one fatal case per year in any area. From 1918 on there was a

⁴⁴ Rogers, p.2.

steady decline in puerperal septicemia both in St. John's and the country in general. This occurs prior to efforts to train midwives and well before medicalization of childbirth and may have been due to a greater general awareness of the importance of cleanliness in childbirth, a topic which will be returned to in Chapter Three.

Infant mortality includes all deaths of children under one year of age and the rate is calculated per 1,000 live births. Currently Canada has an infant mortality rate of about 9 per 1,000 live births and the U. S. has a rate of about 12.⁴⁵ In the early decades of this century, the infant mortality rates in Newfoundland can only be described as excessive (see Tables 5 and 6). In 1910, the infant mortality rate for the country was 141; about one quarter of the people who died in Newfoundland that year were less than one year old.⁴⁶

⁴⁵ J. Larry Brown, "Hunger in the U. S.," Scientific American, 256:2 (1987), p.41.

⁴⁶ JHA 1911, p.513.

Table 1

Maternal Mortality in Canada and Other Countries

YEAR BIRTHS	COUNTRY	NUMBER OF DEATHS	RATE PER 1, 0 0 0
1922	Denmark	146	2.0
1922	Netherlands	454	2.5
1918	Sweden	304	2.5
1916	Italy	2,351	2.6
1920	Switzerland	235	2.9
1923	England and Wales	2,892	3.8
1922	Australia	621	4.5
1923	Spain	3,010	4.6
1923	Irish Free State	297	4.8
1923	Northern Ireland	148	4.9
1920	Germany	7,865	4.9
1922	New Zealand	149	5.1
1922	Belgium	827	5.4
1922	Canada (Registration Area)	907	5.5
1916	France	1,895	6.0
1923	Newfoundland	46	6.2
1923	Scotland	718	6.4
1922	United States (Registration Area)	14,657	6.6

From Dr. Helen MacMurchy, Maternal Mortality in Canada. Report of an Enquiry made by the Department of Health, Division of Child Welfare (Ottawa: F. A. Acland, Printer to the King's Most Excellent Majesty, 1928), p.60.

By comparison the United States, considered to have a poor record on infant mortality among developed nations, had a rate of 124 per 1,000 live births in 1910 and Britain had a rate of 106.⁴⁷ The infant mortality rate in St. John's that year was 186 and Toronto had an infant mortality rate of about 158.⁴⁸ Montreal, perhaps the worst North American city for infant mortality, had a rate in excess of 280.⁴⁹

The Journal of the House of Assembly divided infant mortality statistics into "premature birth" and "congenital debility." Premature birth is still a major cause of infant mortality. About half of the premature births that occur today cannot be explained, but poor maternal nutrition is often an important factor.⁵⁰

⁴⁷ Litoff, American Midwives, p.108.

⁴⁸ Michael J. Piva, The Condition of the Working Class in Toronto: 1900-1921 (Ottawa: Univ. of Ottawa Press, 1979), p.114.

⁴⁹ Terry Copp, The Anatomy of Poverty: The Conditions of the Working Class in Montreal, 1897 to 1929 (Toronto: McClelland and Stewart Ltd., 1974), p.167. The Montreal church parish system ensured that accurate vital statistics were collected for the francophone population and this may create an unfavorable distortion. In most places, problems of collecting vital statistics among the transient poor made for uncertain accuracy.

⁵⁰ Wohl, p.16.

Table 2

Causes of Maternal Mortality in St. John's,
1909 to 1930

Year	Causes			Rate per 1,000 live births
	Puerperal Sepsis	Convulsions	Other	
1909	4	0	1	
1910	8	0	5	8.7
1911	5	1	3	8.0
1912	no vital statistics			
1913	no vital statistics			
1914	2	0	4	3.7
1915	0	1	1	1.3
1916	2	0	6	5.5
1917	3	0	5	5.2
1918	1	1	1	2.1
1919	3	N/A	2	3.0
1920	0	N/A	1	0.6
1921	1	N/A	8	5.3
1922	0	N/A	4	2.4
1923	0	0	6	3.5
1924	no vital statistics			
1925	0	N/A	0	0
1926	1	N/A	0	.58
1927	1	0	4	3.1
1928	0	0	2	1.2
1929	1	2	4	4.3
1930	2	0	5	4.5

Figures are taken from the JHA, 1908 to 1931. No vital statistics were recorded from 1931 to 1934, perhaps because the government was approaching bankruptcy. N/A means that deaths from convulsions were not recorded as a separate statistic. Maternal mortality rates calculated by the author, with help from Michael Wallack.

Table 3

Causes of Maternal Mortality
in Newfoundland, 1909 to 1930

<u>Year</u>	<u>Causes</u>			<u>Total</u>	<u>Rate per 1,000 live births</u>
	<u>Puerperal Sepsis</u>	<u>Convulsions</u>	<u>Other</u>		
1909	22	3	21	46	6.4
1910	15	2	43	60	8.3
1911	19	1	45	65	9.4
1912	no vital statistics				
1913	no vital statistics				
1914	7	7	40	54	7.0
1915	9	6	30	45	5.7
1916	11	2	35	48	6.5
1917	10	7	28	45	6.5
1918	5	2	43	50	6.6
1919	3	n/a	37	40	5.4
1920	1	n/a	39	40	5.1
1921	1	n/a	52	53	7.1
1922	2	n/a	50	52	6.9
1923	1	2	43	46	6.5
1924	no vital statistics				
1925	1	n/a	26	27	3.8
1926	8	n/a	26	34	4.6
1927	2	3	30	35	4.9
1928	1	3	20	24	3.5
1929	4	3	30	37	5.3
1930	5	2	28	35	5.2

Figures are taken from the JHA, 1910-1931.

Table 4

Maternal Mortality Rates in Newfoundland
 Calculated per 1,000 live births

YEAR	RATE	YEAR	RATE
1910	8.3		
1915	5.7	1950	1.6
1920	5.1	1956	1.6
1925	3.8	1960	1.1
1930	5.2	1970	.4

Statistic for 1910 to 1930 are taken from the JHA, from 1950 to 1970 from the annual reports of the Department of Health. Maternal mortality rates were not published during Commission of Government.

Table 5

Infant Mortality Rates in St. John's,
1906 to 1967

Calculated per 1,000 live births

Year	Rate	Year	Rate	Year	Rate
1906	240	1931	132	1956	37
1907	168	1932	119	1957	30
1908	214	1933	106	1958	31
1909	222	1934	117	1959	36
1910	186	1935	117	1960	20
1911	261	1936	97	1961	26
1912	172	1937	145	1962	23
1913	221	1938	114	1963	21
1914	169	1939	92	1964	22
1915	163	1940	74	1965	19
1916	184	1941	102	1966	20
1917	118	1942	108	1967	23
1918	136	1943	111		
1919	114	1944	122		
1920	146	1945	92		
1921	132	1946	77		
1922	137	1947	61		
1923	103	1948	62		
1924	142	1949	44		
1925	103	1950	33		
1926	70	1951	46		
1927	124	1952	60		
1928	136	1953	45		
1929	128	1954	43		
1930	134	1955	31		

Figures for 1906 to 1909 and 1917 to 1924 were taken from the JHA. From 1910 to 1916, figures were taken from Gilbert W. Gosling, "Infant Mortality," Daily News [St. John's], 26 July 1917, p.4. From 1925 to 1967, figures were taken from the Child Welfare Association Annual Report, 1926 to 1967. All numbers have been rounded off.

Table 6

Infant Mortality Rates in Newfoundland,
Selected Years, 1910 to 1960

Calculated per 1,000 live births

YEAR	RATE	YEAR	RATE
1910	141	1936	103
1915	122	1940	91
1920	129	1944	101
1925	115	1948	59
1930	135	1955	42
		1960	36

Statistics for 1906 to 1930 taken from the JHA; for 1936 to 1948 from the annual reports of Commission of Government; For 1955 and 1960 from the annual reports of the Department of Health.

"Congenital debility" accounted for three to four times as many deaths as prematurity in the early decades of this century. This category meant unhealthy at birth but also included all deaths not listed as premature so that genetic disorders, damage due to birth trauma such as might result from prolonged labour or poor obstetric care, accidents in the first year of life and death from disease were included.⁵¹

The precise causes of infant mortality in most of Newfoundland in the early decades of this century are unknown, but thanks to the Child Welfare Association it is possible to create a detailed picture of infant mortality in St. John's. Prematurity was consistently blamed on lack of proper prenatal care and poor nutrition. Debility at birth resulted from genetic defects such as spina bifida. Congenital syphilis also accounted for many such deaths until the introduction of penicillin after World War II. Tuberculosis, a serious and pervasive health threat in Newfoundland into the 1940s, was responsible for many deaths in the first year of life. Many other infectious diseases caused infant mortality rates to rise periodically. For example, in 1916 there was an epidemic of measles which resulted in 5,000 reported cases and caused the increase in the

⁵¹ Child Welfare Association Annual Report, 1929 (St. John's: The Evening Telegram Ltd., 1930), p.9.

infant mortality rate that year.⁵² In 1928 cholera contributed to a rise in infant mortality and an epidemic of mumps was partly responsible for the sharp increase in 1937. Diphtheria, measles and pneumonia also played their part.

One disease was chronic and more or less predictable. This was gastroenteritis, called "summer complaint" because it often peaked in the warm months of July to September. In cool wet summers there were few problems, but when the weather was hot and dry infant mortality rates always rose. Summer complaint was pervasive in many smaller communities and caused precipitous increases in infant mortality in St. John's in 1920 and 1924.⁵³ Infant mortality rates in Newfoundland did not show consistent decline until after World War II.

It is difficult to generalize about Newfoundland, but in St. John's the majority of infant deaths in the first half of this century can be attributed to environmental factors and disease. Unsanitary living conditions and poor nutrition meant that infants were often born in poor health and exposed to many infectious diseases. Children were very much at risk in the first

⁵² JHA, 1917, p.513.

⁵³ JHA, 1921, p.586; Child Welfare Association Annual Report, 1928, p.9.

year of life. When Sinclair Tait stated that instructing mothers in proper feeding methods would benefit the infants of St. John's more than a maternity hospital, it was in recognition of the fact that gastroenteritis killed many more infants than did midwives. Like many doctors of his generation, he believed that "artificial feeding" of infants (use of foods other than breast milk) was mainly responsible for high mortality.⁵⁴ The problem was, however, more complex than was supposed at the time and even if artificial feeding had ceased entirely high infant mortality would not have disappeared. In spite of the fact that midwifery was never conclusively related to high rates of mortality, the idea persisted and contributed to pressure on the government to control the practice of midwives.

Midwives and Legislation

Efforts were made to introduce midwifery legislation in the House of Assembly in 1920 and again in 1926 without success. In 1931, comprehensive legislation concerning midwives was passed as part of an omnibus Public Health Act, but these laws were not enforced.

⁵⁴ Anthony Wohl notes that bottle feeding was the bête noir of medical men from the 1860s onward. See Wohl, pp.20-23. For a discussion of the artificial feeding question in Britain see Carol Dyhouse, "Working-Class Mothers and Infant Mortality in England, 1895-1914," Journal of Social History, 12 (1978-79), pp.255-257.

Significant efforts to licence midwives were not made in Newfoundland until the Commission of Government era. Earlier attempts to introduce legislation deserve some attention however, because they detail the history of the midwife question in Newfoundland and were related to significant efforts to train midwives.

"An Act Concerning the Registration of Midwives" was passed by the government of Newfoundland in 1920 at the insistence of Governor C. Alexander Harris and his wife Constance.⁵⁵ There was conflict over whether this act should be applied to the whole of Newfoundland, as Harris wished, or only St. John's in accordance with the wishes of doctors in the city.⁵⁶ Perhaps because of this the act was extremely vague, simply stating that

it shall be lawful for the Governor-in-Council to make rules and regulations governing the training, qualifications, and registration of persons practicing the profession of midwifery in this Colony, and to fix penalties for the breach thereof. Such rules and regulations and penalties shall be published in the Royal Gazette, and shall thereupon have the force and effect of

⁵⁵ For details see Constance Harris, "Child Welfare: Address Delivered By Lady Harris at the Annual Meeting of the W.P.A. Yesterday," Daily News [St. John's], 5 December 1919, p.4; PANL GN 1/3a 1920, File 24; PANL GN 8/2, File 41, correspondence between C. A. Harris and Richard Squires; PANL GN 8/2, File 45, Department of Justice Correspondence.

⁵⁶ In correspondence with Squires, Harris referred to "the practice of midwifery by women who you described as the "grannies" which the doctors of St. John's are most anxious to control." PANL GN 1/3a 1920, File 24.

law.⁵⁷

This act provoked no debate in the House of Assembly, but did provide Alexander Campbell, then Minister of Agriculture and Mines, the opportunity to speak again about the dangers of midwives. He said,

ever since I have been practicing, I think, I have seen valuable lives lost and people maimed for life through ignorance on the part of women practicing Midwifery, and to try and correct that is some of the objects of this Bill...While there may be escapes from accident by amateurs in 99 cases out of 100, in the other case there may be a fatal accident to both mother and child. The object of this bill is to have some control over Midwives...⁵⁸

In October of 1921 the government appointed the Newfoundland Midwives' Board, a voluntary organization, to define and then oversee the 1920 Act. The Board was composed of Dr. Cluny MacPherson, chairman, Dr. R. A. Brehm, medical health officer for St. John's, Dr. John Murphy, secretary until his death in 1925, Mary Southcott, Mrs. J. A. [Evelyn Cave] Hiscock, and Miss Myra Louise Taylor.⁵⁹ These women were all registered

⁵⁷ Acts of the General Assembly of Newfoundland (St. John's: J. W. Withers, 1920), p.69.

⁵⁸ Proceedings of the House of Assembly, 1920 (St. John's: The Evening Telegram Ltd., 1921), p.89.

⁵⁹ PANL GN 13, Box 173, File 43: Correspondence concerning the Midwives' Act of 1920.

nurses with a special interest in midwifery.⁶⁰

In the winter of 1921 Evelyn Hiscock took control of the Midwives' Club, begun by the Child Welfare Association in 1920, and the Midwives' Board met weekly to consider the Midwives' Act of 1920.⁶¹ But when a proposed act was submitted to the Ministry of Justice in 1922, it was declared that the Board had no authority to exist under the 1920 Act.⁶² To remedy this a new bill would have to be introduced, giving the Midwives' Board the right to licence midwives and govern their practice, set exams, and recognize certificates from other places. The Justice Department also felt the act should contain penalties for practicing without a licence.⁶³

It must have come as a shock to the Midwives's Board to discover that there was no legal basis for the organization's existence. This came to light as the first class of the Midwives' Club graduated. When Evelyn Hiscock requested that the Midwives' Board issue certificates to women who passed the exams she discovered that the board had no authority. She wrote Governor

⁶⁰ For information on Myra Taylor see Nevitt, p.94. Evelyn Hiscock will be discussed below.

⁶¹ PANL GN 1/3a 1920, File 24.

⁶² PANL GN 13, Box 173, File 43. Unfortunately, the recommendations of the Midwives' Board are missing, as is a letter by Alexander Campbell criticizing these recommendations.

⁶³ PANL GN 13, Box 173, File 43.

Harris in July of 1922 to ask for his help. Harris was about to retire as Governor and leave Newfoundland, and she feared that certificates might never be granted to these women if they were not given before Harris departed.⁶⁴ She felt she was losing two important allies in the governor and his wife. Harris was willing to define the law in order to grant certificates to Midwives' Club graduates, but for unknown reasons this was never done.⁶⁵

Over the next few years members of the Midwives' Board lobbied the government to introduce a new law, but to no avail. The frustration felt by Evelyn Hiscock was apparent in 1924, when she stated "let us hope that measures will not be further delayed to ensure the protection which is due our women and children."⁶⁶ New legislation called "An Act to Secure the Better Training of Midwives and to Regulate Their Practice," was introduced in 1926 mainly at the insistence of the Midwives' Board. This act was based on the 1902 Midwives Act of Britain, and had the support of graduates of the Midwives' Club, the Midwives' Board and the newly formed

⁶⁴ PANL GN 1/3a 1920, File 24.

⁶⁵ PANL GN 1/3a 1920, File 24.

⁶⁶ Evelyn Cave Hiscock, "Better Nursing Care in Newfoundland: Launching the Outport Nursing Scheme and Improving Maternity Nursing for St. John's," Newfoundland Quarterly, 24:3 (1924), p.30.

Newfoundland Medical Association. Unlike the 1920 Act, it provoked considerable debate in the House of Assembly. Questions included whether the government had a right to intervene in what was regarded as a private matter for women, or question the competence of practicing midwives; whether health care legislation should be brought in when there was no ministry to oversee it; how costly this would prove to the government, and, again, whether the act could or should be applied to St. John's only or the entire dominion.⁶⁷ The bill passed the House of Assembly in May of 1926 but the Legislative Council chose to appoint a select committee of both houses rather than promulgate the act. This committee never reported to the House, and the 1926 Midwives' Act died in a tangle of red tape.

Legislation finally passed in 1931 as section fifteen of the Public Health Act was also based on the British Midwives' Act of 1902. The 1931 Act required that a list of practicing midwives be published in the Royal Gazette annually, but this was never done. It seems that little effort was made to put these laws into effect, probably because midwifery was never a priority with the government and the dominion of Newfoundland was on the road to bankruptcy.

⁶⁷ See Proceedings, 1926, pp.444-446; 457-461; 466-473; 475-478; 672.

In 1936, Commission of Government repealed section fifteen of the 1931 Public Health Act, and "An Act to Govern the Practice of Midwifery" was passed. The first documented licences held by empirically trained midwives in Newfoundland were issued under this Act which remained in effect after Confederation with Canada and was still valid in 1970.⁶⁸ The 1936 Act also required a list of licenced midwives to be published annually in the Newfoundland Gazette, just as a list of medical practitioners was. In fact this was never done. Instead, the government periodically listed areas in which the Midwives' Act was brought into effect, and declared each district nurse responsible for all midwives in her area. This was done in part to quell the old controversy over where such an act should be applied, but also served to prevent licenced midwives from gaining legitimacy and recognition as individual practitioners. By January 1938, the Midwifery Act of 1936 was operative in some 143 communities in twenty-three nursing districts.⁶⁹

Technically, midwives who practiced without a licence were liable to fine or imprisonment after 1931. But the public health bureaucracy was not heavy-handed or

⁶⁸ The Revised Statutes of Newfoundland, 1970, Vol. VI (St. John's: E. Ralph Davis, n.d.), pp.3581-3587.

⁶⁹ "Public Notice [Areas henceforth under the Midwives' Act of 1936]," The Daily News [St. John's], 31 January 1938, p.6.

punitive in dealing with midwives. In the 1940s and '50s, efforts were made to urge women already established as midwives to attend public health training and acquire licences. But women unable to do this practiced into the 1960s without certification and, although some were told in the 1950s and '60s that it was illegal for them to practice, no one was prosecuted.⁷⁰ Midwives who performed internal examinations during labour were supposed to lose their licences but this rule was not enforced. Two directors of Public Health Nursing could recall only one instance of a midwife losing her licence.⁷¹ The notorious "bag checks," used in the Southern United States to keep midwives under strict control of public health officials, were never instituted in Newfoundland.⁷² Government

⁷⁰ See 79-674, Ms p.24; 82-166, Ms p.19; 88-281, C11371 for accounts of unlicensed women who knew it was illegal for them to practice. Maggie Lundrigan, midwife in Upper Island Cove from the 1940s to the '60s, was unable to attend public health training in St. John's because she cared for her elderly father-in-law. She practiced without a certificate in full knowledge of local doctors until voluntarily retiring in the 1960s. 88-281, C11374.

⁷¹ 88-281, C11382; C11383. Jean Lewis could not remember details of the one case in which a midwife lost her licence.

⁷² See Beatrice Bell Mongeau, "The 'Granny' Midwives: A Study of a Folk Institution in the Process of Social Disintegration" (diss. University of North Carolina at Chapel Hill, 1973), pp.83-95 and Dougherty, "Southern Midwifery," for discussion of the bag check as it was used to control southern black midwives. In those areas, a midwife could lose her licence for carrying anything beyond the allowed equipment in her bag, even a Bible.

officials may have made a conscious effort to avoid recognizing individual midwives as health care practitioners, but no attempts were made to intimidate these women or eradicate traditional midwifery.

Efforts to Train Midwives

I. The Midwives' Club

In the spring of 1920, the newly formed Child Welfare Association opened a child welfare centre run by a registered nurse, Edith Haslam. As part of her duties, Nurse Haslam began the Midwives' Club. Little is known about the early operation of this organization. Edith Haslam did not remain with the child welfare centre and another nurse, May Benedict, took responsibility for the Midwives' Club before the year was out.⁷³

The Midwives's Club met each Monday evening in 1920. Andrew Carnell lectured every other week, while J. S. Tait, "or a nurse" taught on the alternate nights.⁷⁴ It is not known if any practical experience was provided during this first year, but no exams were given. Some of the women who attended these lectures had a good deal of experience as midwives. Mary Southcott stated

⁷³ Southcott p.4. See Nevitt, p.104 for information about May Benedict.

⁷⁴ Southcott, p.4.

it would not be unreasonable to expect that a woman who had managed 1,000 cases alone would think that she knew all that there is to know...but that is not so. They are most anxious to learn and interested in everything they are taught and the room is full every night.⁷⁵

Evelyn Cave Hiscock became director of the Midwives' Club in 1921. She was born in St. John's in 1885, and studied nursing at the General Hospital. After graduating in 1907 she went to Peter Brent Brigham Hospital in Boston for a course in maternity nursing. Shortly after returning to St. John's, Evelyn Cave married J. A. Hiscock, an accountant. They had two children and, in keeping with the conventions of the time, Evelyn Hiscock gave up professional nursing after her marriage except when her husband was unemployed from about 1926 to 1929. During that time she operated a small private maternity hospital.⁷⁶ In spite of the fact that she practiced her vocation briefly, Evelyn Cave Hiscock was an energetic woman with a sense of social responsibility who devoted herself to volunteer work related to nursing.

The Midwives' Club continued to meet at the child welfare centre on Duckworth Street, but its connection with the Child Welfare Association is unclear. After 1923 the Midwives' Club is never mentioned in the annual reports of the Child Welfare Association and Evelyn

⁷⁵ Southcott, p.4.

⁷⁶ 88-281, C11359.

Hiscock's name does not appear in the list of members. Evelyn Hiscock may have chosen to distance the Midwives' Club from the Child Welfare Association because of prejudice that nurses employed by this organization exhibited towards the women she trained.⁷⁷

There was not enough room to accommodate all the women who initially attended the three month course in the winter of 1921.⁷⁸ Most of these women were from St. John's. No effort was made to encourage outport women to take this instruction, although one woman came to St. John's from St. Mary's Harbour specifically for this training, working during the day to support herself while in St. John's.⁷⁹ Like Lillian Wandling, many women who attended the Midwives' Club were widows with dependent children who sought to support themselves through midwifery.⁸⁰ Evelyn Hiscock had high regard for these women although she felt them to be of a different social class. As the first class of midwives graduated in the spring of 1922, she referred to them as "these splendid women" and stated

⁷⁷ For examples of anti-midwife statements see Nurse M. I. Loder, "Midwives," Child Welfare Association Annual Report, 1929, p.14; Child Welfare Association Annual Report, 1931, p.11.

⁷⁸ 88-281, C11359.

⁷⁹ 88-281, C11359.

⁸⁰ PANL GN 1/3a 1920, File 24.

may I say that a good many of them I am glad to have met, having got down to the personal side of their lives I found traits with a little cultivation brought out finer ones and I feel they can do and are doing a great deal of good.⁸¹

Evelyn Hiscock arranged for this first class to be photographed in their uniforms and appears in the centre of the front row (see Fig. 6). Other nurses helped with the Midwives' Club and Cluny MacPherson, J. Sinclair Tait, Andrew Carnell and John Murphy provided lectures and practical training, taking individual students to confinements. It is not known if other doctors helped with the practical training. Evelyn Hiscock prepared a syllabus of lectures in 1921.⁸² Everyone volunteered their services and no tuition fee was required of the midwives.

Some women dropped out of the class during the winter of 1921 but by the spring of 1922 thirty-six were prepared for exams, at least in the mind of their instructor. When exams were offered, however, only eleven women came forward to write them. Evelyn Hiscock was disappointed by this turn out which she attributed to a number of causes. A five dollar sitting fee was required of these women. This money was intended to cover the cost of administering the Midwives' Board, and especially to

⁸¹ PANL GN 1/3a 1920, File 24.

⁸² This unfortunately disappeared some time after her death in 1944. 88-281, C11359.

pay for travel anticipated when the Midwives' Act of 1920 was applied to the whole of Newfoundland. Five dollars was a considerable sum at that time, however, and was probably prohibitively high for widows with children. Evelyn Hiscock also alluded to hostility towards these women on the part of other trained nurses stating,

I really believe if Dr. [Anna] Wilson [the examiner], Dr. MacPherson, Dr. Murphy and myself could have handled them alone we would have got the whole class, [to write the exam.] [The midwives] are I think just the least bit psychic as to the attitude of the other "ladies of the lamp" who were to supervise.⁸³

She also felt some of her students were sensitive about their lack of formal education, and may have lacked the confidence to write an exam. The eleven women who wrote the first set of exams all passed. Believing this might encourage the others, Evelyn Hiscock organized a second set of exams. All remaining members of the first class attended this sitting. One failed and thirty-four midwives graduated.⁸⁴

After the first years, the Midwives' Club attracted fewer women. In 1924, for example, eleven women were trained. In the same year, sixty graduates of the

⁸³ PANL GN 1/3a 1920, File 24.

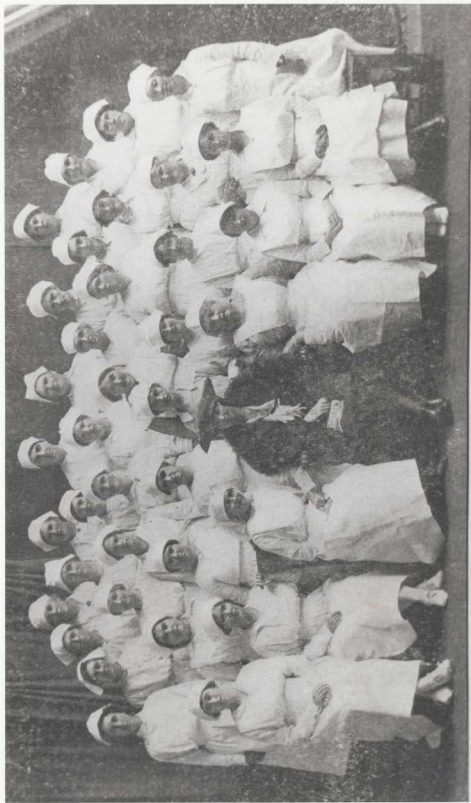
⁸⁴ There are discrepancies in information here. Thirty-six midwives appear in the photograph of the 1921 class but thirty-four are said to have graduated and one failed, which leaves one unaccounted for.

Midwives' Club were active in the St. John's area.⁸⁵ Evelyn Hiscock was not completely satisfied with the progress that had been made, however, stating that many women in the city were still being attended in childbirth by women who had "not availed of the opportunity to better equip themselves for such work, and

⁸⁵ Evelyn Hiscock, "Better Nursing Care in Newfoundland," p.29.

Fig. 6. The first graduating class of the Midwives' Club, 1922. Lillian Moody is on the extreme left hand side in the front row. Evelyn Hiscock is in the centre of the front row.

Source: The Newfoundland Quarterly.



THE FIRST CLASS OF THE FIRST MIDWIVES' CLUB INSTITUTED IN NEWFOUNDLAND.

[Photo by Hollingsby]

as a consequence many risks are taken which should not be permitted."⁸⁶ Rather than poor obstetric care, however, she cited umbilical hernia, and "eye and mouth problems" as the main complaints.⁸⁷

Graduates of the Midwives' Club went to work immediately and were soon integrated into the health care system of St. John's. Evelyn Hiscock wrote

the mental attitude of the Doctors when we started this thing was anything but favorable but now that the women are giving such excellent service (I hear) they appreciate it as they should, seeing...how hampered the Doctors were by not having skilled nursing in their work of saving lives especially amongst the people of small means.⁸⁸

During an epidemic of scarlet fever in 1923 some midwives not yet established were requested to act as nurses at the Fever Hospital and the Belvedere Orphanage. Mary Southcott and Evelyn Hiscock promoted these women as midwives for the poor, but they served all economic classes. Lillian Wandling attended the wives of merchants and lawyers as a live-in nurse-domestic, assisting a doctor at delivery and acting as nurse for the infant for several weeks after. She was also employed just for

⁸⁶ Evelyn Hiscock, "Better Nursing Care in Newfoundland," p.30.

⁸⁷ Evelyn Hiscock, "Health and Maternity Movement of 1920: Report of the Midwives' Club for 1923-24," Evening Telegram, [St. John's], 31 January 1924, p.15.

⁸⁸ PANL GN 1/3a 1920, File 24.

labour and confinement by middle-income and poor women.⁸⁹ Although they were of limited financial means Midwives' Club graduates sometimes served poor women without payment. In 1923 they provided free care for fifty destitute clients.⁹⁰ Lillian Wandling sometimes took her own bed sheets when attending poor women and put up "hundreds of bottles" of preserves a year, which she distributed to needy families that she served.⁹¹ This was apparently typical.⁹² For a brief period, St. John's midwives received government compensation for attending women who were unable to pay them. Such official recognition was usually reserved for doctors.⁹³

Although Evelyn Hiscock often promoted these midwives in terms of the help they could provide for doctors, these women also acted as independent birth attendants. Lillian Wandling, who presided at 700

⁸⁹ 88-281, C11365; C11366.

⁹⁰ Evelyn Hiscock, "Report of the Midwives' Club for 1923-24," p.15.

⁹¹ 88-281, C11365.

⁹² Evelyn Hiscock stated "the Midwives...[have] contributed generously with parcels of clothing and food for needy cases." Evelyn Hiscock, "Health and Maternity Report," The Evening Telegram [St. John's], 17 January 1923, p.8.

⁹³ In 1933, out of a total budget of \$17,900 allowed for health care of charity cases, \$1,500 was listed under "Allow to Nursing and Midwifery." PANL GN 38 S6-1-1, File 1, Department of Public Health and Welfare.

deliveries with no mortalities, delivered breech and face presentation babies alone, and even sutured perineal tears if a doctor was unavailable.⁹⁴ Like untrained midwives in the city and outport midwives, women trained by the Midwives' Club stayed with women throughout labour and visited twice a day during "the lying-in period" morning and evening, to care for mother and child. For these services, they charged about the same as their untrained counterparts.⁹⁵

Evelyn Cave Hiscock supervised the Midwives' Club until Commission of Government was established. After years of effort to train and gain recognition for these women, she was not sorry to relinquish this responsibility. The Midwives' Club provided what was perhaps the most complete obstetric education ever made available to otherwise untrained women in Newfoundland. As a result, capable birth attendants who could work independently served all economic classes in some capacity and were useful assistants to St. John's doctors for many years.

II. Commission of Government to 1961

Under Commission of Government a Department of

⁹⁴ 88-281, C11355.

⁹⁵ Lillian Wandling was paid five dollars in 1922, and never received more than ten dollars. 88-281, C11355.

Public Health and Welfare was organized. Lillian Whiteside, an English nurse who was Superintendent of Nurses from 1935 until 1939, took over the training of midwives in the early years and in the city she continued much in the same vein as the Midwives' Club.⁹⁶ Provision of health care to the outports became a priority under Commission of Government and for the first time efforts were made to train midwives outside St. John's. In 1935 Lillian Whiteside gave the first course for outport midwives.⁹⁷ This course consisted of lectures and practical instruction at the Duckworth Street public health prenatal clinic in St. John's.⁹⁸ Efforts were made to reach women unable to travel to the city as well. For example, Myra Bennett, a British-born nurse who had served in Daniel's Harbour since 1921, was instructed by the government to provide a six month training course for six local women of her own choosing. Five of these passed exams and were issued certificates.⁹⁹ Other district nurses may also have been instructed to provide similar

⁹⁶ St. John's midwife Elizabeth Day trained with Lillian Whiteside for two years. See 73-44, Ms p.5.

⁹⁷ Report by the Commission of Government on the Work of the Commission, January 1936 (London: His Majesty's Stationery Office, 1936), p.26. See 81-328, Ms p.17 for information on an outport midwife who received this training.

⁹⁸ See 73-44, Ms p.5.

⁹⁹ 84-332, Ms p.3.

training. Thirty midwives were trained in 1936.¹⁰⁰ In 1937, Department of Health and Welfare officials toured at least as far as Conception Bay North, examining midwives already active in their home communities so that they could be certified.¹⁰¹

In the first years, women were trained to act as independent birth attendants. However, there was a subtle shift in attitude towards empirically trained midwives as Commission of Government became established. At the suggestion of H. M. Mosdell, secretary of the Public Health division, St. John's midwives soon lost the right to reimbursement for charity cases.¹⁰² Cost was ostensibly the reason for this change, but it is also likely that Mosdell was attempting to curb what doctors in the city must have viewed as an undesirable degree of government recognition for midwives. Around 1938 there was also an significant change in training as instruction

¹⁰⁰ Annual Report of the Commission of Government for the Year 1936 (London: His Majesty's Stationery Office, 1937), p.9.

¹⁰¹ See 86-254, Ms p.26; p.92.

¹⁰² See GN 38, S6-1-1, File 1, "Statement of Medical and Nursing Services Situation at St. John's," 23 February 1934. Relief officers were subsequently instructed to provide no payment for midwives. See Newfoundland Department of Public Health and Welfare, Instructions to Relief Officials (St. John's: Department of Public Health and Welfare, 1935), p.9.

moved mainly to the Grace Hospital.¹⁰³ Women trained under this plan were provided with transportation costs and room and board by the Department of Public Health and Welfare. Training was supposed to last two months, but it varied from three to six weeks or three months. Perhaps this difference was due to the experience an individual brought with her. There were no exams, and one midwife was simply told that she was ready to receive her certificate after a few weeks.¹⁰⁴ No classroom instruction was provided, although mimeographed instructions were given out.¹⁰⁵ No hands-on experience was allowed; these women only observed deliveries.

In this course women were chiefly taught "when you should call a doctor; that you must be clean; [and] the terrible responsibility that lies in your hands."¹⁰⁶ Midwives were told "if the afterbirth or hand presented

¹⁰³ Training of outport midwives at the Grace Hospital under government auspices is first mentioned in the Annual Report by the Commission of Government on the Work of the Commission During 1938 (London: His Majesty's Stationery Office, 1939), p.48. Some instruction continued at the public health prenatal clinic.

¹⁰⁴ 88-281, C11384.

¹⁰⁵ Department of Public Health and Welfare, [Untitled, Mimeographed instructions for midwives], n.d. [circa 1940s]. Copies of these sheets, belonging to Elizabeth Austin, were made available to me by Sidney Morris Chipp in Grand Falls in the summer of 1983. Most of the discussion that follows is based on information from this source.

¹⁰⁶ [Mimeographed instructions for midwives], p.21.

you should call a physician immediately. Keep the patient calm and quiet as possible."¹⁰⁷ A doctor was also to be called if labour continued for more than eighteen hours, and in case of mal-presentation, eclampsia, perineal tears or haemorrhage. Breech presentation was the only complication midwives were taught to deal with alone. They were warned they could lose their licences if they invaded the birth canal. This interdiction was largely ignored because it seriously limited the midwife's ability to diagnose and deal with complications. This training represents the resolution of the midwife question in Newfoundland. Midwives were treated as though they would be doctors' assistants, although the nearest doctor might be several hours away. The government did not acknowledge these women as independent birth attendants, just as it avoided publishing lists of individual midwife-practitioners.

About 225 women were trained and licenced under this programme during Commission of Government.¹⁰⁸ Confederation with Canada had no immediate effect on policy regarding midwives in Newfoundland. Public health training continued at the Grace Hospital and outport women were still encouraged to attend. Twelve women were

¹⁰⁷ [Mimeographed instructions for midwives], p.16.

¹⁰⁸ Annual Report of the Department of Health, 1952 (St. John's: Bowden and Co. Ltd, 1953), p.12.

trained and licenced in 1951, and eight more in each of the following two years.¹⁰⁹ After 1955 however, there were never more than four women trained in any year and the average number was two. Noting that it was increasingly difficult to interest younger women in becoming midwives, and the demand for home confinement was falling off, the Department of Health stopped training and licensing midwives in 1961.¹¹⁰

It is difficult to document the decline of midwifery in concrete terms. Statistics for midwife-attended delivery of unwed mothers in St. John's were available occasionally but public health nurses began to attend home confinements during Commission of Government and may be included. These figures probably lag behind general trends as women who did not enter an institution for unwed mothers may have preferred to remain at home to avoid social censure.¹¹¹ These numbers do document a decline in births outside of institutions however. In 1943, eighty-two out of 139 such births were attended at home "by midwives, and when necessary, doctors."¹¹² In

¹⁰⁹ See Annual Report of the Department of Health 1953, (St. John's: The Trade Printers, 1954), p.131.

¹¹⁰ See Annual Report of the Department of Health, 1954, p.179; 1955, p.159; 1961, p.212.

¹¹¹ Dr. Nigel Rusted reported that married women protested vigorously if placed with an unwed mother in hospital. 88-281, C11362.

¹¹² Child Welfare Association Annual Report, 1943, p.11.

1946, the number was sixty out of 205.¹¹³ In 1950, this dropped to nineteen out of 109. By 1951 it was policy for public health nurses to attend confinements in St. John's only if the mother could not be persuaded to enter a hospital.¹¹⁴ Only indigent women were said to be relying on midwives in the city by 1964.¹¹⁵ Hospital deliveries did not eliminate empirically trained midwives as they adapted to work as private maternity nurses, providing personal care for women during hospital confinements.¹¹⁶ While this practice continued into the 1950s, it seems that most women in St. John's accepted doctor-attended childbirth in hospitals in the 1940s.

As might be expected, midwives remained active longer in the outports. In 1962, eighty-six midwives were still registered and a number of unregistered women continued to practice.¹¹⁷ Home birth was however rapidly vanishing. Ninety-seven per cent of all the births recorded in 1964 took place in hospital or a nursing

¹¹³ Child Welfare Association Annual Report, 1945, p.11.

¹¹⁴ Annual Report of the Department of Health, 1951, ([St. John's]: David R. Thistle, 1955), p.8.

¹¹⁵ Annual Report of the Department of Public Health, 1964, p.179.

¹¹⁶ 88-281, C11377.

¹¹⁷ Annual Report of the Department of Public Health, 1962, p.199.

station.¹¹⁸ Empirically trained midwives were active in rural areas even into the 1970s, occasionally attending a woman having a child out of wedlock, a woman "caught" by bad weather, a family member, or an older woman who was simply accustomed to giving birth in her own home. But these midwives had been active for many years. When they retired or died, they were not replaced.

Successive governments trivialized the role of midwife in Newfoundland, by not publishing lists of individual practitioners, by depriving them of the right to reimbursement for charity work, and by educating them to be doctors' assistants although most worked independently. But on the whole, the public health approach to the midwifery question prevailed and traditional obstetric care did not disappear in response to government policy or pressure. Rather, midwifery declined as women stopped training as midwives, and clients grew accustomed to doctor attended hospital birth. This same pattern of gradual decline without confrontation is apparent in other places where the public health approach was dominant.¹¹⁹ Many of the

¹¹⁸ Ellen W. Starr, "The Role of the Midwife in Rural Newfoundland" (honours thesis, Middlebury College, 1981), p.23.

¹¹⁹ The public health approach prevailed in New York City as well. In 1911, New York created the first municipally sponsored school for midwives. In 1935, this school was closed due to a lack of students. See Litoff, p.93; p.108.

reasons why this change occurred in such an undramatic manner in Newfoundland are to be found in the structure of the role of midwife and the nature of traditional obstetric care itself, and will be considered in following chapters.

Chapter III

Traditions of Obstetric Care

Medicalization of childbirth may be understood in terms of the outward manifestations discussed in Chapter Two: the replacement of empirically trained midwives with health care professionals and the shift from home to hospital birth. But unless this change is imposed on an unwilling population, it also involves the more subtle process of syncretism, whereby those who adhere to a traditional health care system gradually adopt many of the practices and values of medical obstetrics. This process is clearly apparent in Newfoundland.

This chapter discusses how traditional and medical obstetric systems overlapped and conflicted, detailing the way in which one type of obstetric care gradually gave way to the other. The traditional obstetric system that shaped childbearing in Newfoundland is presented below in three parts: prenatal care; labour and childbirth; and confinement. This last term is used here to denote the nine to ten day post-natal period in which the mother was literally confined to bed. There was no emic term for this phase in Newfoundland; "confinement"

included labour, delivery and recovery.¹ There was, however, a distinct post-natal period, so the term confinement has been appropriated for this use here.

Margaret Mead and Niles Newton outline two basic approaches which may be taken by birth attendants. Those who are "active" attempt to assist even normal labour, while "laissez-faire" attendants intervene as little as possible.² The approach of medical obstetric practitioners is generally active, especially in North America. Most studies of traditional obstetrics, whether based on historical analysis of European material or ethnographic study of pre-industrial peoples, have found that birth attendants in traditional systems tend to take a laissez-faire approach to uncomplicated childbirth.³ Edward Shorter is the exception to this consensus. In his historical reconstruction of European midwifery Shorter maintains that

¹ Hispanic-Americans refer to the thirty day period following birth as the dieta. Buss, p.135; Grace Granger Keyes, "Mexican American and Anglo Midwifery in San Antonio, Texas" (diss. University of Wisconsin, 1985), p.48.

² Margaret Mead and Niles Newton, "Cultural Patterning of Perinatal Behavior," in Childbearing: Its Social and Psychological Aspects, eds. S. Richardson and A. Guttmacher (New York: Williams and Wilkins Co. 1967), p.143.

³ See Donegan, p.10; Jordan, pp.11-31; Keyes, pp.139-176; Catherine Scholten, "On the Importance of the Obstetrick Art: Changing Customs of Childbirth in America, 1760 to 1825," William and Mary Quarterly, 34 (1977), p.433.

midwives of traditional Europe and England intervened furiously in the natural process of birth. Constantly tugging and hauling at the mother's birth canal, at the infant's head, and at the placenta, they were captives of a folkloric view that the best midwife is the one that interferes most.³

This chapter questions this assertion.

Attitudes towards pregnancy and childbirth are also considered below. It is not necessary to strain the imagination to see the "tripartite diachronic structure" of separation, seclusion and reentry into normal life that shaped the cultural interpretation of pregnancy and childbirth in early twentieth century Newfoundland.⁴ When Arnold van Gennep put forward this framework for the social treatment of life crises he distinguished between rites of separation and rites of protection.⁵ Separation of the pregnant woman occurs "either because she is considered impure and dangerous or because her very pregnancy places her physiologically and socially in an abnormal condition."⁶ Rites of protection are intended "to protect mother and child...against evil forces, which

³ Shorter, p.59. See Shorter pp.58-65 for his detailed reconstruction of meddlesome traditional obstetrics.

⁴ Victor Turner, The Ritual Process: Structure and Anti-Structure (Ithaca: Cornell University Press, 1969), p.14.

⁵ Arnold Van Gennep, The Rites of Passage (Chicago: the University of Chicago Press, 1960), trans. Monika B. Vizedom and Gabrielle L. Caffee, pp.41-49.

⁶ van Gennep, p.41.

may be impersonal or personified."⁷ In Newfoundland, the distinction between separation and protection of mother and infant was not always clear, in part because pregnancy was not as overtly connected with pollution or danger here as it was in many of the pre-industrial cultures van Gennep examined. It is, however, possible to discern the idea of pregnancy as a dangerous state and its association with impurity.

Medical materialism, the tendency to rationalize past or primitive ritual and belief in terms of current concepts of medicine or hygiene, has been used both to defend and revile traditional obstetrics through comparison to a type of care that was unavailable or did not even exist when empirically trained midwives were active.⁸ In this chapter, I will attempt to avoid the approach of medical materialism. This is sometimes difficult because empirical observation, important in all health care systems, often leads adherents of different systems to adopt apparently similar practices which may in fact have a very different underlying rationale. Where such overlaps occur, it may be difficult for the

⁷ van Gennep, p.41.

⁸ See Mary Douglas, Purity and Danger: An Analysis of Concepts of Pollution and Taboo (London: Routledge and Kegan Paul, 1966), pp.29-32 for discussion of medical materialism. This concept shapes much of Shorter's analysis of traditional obstetrics. See Shorter, pp.35-138.

researcher to resist the urge to "make sense" of traditional health care by casting these practices in terms of current medical knowledge. But medical materialism avoids a more significant issue for the folklorist: the meaning of these practices to the people who used them in the context of their own time and culture.

Because Newfoundland midwives began to incorporate innovations from medical obstetrics into their practice early in the twentieth century, it is necessary to determine where possible which practices and beliefs originated in which health care system. This is not done out of any purist sentiment, but to facilitate description of the health care system which prevailed prior to the medicalization of childbirth, and determine how and to what degree these traditions were influenced by modern innovations.

Prenatal Care

The prenatal care of medical obstetrics was certainly lacking in Newfoundland. Even in St. John's the first prenatal clinic, operated briefly by the Child Welfare Association in 1927, closed because of lack of attendance and was not re-established until 1934.⁹ Child

⁹ This prenatal clinic opened in April, 1927 but it was reported that "attendance has not been encouraging." Child Welfare Association Annual Report 1927, p.19. After

Welfare Association annual reports consistently note lack of medical prenatal care in the city. As late as 1957 most women in St. John's did not visit a doctor until mid-pregnancy, and no concerted effort was made by doctors to provide regular prenatal care until the late '50s.¹⁰

Lack of medicalized prenatal care was most evident in the outports. District nurses tried to screen women during pregnancy to detect complications requiring hospitalization. Some midwives trained by doctors and a few with no formal training also monitored women near the end of pregnancy to determine a due date and anticipate problems.¹¹ Well into this century, however, many women would see a nurse, midwife or doctor only to engage them for the delivery. The government promoted medicalized prenatal care from the time of Commission of Government, and trained midwives were expected to provide advice on diet, rest, exercise and hygiene to their clients. But Mary Sweetapple, midwife in Hodge's Cove, Trinity Bay and

1927 it was not mentioned until 1929 when it was said to have been unsuccessful. Child Welfare Association Annual Report 1929, p.5.

¹⁰ 88-281, C11357.

¹¹ See 76-255, Ms p.7 for information about a doctor-trained midwife who provided such prenatal care. See 78-119, Ms p.22 and 79-508, Ms p.5 for references to midwives with no formal training. Unfortunately, these latter papers are based on posthumous material, so information about care is sketchy.

Glovertown in the 1950s and '60s rarely saw her clients before they delivered and her experience was not unique.¹²

In many areas women would engage the midwife when they met on the road.¹³ One midwife was often engaged without seeing her clients at all. In Muddy Hole, Hermitage Bay, Mary Elizabeth Wells was approached by the father-to-be in an indirect manner. The midwife understood his purpose and replied "I delivered the others so I might as well deliver this one."¹⁴ In other places, it was customary to engage the midwife during a formal house visit.¹⁵ At that time she determined a probable due date and gave basic prenatal advice.¹⁶ Constipation was often discussed at such times as it is a common discomfort of pregnancy, but also because it was

¹² 88-281, C 11384. This was also the experience of Mary Guzzwell a district nurse who ran prenatal clinics in Winterton, Trinity Bay and Labrador in the 1930s. See 78-116, Ms p.27. Also see 79-417, Ms p.29; 80-229, Ms p.3; 88-281, C11356.

¹³ Josephine Kennedy engaged her midwife and a doctor who attended one of her deliveries in this way. 88-281, C11358.

¹⁴ 79-508, Ms pp.4-5. Louis Chiaramonte found that skilled craftsmen were often engaged in a similarly indirect manner. Louis J. Chiaramonte, Craftsman-Client Contracts: Interpersonal Relations in a Newfoundland Fishing Community (St. John's: Institute of Social and Economic Research, 1970), p.22.

¹⁵ See 75-21, Ms.p.7; 76-258, Ms. p.11; 88-281, C11379.

¹⁶ 88-281, C11379.

considered to be an important root of ill health in traditional medicine.

Because of this limited contact between midwife and client it is usually assumed systematic prenatal care was entirely lacking in traditional obstetrics.¹⁷ Pregnancy-related beliefs have been widely documented, but are rarely understood as part of an obstetric system. In spite of the fact that Newfoundland women seldom saw midwives during pregnancy, it would be wrong to assume that prenatal care was ignored. Traditional prenatal care did not depend upon specialized knowledge dispensed by recognized healers. Rather, this information was shared by many.¹⁸ This is attested to by a huge body of material concerning prenatal occurrences and their impact on pregnancy, presented as prohibitions against specific kinds of behaviour and cautionary narratives describing transgressions of customary treatment and behaviour of pregnant women.

Knowledge of this prenatal care was shared by all adults, especially women. Student collector Carol Ann Ruby was told "the pregnant woman was protected from as

¹⁷ See, for example, Ann Oakley, The Captured Womb: A History of Medical Care of Pregnant Women (Glasgow: Bell and Bain Ltd., 1984), pp.11-12.

¹⁸ A "high degree of shared knowledge between public and practitioner" is seen as a definitive characteristic of traditional health systems. See Irwin Press, "Urban Folk Medicine. A Functional Overview," American Anthropologist, 80 (1978), p.71.

much stress as possible by the older women of the community, especially relatives who dictated the acceptable mode of behaviour [during pregnancy]."¹⁹ Midwives also contributed by relating narratives about prenatal behaviour and offering informal advice, especially as one midwife noted, when a woman was "doing something she shouldn't, such as lifting heavy objects or reaching."²⁰ Although midwives were not involved in day to day care, one could be called upon for advice and aid, especially if complications occurred. Mary Norris described how Agnes Horwood helped her during a miscarriage.²¹ In less serious circumstances, a midwife on the Southern Shore was once called at three a.m. because a pregnant woman craved a type of fish not available in the community. The midwife dispatched her husband to St. John's by horse and cart, a round trip of about sixty kilometres, lest the unborn child be marked by the mother's unsatisfied craving.²²

Traditional prenatal care pervaded every aspect of the pregnant woman's life. At the beginning of this century, an obviously pregnant woman stayed out of public

¹⁹ 78-211, Ms p.36. Also see 76-494, Ms p.13 and 84-383, Ms p.5.

²⁰ 76-258, Ms. p.11.

²¹ 88-281, C11364.

²² 72-49, Ms p.8.

view as much as possible.²³ Although she might be required to work at the fish flakes and stages, she did not attend social events. This was rationalized in different ways by different women. Some recalled pregnancy as an embarrassment, perhaps because it proclaimed a woman to be sexually active.²⁴ Other women cited lack of proper maternity clothes as a reason for staying out of sight.²⁵

But this practice also reflects customary separation based on the relation of pregnancy to ritual impurity, an idea fostered by church doctrines and folk interpretations of them. For example, some Anglicans believed that a pregnant woman could not be a God-parent because she was not allowed to approach the font.²⁶ In some Catholic communities, pregnant women either remained at home or entered the church after most people to sit in

²³ French-Canadian women in nineteenth century Maine lived "in near total seclusion from the public" while pregnant. See Roger Paradis, "Henriette, la capuche: The Portrait of a Frontier Midwife," Canadian Folklore canadien, 3 (1981), p.114.

²⁴ See 78-211, Ms p.36; 82-126, Ms p.25. Elizabeth Roberts found similar attitudes among contemporary working-class women in northern England. See Elizabeth Roberts, A Woman's Place: An Oral History of Working-Class Women, 1890-1940 (Oxford: Basil Blackwell, 1984), p.104.

²⁵ 75-21, Ms p.4.

²⁶ 78-211, Ms p.79. Some Roman Catholic women were also not permitted to act as God-parents while pregnant, but no rationale was given. See 76-351, Ms p.6; 88-281, C11358.

"the choir," located at the rear of the church.²⁷ Mary Harriet Doyle was told that the choir was referred to as "the maternity ward" because of this. After Mass, pregnant women waited for the congregation to leave the church before going home.²⁸ One woman explained this was a way of allowing pregnant women to leave the church discreetly if they became ill during the service.²⁹ But nausea is only a problem in the first trimester of most pregnancies, and women remained apart from the main congregation throughout their pregnancies in some places, so this was unlikely to be the only reason for the practice. The concept of impurity will be returned to below.

Ordinary housework included strenuous tasks such as washing clothes by hand and scrubbing floors on hands and knees. "Women's work" in the outports also included keeping a garden, and in many communities women worked side by side with men in the labour-intensive process of "making" (salting and drying) fish.³⁰ While children were

²⁷ French-Canadian women in nineteenth century Maine refrained from attending church in the last months of pregnancy. See Paradis, p.114.

²⁸ 75-21, Ms p.3.

²⁹ 88-281, C11358.

³⁰ See Hilda Chaulk Murray, More Than Fifty Percent: Woman's Life in a Newfoundland Outport, 1900 to 1950 ([St. John's]: Breakwater Books Ltd., 1979), Chapter Two for a detailed description of the role of women in the in-shore fishery, and pp.112-132 for a description of

expected to share household responsibilities, and even families of modest means employed young, unmarried women "in service" as domestic help, the lot of married women was not easy.³¹

Hilda Murray found that women's work in outport Newfoundland before 1950 was "more than fifty percent" of the family labour. Near the end of World War II, T. O. Garland and D'Arcy Hart reached the same conclusion in their study of tuberculosis. In contrast to the United States and Britain, women in Newfoundland suffered a higher rate of tuberculosis than did men. They concluded,

it is usually believed that the higher male tuberculosis death rate in Britain and other countries is due to the greater stress of the man's life and his greater opportunities for infection. If that be true, it would not be difficult to explain the higher female rate in Newfoundland by the extremely hard life led by the women in the inshore-fishing outports. These women not only have their housework, but they also may toil in their vegetable gardens (often at a distance from their houses), milk cows, and in addition help to prepare bait, nets, etc. and assist with the daily fishing catch. On the other hand, while

housework in an outport.

³¹ In the early decades of this century, many women supported themselves by working as domestic servants before marrying. They received only a few dollars a month plus room and board. See Dona Lee Davis, Blood and Nerves: An Ethnographic Focus on Menopause (St. John's: Institute of Social and Economic Research, 1983), pp.57-59; Nancy M. Forestell, "Women's Paid Labour in St. John's Between the Two World Wars," (M. A. thesis, Memorial University of Newfoundland, 1987), Chapter Four, "'It Was the Thing to Do:' Domestic Service," pp.128-150.

the men folk have a fatiguing life during the short fishing season, a large percentage of them is without a regular occupation during the winter.³²

In spite of the arduous nature of women's work, attitudes about work during pregnancy varied greatly. One woman recalled that neighbours helped expectant mothers with housework and "all in all, the pregnant woman led a fairly pampered and easy life because of her condition."³³ But some women continued to work in their gardens and on the stages until the seventh or eighth month of pregnancy.³⁴ In Portugal Cove

women worked on the flakes, lifted barrels of fish and cared for their homes up to the minute prior to delivery...[the pregnant woman] was expected to continue to carry her share of the family burdens. She did so and apparently considered it part of her duty.³⁵

Many women struggled with their usual household tasks during pregnancy regardless of attitudes towards pregnancy and work. One woman, who believed that she miscarried during her first pregnancy because of her usual household chores, was nevertheless unable to reduce her work load in subsequent pregnancies because she had

³² T. O. Garland and D'Arcy Hart, Tuberculosis in Newfoundland in 1945 (n.p.: Trade Printers and Publishers Ltd., n.d.), p.21.

³³ 72-251, Ms p.3.

³⁴ 76-255, Ms p.8. Also see 81-328, Ms p.14.

³⁵ 78-211, Ms p.63.

no help.³⁶

Some people believed that hard work was good for pregnant women and even eased childbirth, a belief also collected in Germany and Finland in the early twentieth century.³⁷ Edward Shorter sees this as a manifestation of "husbandly indifference to the wife's health" which enabled communities to "elaborate justifications for keeping hugely pregnant women in the fields."³⁸ In Newfoundland, the amount of work done by a pregnant woman was more likely to be dictated by necessity than attitudes or beliefs. Many people felt that strenuous labour was harmful during pregnancy.³⁹ This wide variation in attitudes may explain why there are apparently no narratives attributing harm to mother or child to overwork. One prohibition about physical activity during pregnancy was more uniform. This widespread belief, still current in Newfoundland and other places states that lifting over the head during pregnancy may "cord" the baby, wrapping the umbilical

³⁶ 88-281, C11358.

³⁷ 73-161, Ms p.3; 79-417, Ms pp. 29-30; 81-328, Ms p.25. For European references see Shorter, p.53.

³⁸ Shorter, p.53.

³⁹ See 72-251, Ms p.26; 76-255, Ms p.8; 76-494, Ms p.13; 79-508, Ms p.5.

cord around its neck.⁴⁰ This may cause the child to strangle or be held in the birth canal by the umbilical cord.

Most prenatal beliefs in Newfoundland concern "maternal impressions," the idea that experiences of a pregnant woman directly influence the character, appearance and well-being of her child. Herbert Halpert states this is part of "a folk belief, still actively held in the United States and the British Isles, that an unborn child can be 'marked' by any experience that makes a strong physical impression on the mother during pregnancy."⁴¹ The theory of maternal impressions was once part of formal medicine.⁴² Although medical men in early

⁴⁰ 72-251, Ms p.3; 78-211, Ms p.66; 88-281, C11371; one St. John's woman blamed her daughter for cording her grandchild, born in 1984, because the daughter hung out her own washing while pregnant. This belief was also held by a nineteenth century French-Canadian midwife in Maine. See Paradis, p.115. For working class women in Britain in the early twentieth century see Maternity: Letters from Working Women, ed. Margaret Llewelyn Davies, 1915; rpt. (London: Virago Press, 1978), p.103. For Mormon women in Utah in the 1970s see Austin Fife, "Birthmarks and Psychic Imprinting of Babies in Utah," in American Folk Medicine: A Symposium, ed. Wayland Hand (Berkeley: Univ. of California Press, 1976), p.280. For present-day Ontario see Carpenter, "Tales Women Tell," Canadian Folklore canadien, 7 (1985), p.22. For Hispanic-Americans see Keyes, p.48 and Kay, p.56.

⁴¹ Herbert Halpert, "Legends of the Cursed Child," New York Folklore Quarterly, 14 (1958), p.233.

⁴² Angus McLaren notes that this idea was widespread among physicians until the mid-eighteenth century. His examples are identical to beliefs collected in twentieth century Newfoundland. Angus McLaren, Reproductive Rituals: The Perception of Fertility in England from the

eighteenth century England began a campaign to discredit this theory, doctors continued to report cases of maternal impressions in medical journals into the nineteenth century.⁴³

A few examples of maternal impressions found in Newfoundland concern emotional states. Occasionally, it was said that the mother's disposition during pregnancy would influence her child's character. One collector was told "if you were crooked and stubborn then the child would 'turn after' (have the same temperament) [as] the mother."⁴⁴ However, the most common expressions of maternal impressions are "marking stories," which explain birthmarks and physical deformities of the child.⁴⁵ Credence in these beliefs declined in this century in Newfoundland, but not entirely. Dona Davis notes "young women regard many of their mothers' and grandmothers' beliefs about pregnancy and birth as old-fashioned and ungrounded in fact (except for the

Sixteenth to the Nineteenth Century (London: Methuen, 1984), p.50.

⁴³ See McLaren, p.50 and Jennifer J. Connor, "Folklore in Anglo-Canadian Medical Journals 1845-1897," Canadian Folklore canadien, 7 (1985), pp.42-51.

⁴⁴ 76-351, Ms p.6. For similar beliefs see 72-62, Ms p.11; 72-251, Ms p.3. This idea is found among Mexican and Hispanic-American women. See Kay, p.57.

⁴⁵ For examples from the American south see Wayland D. Hand, Frank C. Brown Collection of North Carolina Folklore (Durham, N. C.: Duke University Press, 1961), Vol. VI, pp.17-23.

causes of birthmarks, which are still widely believed)."46

Marking stories are grouped by Violetta Halpert into three major categories according to the cause of harm. These are: "unsatisfied food craving on the part of the mother; direct physical injury to the mother; and frightening experiences during pregnancy."<47 Herbert Halpert adds a fourth category: harm caused by behaviour of a parent.⁴⁸ Halpert refers to social behaviour rather than physical activity. Many Newfoundland narratives incorporate other, related beliefs. For example, many women believed that marks caused by a fright or injury could be averted if the woman held her hips instead of touching another part of her body or the place where she was injured.⁴⁹ If this was not done, the child's body was always marked where the mother touched herself.

A mother's unsatisfied craving for a food was believed to result in birthmarks rather than more serious deformities. Marks often took the shape and colour of the longed-for food. Craving for berries, for example would

⁴⁶ Dona Davis, p.83.

⁴⁷ Halpert, p.233.

⁴⁸ Halpert, p.234.

⁴⁹ See Hand, Frank C. Brown Collection, Vol. VI, p.20. For Newfoundland examples see 71-99, Ms pp.3-4; 78-211, Ms p.68; 84-364, Ms p.7; 88-281, C11353.

result in a berry-shaped birthmark.⁵⁰ Longing for rabbit meat could cause a mole covered with hair on the infant. This belief was taken seriously enough to send husbands of pregnant women who longed for rabbit meat out hunting as a prophylactic measure. One man was afraid his child might be born deformed if the craving was not satisfied, but this idea was not common.⁵¹ Unsatisfied cravings during pregnancy could also leave the child fretful, due to a permanent hunger for the food.⁵²

Physical harm to the mother could also cause birthmarks. For example, a pregnant woman who was "lightly kicked" on the leg by a horse immediately knelt down and touched the place, causing a hoof-shaped birthmark on her child's leg.⁵³ In another case, a child was born with a purple mark on his nose because the mother rubbed a bee sting on her nose.⁵⁴ More serious

⁵⁰ This idea was popular with doctors in eighteenth century England. See McLaren, p.50. Many examples have been collected in North America, even recently. See Fife, pp.277-278 for examples from Utah in the 1950s to 1970s and L. F. Snow, and S. M. Johnson, "Folklore, Food, Female Reproductive Cycle," Ecology of Food and Nutrition, 7 (1978), pp.44-45, for items from Michigan in the 1970s. For Newfoundland examples see 71-99, Ms p.3; 72-49, Ms p.7; 72-251, Ms p.25; 75-21, Ms p.7; and 78-211, Ms p.70.

⁵¹ 75-21, Ms p.6.

⁵² 75-21, Ms p.6; 88-281, C11379; C11380.

⁵³ 71-99, Ms p.3.

⁵⁴ 71-99, Ms p.4.

harm might result from such injury. A woman who broke her leg during pregnancy was said to have had a child with a deformed leg.⁵⁵ But this belief was not widespread.

The third category of marking stories concerns frightening experiences during pregnancy. For example, a woman frightened by a goat during pregnancy gave birth to a child that had "a brown patch of skin on her face covered with hair."⁵⁶ A registered nurse-midwife related the following narrative about her own birthmark:

J. M. ...my grandmother used to say that if a woman was frightened by a mouse she'd have, the baby would have a birthmark like a mouse (laughter, as informant indicates a large, oval shaped birthmark on her right forearm). Where did that birthmark come from?

A. K. That's my mouse. I was saying to the women the other night, a friend of mine, you know, I had short sleeves on you see and I said "Did you see my mouse?" (laughter) ...My mother was pregnant, she was in the early stages of pregnancy. I think you got to be in the early stages of pregnancy for these marks to happen to you. And my father, he had a mouse by the tail, a dead one, and chasing her with it. (laughter)

J. M. I guess nobody had ever told him that.

A. K. He didn't know she was pregnant and he didn't know anything, I don't think. He was only a young man, twenty-two years old. And she ran into the bedroom screeching to him you know and he was trying to open, trying to push the door you know and she says, "Oh you fool, don't you know I'm pregnant!"

⁵⁵ 71-84, Ms p.1.

⁵⁶ 71-99, Ms p.3.

J. M. And that was how he found out?
(informant nods).⁵⁷

Narratives such as this are usually told in a more serious tone. For example, a birthmark on the side of a man's face was attributed to a shock his mother received during pregnancy when she saw a horse injured by falling through an old fishing stage.⁵⁸ The woman "unthinkingly put her hand to her face, thus guaranteeing that the baby would be marked."⁵⁹

Related stories deal with more severe deformities. For example, a midwife trained at the Grace Hospital and active from 1949 to 1976, delivered a child in the 1970s deformed by "the many frights the mother got while carrying the baby."⁶⁰ While this woman was pregnant a neighbour died, her father-in-law was very sick and her brother-in-law wounded himself with a shotgun. The baby was born with what sounds like a severe case of spina bifida. The midwife felt the "big red place on [the baby's] back" looked like a gun shot wound, and was mainly due to the mother's shock at her brother-in-law's accident.

In both these cases, mothers experienced unavoidable

⁵⁷ 88-281, C11353.

⁵⁸ 78-211, Ms p.68.

⁵⁹ 78-211, Ms p.68.

⁶⁰ 77-139, Ms p.19.

stress. Other narratives emphasize the responsibility of those close to the pregnant woman to protect her from stress. The midwife who described how her own mouse-shaped birthmark was caused related a narrative making this point.

J. M. What about cravings? I heard some people say, well, if a pregnant woman has a craving you should give her the food that she wants 'cause it's bad for the baby if you don't.

A. K. Well they say if you, if you put your hands anywhere on you'll probably mark the baby. I know I did see one girl, a little girl that had marks on her. And her mother told me what caused it was her brother-in-law had the first of the blueberries and he came into her house with 'em and had 'em in a dish and he was "You want some?" and he'd poke them across the table to her and took it away, you know, tormenting her. She got sort of fed up with it...and she put her hands up here (puts her hands over her face). She'd, she had the two marks around the baby's eyes, on the little one's eyes.

J. M. What kind of marks?

A. K. Red marks, they were red marks.⁶¹

This narrative combines a number of beliefs. The pregnant woman is subjected to undue emotional stress, an idea closely related to beliefs about frightening experiences. The child is marked partly because of an unsatisfied craving and because the mother touched her face under

⁶¹ 88-281, C11353.

duress.

The final category concerns the belief that a child could be marked by sinful or unjust behaviour of the parents. Herbert Halpert's examples include legends in which cruel behaviour of an entire family results in deformities visited upon several generations of children.⁶² Such narratives are uncommon in Newfoundland. Here the actions of the mother alone usually result in harm to the child of one pregnancy only.

A woman could mark her child by being excessively cruel during pregnancy. One woman who kicked some sheep that got into her garden gave birth to a baby with a mark resembling a sheep's head.⁶³ But the most common theme in this category concerns the belief that a pregnant woman should not mock anyone with a deformity or affliction. In such narratives, a mother who mocks a mentally retarded or crippled person gives birth to a child with the same condition.⁶⁴ One collector found

crippled arms and legs in a newborn were often said to result from mocking a person afflicted with a crippled arm or

⁶² Halpert, p.235.

⁶³ 78-211, Ms p.72.

⁶⁴ See Hand, Frank C. Brown Collection, Vol. VI, p.23 and Helen Creighton, Bluenose Magic: Popular Beliefs and Superstitions in Nova Scotia (Toronto: McGraw-Hill, Ryerson, 1968), p.142. For Newfoundland see 78-211, Ms pp.72-73; 88-281, C11353.

leg. It was believed that the deformity was sent from God and to teach a lesson never to mock an afflicted person.⁶⁵

One midwife delivered the child of a woman who, during her pregnancy, mocked another woman in church for wearing a funny looking hat. The child was born with "a birthmark the shape of a hat" on its head and died. The midwife and the mother "agreed that this was her punishment for making fun while in a place of worship" and both held the mother directly responsible for the harm that befell the child.⁶⁶ Because the pregnant woman was not mocking a physical handicap and the retribution was death, this narrative is more extreme than most.

After birth, minor harm caused by violations of proper prenatal care could sometimes be remedied. A piece of afterbirth placed on the mark for an hour might remove a birthmark.⁶⁷ Both birthmarks and cravings for foods might be cured if the child was given the juice of or a piece of the desired food wrapped in cloth to suck

⁶⁵ 75-21, Ms p.7.

⁶⁶ 77-139, Ms p.18. The midwife was Roman Catholic and the mother was Salvation Army so this belief was not limited to members of either religion.

⁶⁷ 78-211, Ms p.74; 88-281, C11378; C11379. Hand reports that "rubbing of the birthmark with the afterbirth, or with placental blood [is] the common European prescription" for curing birthmarks, and this is also found in the United States. Hand, Frank C. Brown Collection, Vol. VI, p.18.

on.⁶⁸ Touching the mark to a corpse was another cure.⁶⁹ One woman suggested this cure for her grandson who was born with a large, raised birthmark on his forehead. She took the child to a church where a dead relative awaited burial, and touched the hand of the corpse to the mark, saying, "in the name of the Father, Son, and Holy Ghost, I believe." The birthmark disappeared gradually after.⁷⁰ One common type of birthmark, known by the medical term "strawberry mark," is "bright red and slightly raised, with a tendency to grow larger before shrinking and finally vanishing."⁷¹ The fact some marks disappear spontaneously helps to explain continued belief in various cures.

In his discussion of narratives in which harm befalls a child as a result of unkind or wrongful actions

⁶⁸ Hand states "prominent among other methods of removing birthmarks in the United States is ...to feed the baby a few drops of whatever caused the mark." Hand, Frank C. Brown Collection, Vol. VI, p.18. For Newfoundland examples see 75-21, Ms p.7; and 78-211, Ms p.62 in which colic is said to be caused by unsatisfied longing during pregnancy and the same cure is described.

⁶⁹ Hand reports that this cure is known "from Nova Scotia to California" and in Europe as well. Hand, Frank C. Brown Collection, Vol. VI, p.18.

⁷⁰ 84-358, unnumbered Msc. The woman who performed this cure believed that it would only work if the dead person was of the opposite sex of the marked child. She also thought that the mark disappeared as the dead person rotted, which is similar to some wart cures which use meat. This event occurred in 1972.

⁷¹ Peter Wingate, The Penguin Medical Encyclopedia (Baltimore: Penguin Books, 1972), p.62.

during pregnancy, Herbert Halpert concludes that it might be possible to "use this group of stories in an attempt to define what folk tradition would regard as a moral code by showing what things are punished."⁷² The Newfoundland material indicates that Halpert's hypothesis can be expanded to include all prenatal narratives. It is possible to discern not only a code of behaviour for the pregnant woman, but the responsibilities of the community towards her as well.

Women curtailed social life during pregnancy and remained out of sight as much as possible. Attitudes toward physical labour varied, but the pregnant woman was not to lift above the head, lest the baby be "corded." Some people also felt that pregnant women should maintain a cheerful disposition, and it was more commonly believed that they should not treat others cruelly. Those close to a pregnant woman were expected to protect her from physical harm, frightening experiences and undue stress, and make an effort to satisfy her cravings. Any violation of this code might damage the unborn child.

In addition to defining a code of behaviour for pregnant women and those close to them, these beliefs and practices constitute a system of prenatal care. The single unifying theme is the concept that any

⁷² Halpert, p.240.

transgression of proscribed behaviour, either by mother or those around her, could directly harm the infant. These traditions were a form of preventative health care intended to protect the infant from disfiguring marks and deformity. Preventative measures could be taken by anyone, husbands who endeavoured to provide their wives with the food they craved, for example. But the main responsibility rested with the mother, as her behaviour was most likely to harm the child.

The focus on the infant alone is striking. Many cultures elaborated prenatal beliefs to ensure safer or less painful labour for the mother. But, except for the connection between hard work and an easy labour, such beliefs were uncommon in Newfoundland.⁷³ Constipation was the only physical discomfort widely dealt with, and symptoms now recognized to indicate danger to mother and child, such as blurring of vision and excessive swelling of face and hands, were ignored. Marking of the infant had no effect upon the health of mother, who was regarded as relatively safe until labour began.

⁷³ Another belief which aimed to ease labour was recorded by Carol Ann Ruby. She was told that "sexual relations between husband and wife were to continue during pregnancy. The midwife maintained that the more frequent these 'occasions,' the less difficulty the woman would have in delivering her child....One midwife recommended that a week before the delivery the married couple should spend an entire night indulging in such activities." 78-211, Ms p.66-67. Similar beliefs are found among Hispanic-Americans. See Kay, p.57.

Traditional prenatal care was a reflection of demographic realities. The likelihood that a child would die in the first year of life was extremely high. And, although women died as a result of pregnancy and childbirth at a much greater rate than they do now, a mother was never as vulnerable as a child. Gestation was an uncertain, even dangerous process. Traditional prenatal care relieved anxiety by allowing a degree of control over the highly uncertain fate of the unborn child.

Labour and Delivery

In Newfoundland, attitudes towards childbirth were revealed in language. The term "took sick" meant going into labour and a woman giving birth was said to be sick.⁷⁴ Sick was also less commonly used as a euphemism

⁷⁴ See 75-21, Ms p.10; 75-285, Ms p.2; 78-21, Ms p.80; 78-401, Ms p.12; 78-415, Ms p.10; 78-401, Ms p.12; 82-166, Ms p.15; 84-332, Ms p.33; 84-379, Ms p.5; 88-281, C11364. Similar terms were used in early America. In 1677, Samuel Sewall, a Massachusetts Puritan, described in his journal how he "waked and perceived my wife ill" when she went into labour. Deborah A. Cozort, "Travail: The Midwife and the Pregnant Christian" (honours thesis, University of Massachusetts, 1973), p.52. Martha Moore Ballard, a midwife in Maine from 1778 to 1812, routinely referred to women in late pregnancy and labour as "unwell" and "ill." Wertz and Wertz, p.10. A nineteenth century Mormon midwife also referred to women in labour as "sick." Claire Noall, "Mormon Midwives," Utah Historical Quarterly, 10 (1942), p.105. In early twentieth century Northern Ireland, women in uncomplicated labour were said to have "took bad." Linda-May Ballard, "Just Whatever They Had Handy: Aspects of Childbirth and Early Child-care in Northern Ireland Prior

for pregnant.⁷⁵ Such usage was so pervasive that people tend to take it for granted and examples abound.⁷⁶ A registered nurse worked in a hospital "until I got sick, pregnant."⁷⁷ One midwife referred to the home of a woman in labour as a "sick house" and another called a woman who gave birth a "sick woman."⁷⁸ Mothers were also said to be sick during confinement following birth.⁷⁹ Sick, ill and indisposed were also euphemisms for menstruation. Pregnancy, childbirth and menstruation were probably not viewed as illnesses, but such usage indicates that were they not regarded as normal states of health.

to 1948," Ulster Folklife, 31 (1985), p.66. Mayan women refer to the pregnant woman as enferma, from the Spanish word enfermedad, illness. Jordan, p.22. Enferma is also used by Hispanic-Americans, who say ya sano and ya se compuso (has healed or gotten well) after delivery. Keyes, p.49.

⁷⁵ This use was so common that the DNE defines "sick" as pregnant. "Sick," DNE, p.479. Sick was also used in the usual sense. Thus a woman might "take sick" (go into labour) at a time when the midwife was sick with the flu and unable to attend her. Hispanic-American women used the expression "ill with child" as a euphemism for pregnant. Kay, p.55.

⁷⁶ Murray, for example, never discusses this usage, but when an informant stated she was "...fraid I would take sick...in the middle of the night," Murray notes that she was referring to labour. Murray, p.88. Only spontaneous, unambiguous use of sick to refer to pregnancy or labour will be used in this discussion.

⁷⁷ 88-281, C11353.

⁷⁸ See 75-21 p.11 for "sick house" and 88-281, C11356 for "sick woman." The woman referred to was not experiencing complications.

⁷⁹ 75-21, Ms p.25; 78-211, Ms p.80.

Dona Davis found "the trauma and drama of giving birth, especially in the old days, [was] a favorite topic of conversation" among her informants.⁸⁰ She felt that the "lore surrounding childbirth reflects the reality of fear. Most women feared and dreaded childbirth."⁸¹ While this is a fairly sweeping generalization, childbirth was certainly not treated casually. A woman might give birth alone or with the help of a friend if the midwife was delayed by bad weather or another delivery, or if labour was precipitous. But this was accidental and Newfoundland women, unlike some other Anglo-Americans, never willingly gave birth without a skilled attendant.⁸²

Before medicalization, the midwife was commonly aided in her work by "a few responsible women of the neighbourhood."⁸³ This was true in seventeenth century England and eighteenth century America.⁸⁴ In Newfoundland

⁸⁰ Dona Davis, p.67.

⁸¹ Dona Davis, p.68.

⁸² In contrast, in North Carolina, women are said to have delivered unassisted by choice. "There were women who never bothered with them [midwives]. [An informant said] 'Now some women'ud have their babies by theirselves and take care of them and get up and go on back to th'fields t'work.' Elliot Wigginton, ed., Foxfire 2 (Garden City, N.Y.: Anchor Press, 1973), p.281.

⁸³ R. V. Schnucker, "The English Puritans and Pregnancy, Delivery and Breast Feeding," History of Childhood Quarterly, 1 (1974), p.640.

⁸⁴ For Britain see Alice Clark, The Working Life of Women in the Seventeenth Century (London: George Routledge and Sons, Ltd. 1919), p.269; and Donnison, p.3.

it is sometimes difficult to ascertain who was in the room during birth, but the traditional pattern prevailed in some places. For example, Olive Bishop, who was a district nurse in Hermitage Bay, told of a midwife who dropped dead in the middle of a delivery. The women in the room with her assumed she had fainted and completed the delivery.⁸⁵ Another woman described how "one of the women who came to help the midwife" supported her while she gave birth.⁸⁶

Such women provided mother and midwife with assistance and moral support and were witnesses who could vouch that no incompetence or deliberate harm occurred. Perhaps most importantly, these women gained practical obstetric knowledge, becoming the passive bearers of obstetric traditions from whom the next generation of midwives would be chosen. The concept of active and passive bearers of tradition was first put forth by Carl von Sydow with reference to folktale transmission.⁸⁷ Unlike folktales, obstetric knowledge may be communicated outside of the "performance" situation of labour and

For America see Leavitt, Chapter Four, "Only a Woman Can Know: The Role of Gender in the Birthing Room," pp.87-115; Wertz and Wertz, pp.2-5; Scholten, p.432.

⁸⁵ 88-281, C11369.

⁸⁶ 74-21, Ms p.14.

⁸⁷ C. W. von Sydow, "Folktale Studies and Philology: Some Points of View," in The Study of Folklore, ed. Alan Dundes (Englewood Cliffs: Prentice Hall, 1965), pp.219-242.

delivery, and in this sense midwives were not the only active bearers of these traditions. But women present at childbirth may be regarded as passive bearers because they did not act upon their obstetric knowledge.

Because they were present at childbirth and listened to stories about deliveries, many women had good understanding of the management of childbirth. The basic obstetric skills of ordinary women are attested to in the many narratives of those who successfully attended births in emergencies. For example, in the 1930s Mary Norris was called to aid a neighbour in St. John's because it was known she previously assisted a midwife when a friend gave birth to twins.⁸⁸ The neighbour had engaged both midwife and doctor, but the midwife was busy at another birth, and the doctor was not called, perhaps because the family could not afford him. With reluctance, Mary successfully delivered the child, cut the umbilical cord, wiped the baby's mouth and eyes, and wrapped the child in a blanket, acting on memory of her friend's delivery.

Dorothy Prince found herself alone with a neighbour who gave birth while the husband was fetching a midwife in Princeton, Trinity Bay in the 1940s. The delivery was complicated because the umbilical cord was wrapped around the baby's neck and Dorothy had to ease it over the head so that the child could be born. She then tied the cord

⁸⁸ 88-281, C11364.

in two places and cut between the ties. She was twenty-one at the time, her first child was a few months old and she had never observed a birth. Yet Dorothy cut the cord in accordance with traditional practice. If the cord was not cut in this way, Newfoundland women believed the mother or child might bleed, perhaps dangerously. Dorothy described her actions as "instinctive," and had no idea how she learned to do this.⁸⁹ Basic obstetric skills were simply part of the everyday knowledge of many adult women.

Women who became midwives were chosen from such passive bearers of obstetric traditions. While these women were not extraordinary, not everyone acquired such knowledge and skill. Many women in Mary Sweetapple's community would run away if they "got caught" with a woman about to give birth because they were "scared stiff."⁹⁰ Any woman who was unwilling or unsuited to attend childbirth could excuse herself from being present because of "bad nerves."⁹¹ This would prevent her from becoming a passive bearer of these traditions, and effectively declare her unsuited to the role of

⁸⁹ 88-281, C11354.

⁹⁰ 88-281, C11378.

⁹¹ Dona Davis notes "pleading nerves is a convenient way of avoiding undesirable responsibilities it may otherwise be impolite to refuse." Dona Davis, p.140.

midwife.⁹²

In the twentieth century, this old pattern of birth attendance began to die out. Annie Power of Branch, St. Mary's Bay was the grandchild of two midwives, and regularly assisted a midwife of her mother's generation. She recalled there were always three or four women at a birth in her grandmothers' time, "but...as we started moving into the modern age I call it, it would be just the two women," usually the midwife and her.⁹³ Many midwives relied on an "apprentice" like Annie, a topic examined in Chapter Four. Others worked with a neighbour or relative of the woman giving birth.⁹⁴

One midwife worked with another woman because "you were supposed to have someone in the room, you know, with you."⁹⁵ Susan Everleigh worked with a witness until a doctor told her this was unnecessary and thereafter she worked alone.⁹⁶ Another midwife who assisted at the birth of a deformed child that died called a witness to attest

⁹² See Chapter Four for a narrative containing reference to a woman who declined to deliver a child because she was "nervous."

⁹³ 88-281, C11371.

⁹⁴ 75-23, Ms p.13; 78-119, Ms p.23; 79-159, Ms p.25; 79-508, Ms p.5; 82-166, Ms p.18; 83-312, Ms p.9.

⁹⁵ 82-166, Ms p.18.

⁹⁶ 76-165, Ms p.22.

to the condition in which the child had been born.⁹⁷ This suggests that midwives regarded a witness as necessary to protect themselves from suspicion of incompetence or infanticide.⁹⁸

Health care professionals had some impact on traditions of birth attendance. Susan Everleigh was directly influenced by a doctor as noted above. Mary Sweetapple, Freida Guinchard and Lillian Wandling, all "trained midwives," usually worked without assistance, perhaps because of their training.⁹⁹ Doctors and registered nurses discouraged the presence of many women perhaps to reduce the risk of infection, and because they were accustomed to privacy. A district nurse stated

it was strange to me, when I made a home visit to find the house filled with neighbours and friends, even at a maternity case. I let it be known I expected privacy when visiting and at deliveries, and the people co-operated very well.¹⁰⁰

But in Branch this transition occurred in the absence of

⁹⁷ 88-281, C11373. This child was born with the throat open from ear to ear. This unusual condition may have caused the midwife to fear that someone might think the child, who had other deformities, had been killed.

⁹⁸ The implications of this are explored in Chapter Five.

⁹⁹ 84-332; 88-281, C11355; C11378.

¹⁰⁰ Margaret Giovannini, Outport Nurse, ed. Janet McNaughton (St. John's: Faculty of Medicine, Memorial University, Occasional Papers in the History of Medicine, Number 8, 1988), p.4.

health care professionals. Growing awareness of the causes of puerperal infection among empirically trained midwives and a desire to incorporate aspects of medical obstetrics may have influenced the number of birth attendants deemed desirable.

This change greatly affected traditional obstetrics. As the opportunity to observe a midwife at work was lost to most women this knowledge became arcane, and the level of shared knowledge which characterizes a folk system of health care declined. The number of potential midwives in a community was often reduced to one. If the midwife's single assistant was unwilling or unable to step into the role, women began to have their children at the nearest hospital or nursing station and traditional obstetric care ended.

Adult women aside, family members had almost nothing to do with childbirth. Men were often away from home for weeks or even months on extended fishing trips in summer and at lumber camps in winter so it was not unusual for a husband to be away during childbirth.¹⁰¹ If present, however, the husband fetched the midwife and tended the wood stove in winter. These were the only tasks men

¹⁰¹ On the south west coast of the island "one of the most salient characteristics of married life was the periodical absence of the husband." Dona Davis p.61.

performed during childbirth.¹⁰² In rural areas the presence of any man at a birth was considered improper in the early decades of the century and doctors did not attend unless a life-threatening emergency developed. Even then, some women tried to refuse their help for reasons of modesty.¹⁰³ Not until a generation grew up in continued contact with male doctors did rural women accept them as birth attendants for normal deliveries.

Although their siblings were born at home, children were protected from realistic knowledge of pregnancy and birth. Unless labour began in the middle of the night and it was felt the children would not awaken, they were bundled off to relatives or neighbors.¹⁰⁴ However, in small outport houses it was not always possible to disguise a birth. One woman recalled lying awake as a child, listening to the midwife prepare and wondering if her mother would die in childbirth.¹⁰⁵

Because childbirth was treated in such a secretive manner, home birth may well have been more awkward for

¹⁰² See 75-21, Ms pp.11-13; 76-142, Ms p.6; 76-494, Ms p.14; 78-211, Ms pp.80-81; 79-417 Ms p.30. Also see Murray, p.84. Husbands in Northern Ireland played a similar role. See Linda-May Ballard, p.63.

¹⁰³ See 78-415, Ms p.8; 88-281, C11355; C11373.

¹⁰⁴ See 70-15, Ms p.23; 73-161, Ms p.14; 76-258, Ms pp.14-15; 76-494, Ms p.14; 78-211, Ms p.81; 78-401, Ms p.13; 79-508, Ms p.5; 79-658, Ms p.16; 83-312, Ms p.9.

¹⁰⁵ 88-281, C11354.

women than giving birth in hospital, where no elaborate deceptions were necessary. This may explain why some women welcomed the change from home to hospital births.

One said,

I don't know what it was, but childbirth was a bigger event than it is today, so much preparation, so foolish, clothes kept out of sight of small children. Strain on you, that way, having babies at home. If they were born you didn't want the older children in the house, in bed afraid. I can remember when I was in labour, kneeling on the floor, one of the others walked into the room with her doll in her arms. She was too young to realize what was going on, but we tried to shield them. It was wrong, but we did it.¹⁰⁶

On the other hand, women took comfort from the presence of their mothers, sisters and friends during birth, including the midwife. Annie Power said "it was just like they [midwives] were an aunt or a cousin, according to their age...and they'd know so much, it really helped."¹⁰⁷ Another woman said of a midwife,

sweet old lady she was, you know. I always liked her afterwards, she was so good to me....I liked them [the women who assisted] because they were so good to me, so gentle and everything you know.¹⁰⁸

The midwife was sent for early in labour, especially for a first birth. Women who had given birth a number of times tended to wait longer, as first labours generally

¹⁰⁶ 75-21, Ms p.29.

¹⁰⁷ 88-281, C11372.

¹⁰⁸ 88-281, C11376.

provoked more anxiety than did succeeding ones. Once the midwife was called she would remain with the woman until delivery was complete, unless labour had not really commenced.

The location of the birth was determined by pragmatic considerations. Labour and delivery usually occurred in the woman's bedroom, but most houses were heated by a single wood stove in the kitchen and could be quite cold in winter, so women sometimes gave birth in the kitchen or the parlour.¹⁰⁹ The place of delivery had no significance; childbirth was a domain unto itself which subsumed and negated more mundane spatial boundaries.¹¹⁰

Unless birth was imminent, the midwife made preparations for the delivery when she arrived, and these were as varied as individual midwives. Most first washed their hands and put water on the stove to boil, or asked the husband to do so. It was also common to prepare "scorched cloth" and "burnt flour" at this time, though some midwives made these materials in advance. Burnt flour was heated on or in a stove until it turned brown. This was used to dress the baby's navel and also as baby

¹⁰⁹ 76-184, Ms p.25; 79-159, Ms p.28.

¹¹⁰ For discussion of usual spatial boundaries in Newfoundland homes see Gerald Pocius, "Hooked Mats in Newfoundland. The Representation of Social Structure in Design," Journal of American Folklore, 92 (1979), 273-84.

powder before commercial talcum powder became available.¹¹¹ Scorched cloth was placed on or in a stove until blackened. This was also used to dress the navel and was sometimes placed over the maternity pads that absorbed the lochia (the mother's discharge) during confinement.¹¹²

Burnt flour and scorched cloth originated in traditional rather than medical obstetrics. In 1671 English midwife Jane Sharp wrote "when part of the navel string left is fallen off, Midwives use to burn a rag to tinder and to apply to the place."¹¹³ When Mary Breckinridge interviewed Kentucky midwives in 1923 she noted "practically universal is the excellent custom of scorching the rag [to dress the navel]. One midwife...said she had given it up because the doctor did not do it, and one...because it was 'old-timey.'"¹¹⁴ Scorched cloth and burnt flour were also used by Mormon

¹¹¹ See 71-13, Msc 1; 71-26, Msc 4; 73-31, Msc 4; 73-195, Msc 31; 79-405, Ms p.14; 81-491, Ms p.9; 84-307, Ms p.9; 84-491, Ms p.5.

¹¹² For references to scorched cloth see 75-21, Ms p.9; p.21; 78-211, Ms pp.93-93; 79-159, Ms p.27; 79-417, Ms p.34; 79-662, Ms p.26; 84-364, Ms p.5; 84-379, Ms p.8; 86-301, Ms p.13.

¹¹³ Jane Sharp, The Midwives Book, 1671; rpt., (New York: Garland, 1985), p.216.

¹¹⁴ Mary Breckinridge, "Midwifery in the Kentucky Mountains: An Investigation in 1923," Frontier Nursing Service Quarterly Bulletin, 17 (Spring 1942), p.26.

midwives in Utah.¹¹⁵

These substances helped to prevent infection by keeping the navel dry, but this could hardly have been their original purpose, as their use predates understanding of the cause of infection by many years. In Newfoundland the fact that these substances were not related to sterilization was demonstrated by one midwife who threw the cloth on the floor and stamped on it after scorching.¹¹⁶ The original rationale for these substances is now lost, but it is possible that contact with heat was thought to instill protective properties. The importance of heat and cold in traditional obstetrics will be returned to below.

Midwives carried more equipment and made an effort to approximate sterile conditions in childbirth as the century progressed. Prior to these changes, which occurred at different times in different areas, some midwives carried no equipment. One Roman Catholic midwife in Calvert went to births "with just a crucifix in my pocket." To tie the umbilical cord she used scissors and thread on hand in the client's house.¹¹⁷ But midwives in

¹¹⁵ See Juanita Brooks, "Mariah Huntsman Leavitt: Midwife of the Desert Frontier," Forms Upon the Frontier, eds. Austin Fife, Alta Fife and Henry H. Glassie (Logan: Utah State University Press, 1969), p.121-122.

¹¹⁶ 78-119, Ms p.21.

¹¹⁷ 75-21, Ms p.10. See also 79-405, Ms p.12.

Calvert began to carry scissors, towels, rubber gloves, twine, clean rags, oil cloth to protect the bed, and long, white, sun bleached aprons, in home-made black bags which became an emblem of the occupation.¹¹⁸

Lily Clarke of Stanhope, Notre Dame Bay brought nothing to deliveries when she began midwifery, but eventually carried her own scissors and supplied twine if the woman giving birth had none.¹¹⁹ By the 1940s, most midwives brought scissors and ties for the umbilical cord, and many carried homemade dressings, rubber gloves, disinfectant, enema syringes, and some waterproof mattress covering.¹²⁰

Some midwives carried more equipment after receiving formal training, and some were given supplies by doctors or district nurses, so this trend was directly influenced by contact with health care professionals.¹²¹ Enema syringes and breast pumps were also obtained from mail order catalogues.¹²² Such catalogues provided more than access to equipment. They were the very symbol of modernity which implicitly linked these objects with

¹¹⁸ 75-21, Ms p.9.

¹¹⁹ 88-281, C11356.

¹²⁰ See 73-160, Ms p.4; 76-258, Ms p.12; 78-119, Ms p.23; 79-508, Ms p.5; 86-301, Ms p.10.

¹²¹ See 76-258, Ms p.12; 81-328, Ms p.18; 86-254, Ms p.13; 88-281, C11378.

¹²² 84-379, Ms p.9; 88-281, C11375.

progress.

This change is one of many expressions of a desire to provide care midwives believed was closer to medical obstetrics. Such informal medicalization does not, however, always lead to improvements. In fact, by only using materials belonging to the client, midwives may have unknowingly reduced the possibility of spreading infection. Like district nurses, some Newfoundland midwives who had continuous contact with doctors carried minimal equipment such as scissors and ties, and expected the woman giving birth to have dressings and bedding ready, perhaps to reduce the risk of cross-infection.¹²³ However, as puerperal infection usually occurred in single cases in Newfoundland and equipment was boiled, this change did not create the problems it might have.

The practice of sterilizing equipment, especially the scissors and ties used on the umbilical cord, became almost universal in the 1940s.¹²⁴ The aunt who apprenticed Lily Clarke in the 1920s did not sterilize scissors, but Lily learned to do so, perhaps from the doctor in Lewisport whom she occasionally called for difficult cases. At first, midwives in Calvert did not sterilize their equipment because "cleanliness was

¹²³ 76-142, Ms p.4.

¹²⁴ See 76-142, Ms p.4; 76-258, Ms p.12; 81-328, Ms p.20; 84-379, Ms p.6.

considered to be alright," but in the 1930s they began to place scissors and ties in boiling water.¹²⁵ Boiling water came to be a sign that labour was underway.

As with the trend toward more equipment, some midwives learned about sterilization during formal training or from a health care professional called in an emergency. At the same time, however, a general awareness of the cause and prevention of infection developed even among women with little or no contact with medical obstetrics. Other efforts were made to prevent infection as well. One midwife never wore the same apron to more than one client, carrying a clean apron to each woman she visited.¹²⁶

If the bed was to be used for delivery it was protected with a waterproof covering; an oilcloth was used early in the century, rubber or plastic sheeting later. Some women prepared large pads of old newspapers instead which might be sterilized in a warm oven. Bedding was placed over the protective covering; some women made thick quilts for this purpose, to be used by one woman only. In Calvert, such quilts were washed, sun bleached

¹²⁵ 75-21, Ms p.21. This paper contains interviews with two midwives.

¹²⁶ 73-160, Ms p.4.

and put away between deliveries.¹²⁷ Some women used an ordinary bed sheet which might be sterilized in the oven. A sheet or strong cord was often tied to the bottom of the bed for the woman to pull on during the second stage of labour.¹²⁸

If birth was to occur on the floor, some bedding was usually put down for the mother's comfort and she might be provided with a sheet to pull on as well.¹²⁹ If bedding could not be spared, clean straw was sometimes used though this practice declined as prosperity increased. Before the delivery, midwives also collected the child's clothes, soap and water to bathe mother and child, and a container or paper for the afterbirth.

The amount of preparation the woman received depended on the training of the midwife. Most midwives washed women with boiled, cooled water to which

¹²⁷ 75-21, Ms p.12. Sun bleaching may be another example of attempted sterilization as ultraviolet rays of the sun kill micro-organisms. Diapers were often sun bleached for this reason.

¹²⁸ See 72-62, Ms p.11; 75-21, Ms p.12; 79-417, Ms p.31; 79-549, Ms p.18; 83-312, Ms p.9; 88-281, C11376. Medical obstetrics divides labour into three stages. The first stage, by far the longest, begins when the contractions of labour commence and ends when the cervix, the opening of the uterus, is fully dilated. In the second stage the fetus travels from the uterus through the birth canal to be born. The third stage is the expulsion of the afterbirth.

¹²⁹ See 86-301, Ms p.15 for reference to preparation of the floor and pulling on sheet while giving birth in a kneeling position.

disinfectant was sometimes added.¹³⁰ Only some midwives who received formal training shaved the pubic area in preparation for birth.¹³¹ This medical practice came out of urban hospitals during the struggle to control puerperal fever.¹³² Shorter summarizes the controversy surrounding the introduction of shaving into medical obstetrics noting it was not accepted as routine by doctors until 1930.¹³³

Concern with "keeping the bowels open" carried over from prenatal care, partly because constipation can cause discomfort in labour and even impede delivery. Some midwives also recognized that strong intestinal contractions induce sympathetic uterine action, speeding labour. Many midwives gave enemas for either or both of these reasons.¹³⁴ Enemas were part of traditional and

¹³⁰ 72-62, Ms p.2; 76-165, Ms p.12; 78-119, Ms p.23; 78-211, Ms p.92; 79-62, Ms p.26; 79-443, Ms p.15; 81-328, Ms p.20; 88-281, C11372.

¹³¹ 82-326, Ms p.14; 88-281, C11358.

¹³² Wertz and Wertz, p.137.

¹³³ Shorter, pp.167-168.

¹³⁴ See Ann L. Clark and Dyanne D. Affonso, Childbearing: A Nursing Perspective, 2nd ed., (Philadelphia: F. A. Davis Co. 1979), p.707 for the medical rationale. For Newfoundland see 78-211, Ms p.92; 81-328, Ms p.16; 84-379, Ms p.9; 88-281, C11353; C11355. Enemas were also used by a Quebecoise midwife in late nineteenth century Maine. See Paradis, p.118.

medical obstetric care.¹³⁵ Some midwives administered a purgative, usually castor oil, for the same effect. However, many would resort to enemas or purgatives only if labour was long overdue or was "tedious."¹³⁶

Descriptions of labour often lack detail, partly because women tended to recall the dramatic events of difficult labour rather than the more mundane practices of normal births.¹³⁷ Modesty also curtailed discussion to the point where many women either did not know or refused to use words for female anatomy. As a result, many descriptions of labour shift from preparation of the bed to the cutting of the umbilical cord, with no description between. However, it is possible to summarize usual birth practices.

Many women remained active early in labour, walking around, perhaps doing some light housework, resting when they wished.¹³⁸ The midwife Elizabeth Marsh assisted "had

¹³⁵ Wertz and Wertz p.137 note "the enema was an ancient practice, but it became routine [in hospitals] because doctors thought accidental bowel movement might be the contaminating cause of [puerperal] fever.

¹³⁶ See 79-695, Ms p.12 for routine use of castor oil. See 78-211, Ms p.91 for use of castor oil in slow labour.

¹³⁷ Michael Owen Jones notes the tendency of other types of healers to focus on dramatic and unusual events. Michael Owen Jones, "Doing What, with Which, and to Whom? The Relationship of Case History Accounts to Curing," American Folk Medicine, p.305.

¹³⁸ 72-62, MUNFLA transcript C1257 p.4; 75-21, Ms p.13; 76-255, Ms p.9; 88-281, C11373; C11379.

a fashion of walking about [with the women] and giving them something [to drink]" in the early part of labour.¹³⁹ Similarly, in Calvert, a woman would "keep on the go" as long as she could, but when the pains "got too hard" she would lie down.¹⁴⁰ This was a means of preventing the parturient woman from pushing prematurely with her contractions.¹⁴¹

Labour is usually painful and at least potentially dangerous. Traditional obstetrics could deal with pain and danger by natural or supernatural means.¹⁴² Within the realm of the supernatural, resort could be to magic

¹³⁹ 88-281, C11379.

¹⁴⁰ 75-21, Ms p.13. Keyes found among the midwives she studied "the mother is encouraged to walk until the contractions become so strong that she no longer feels comfortable moving about." Keyes, p.145.

¹⁴¹ Jane Sharp was aware of this practice. Sharp, p.187. Quebecoise midwife Henriette Pelletier also kept women active during labour, as did Mexican midwives. See Paradis, p.118, and Kay p.58 respectively. Hand recorded the practice of inducing labour by having the mother "walk to exhaustion," a different matter. Hand, Frank C. Brown Collection, Vol VI, p.7.

¹⁴² David Hufford suggests that classification of folk medicine and healers into the categories of "natural" and "supernatural" should be abandoned because this suggests an unrealistic relationship of natural with rational and supernatural with irrational. David J. Hufford, "Folk Healers," in Handbook of American Folklore, ed. Richard Dorson (Bloomington: Indiana University Press, 1982), pp.309-310. While his point is a valid one, it does not address the fact that folk practitioners themselves often make very clear distinctions between natural skills and supernatural powers.

or religion.¹⁴³ In speaking of pain, women mainly recalled the lack of attention it was given. One midwife used brandy or whiskey with sugar and water to relieve pain and another gave ginger wine, but alcohol was rarely used in labour.¹⁴⁴ Hot compresses were sometimes applied to the abdomen and perineum to soothe, but were also used to encourage labour and prevent perineal tearing.¹⁴⁵

In many Anglo-American areas an ax or knife was put under the bed to "cut the pain" of childbirth.¹⁴⁶ This was the only charm reportedly used in Newfoundland

¹⁴³ In making this distinction, Keith Thomas notes that magic postulates occult forces which may be controlled through spells, whereas religion assumes that the world is directed by a conscious agent who might be influenced by prayer and supplication. The magic of a charm is automatic and implies control, whereas the efficacy of prayer depends upon the uncertain intervention of a more powerful being. Keith Thomas, Religion and the Decline of Magic (New York: Charles Scribner Son's, 1971), p.41.

¹⁴⁴ See 76-255, Ms p.12 and 86-254, Ms p.13 for use of alcohol. In contrast, Jean Donnison notes that strong drink was popularly regarded as "essential to a woman during her labour and lying-in" in late nineteenth and early twentieth century England. Donnison, p.102.

¹⁴⁵ The perineum is the tissue between the vagina and the anus which is stretched during delivery and may tear. Permanent debility may result if a tear extends into the anal sphincter. Hot compresses were also used by Hispanic-American midwives to prevent perineal tearing. Keyes, p.147.

¹⁴⁶ For the American south see Hand, Frank C. Brown Collection, Vol. VI, p.10; p.11; p.12. In Kentucky, Mary Breckinridge found that an ax was placed under the bed to stop haemorrhage. Breckinridge, p.25.

against pain, and it was not common.¹⁴⁷ One woman recalled that an ax was placed under the bed in her mother's day, but the practice had died out when her children were born.¹⁴⁸ With neither charms nor chloroform to help them, women were expected to meet pain with stoicism alone, an important aspect of Newfoundland culture.¹⁴⁹ One woman stated,

most of the time things went alright, and if the pains came quickly the baby came quickly too. Pulling on the twisted sheet gave great support when the [pains] were hard. You went through every bit of it in the raw [without relief from pain]. It wasn't too bad, you got into it, the pains came and came and they were rough, but I don't know, there was something about it. It didn't take the good out of you, and if the pains came quickly you were out of it in no time.¹⁵⁰

Each complication of childbirth was dealt with using a specific set of natural skills, and these will be detailed below. Absence of resort to magic is again striking, but religion was an important means of meeting danger, actual or potential, in childbirth in Newfoundland. Some Protestant and Catholic midwives prayed before or while assisting even at ordinary

¹⁴⁷ For reference to this practice in Newfoundland see 72-251, Ms p.27; 84-363, unnumbered Msc.

¹⁴⁸ 69-11, Msc 1.

¹⁴⁹ See Dona Davis, pp.143-145 for a review of discussion of stoicism in Newfoundland culture by ethnographers.

¹⁵⁰ 75-21, Ms p.13.

births.¹⁵¹ One midwife "prayed the children into the world."¹⁵² Others relied on prayer especially when complications occurred.¹⁵³ Some midwives also used "Our Saviour's Letter," and relied on religious medals.¹⁵⁴ The emphasis in prayer was on the safety of mother and child.

Supernatural practices to ease pain and ensure safety were common in English and other Anglo-American

¹⁵¹ 78-119, Ms p.11; 79-163, Ms p.4; 79-508, Ms p.5; 88-281, C11371.

¹⁵² 76-351, Ms p.37.

¹⁵³ See 75-21, Ms p.13; 79-549, Ms p.14; 84-364, Ms p.4.

¹⁵⁴ One Newfoundland midwife, an Anglican, always placed a copy of Our Saviour's Letter at the foot of the bed when attending births around the turn of the century. The student who collected this information carried a copy of this prayer in her suitcase when she went to hospital for the birth of her child in 1978. 84-369, unnumbered Msc. In rural nineteenth century England, this prayer was purchased as a broadside and hung above the bed or pinned to the mother's clothes "for greater ease and safety in childbirth." Ella Mary Leather, The Folk-Lore of Herefordshire (Hereford: Jakeman and Carver, 1912), p.112. For a text of "Our Saviour's Letter" see William George Black, Folk-Medicine: A Chapter in the History of Culture (London: The Folk-Lore Society, 1883), pp.84-85. The preamble to the prayer states in part "...it being read over any woman in labour she will be delivered safely." This letter was also used in childbirth in the American South. See Hand, Frank C. Brown Collection, Vol. VI, pp.11-13. Hand believes this prayer was German in origin. See 86-301, Ms p.20 for use of a religious medal. There was also a saint specifically for women in childbirth. See Marion I. Bowman, "Devotion to St. Gerard Majella in Newfoundland: The Saint System in Operation and Transition" (M. A. Thesis, Memorial University of Newfoundland, 1985).

traditions.¹⁵⁵ Given that birth is a highly uncertain life crisis, lack of resort to the supernatural in Newfoundland is surprising, but there are some explanations. Some midwives felt folk beliefs were in conflict with formal religion. When mothers asked Marita House to count the lumps in the umbilical cord, she said "don't be so foolish, you'll have as many [children] as God wills."¹⁵⁶ Nora Ellsworth's great-grandson was told that she did not believe in charms. "Rather, she placed a great deal of confidence in herself and the will of God."¹⁵⁷ Others rejected ideas they regarded as old-fashioned. Clara McGrath, one of the first outport midwives to travel to St. John's for public health training, said of pregnancy related beliefs, "washing walls, raising...arms, and visiting graveyards did not harm the mother or child. To believe it was harmful, was Irish nonsense."¹⁵⁸ The term "Irish nonsense" is interesting. Annie Power, also of Irish Catholic descent, referred to people in another area where many pregnancy

¹⁵⁵ For early modern England see Thomas Forbes, "Chalcedony and Childbirth," in his The Midwife and the Witch (Binghamton, New York: Vail-Ballou Press, Inc., 1966), pp.64-79; McLaren, pp.50-52; Sharp p.182; and Thomas, pp.188-189. For the American south see Hand, Frank C. Brown Collection, Vol. VI, pp. 8-11; For Nova Scotia see Creighton, p.206.

¹⁵⁶ 76-258, Ms p.33. This belief will be discussed below.

¹⁵⁷ 78-119, Ms p.25.

¹⁵⁸ 81-328, Ms p.10.

related beliefs were found as "really Irish," meaning old fashioned.¹⁵⁹

Other midwives rejected folk beliefs because of contact with doctors, though medical men also shared and promoted some ideas that were part of traditional obstetrics. Margaret (Mag) Hibbs discounted the theory of maternal impressions when she was told by a doctor that birthmarks were caused by arteries that did not work.¹⁶⁰ She continued to believe that a child would be "puny and hungry all the time" if the mother did not eat enough during pregnancy, however, because of empirical observation. Other reasons for absence of the supernatural are rooted in the role of midwives in Newfoundland and will be considered in Chapter Five.

The informal medicalization of childbirth began prior to the period under consideration here. It is possible that the supernatural played a more important role in childbirth in previous centuries, but there is no way of knowing this. The few traces of magic that are apparent early in the century declined as midwives had access to the more tangible aid of health care professionals. Absence of magic probably helped to ease medicalization, as anthropologists working in other

¹⁵⁹ 88-281, C11372. Annie also referred to the idea of ritual impurity as "an Irish custom."

¹⁶⁰ 72-62, MUNFLA transcript C1257, p.10.

cultures have found that those elements of health care believed to be controlled by supernatural forces are often most resistant to modern medicine.¹⁶¹

Newfoundland midwives did little to speed normal labour. Amniotomy, the deliberate breaking of the amniotic sac, was not practiced here in normal circumstances in spite of Shorter's assertion that this was routine in traditional obstetric care.¹⁶² A few midwives would rupture the amniotic sac rarely if labour continued for a long time without breaking the membrane naturally.¹⁶³ This was accomplished with the hand rather than a foreign object.¹⁶⁴ Most midwives would not break the amniotic sac under any circumstances, probably because this violated their ideas about intervention. Also, the membranes were not ruptured because some women believed birth was easier if the amnion remained intact until delivery, so that the birth was lubricated by the amniotic fluid. Jane Sharp expressed this idea in 1671:

¹⁶¹ See David Landry, "Role Adaptation: Traditional Curers Under the Impact of Western Medicine," American Ethnologist 1 (1974), 106-107, 109.

¹⁶² Shorter, pp. 58-59. See Clark and Affonso, p.395 for the uses of amniotomy.

¹⁶³ 88-281, C11373.

¹⁶⁴ Barbara Rieti was told of one midwife who performed amniotomy with a hairpin. This woman was also said to be dirty in her work and clearly violated normal standards of obstetric care. Personal communication, Barbara Rieti, winter 1984.

these waters make the parts slippery and the birth easie, if the child come presently with them, but if it stay longer till the parts grow dry it [labour] will be hard, therefore Midwives do ill to rend these skins open with their nails to make way for the water to come, nature will make it come forth only when she needs it and not before...¹⁶⁵

In Newfoundland if the amnion broke early this was called "dry labour."¹⁶⁶

If a woman pushes with contractions of labour before the cervix is fully dilated, pressure may cause the cervix to swell closed and birth will be impeded.¹⁶⁷ It is normal however for women to experience a strong urge to bear down before the cervix is fully open. Therefore, an ability to judge when a woman should begin to push with her contractions is perhaps the most important skill a birth attendant can bring to uncomplicated labour. An inexperienced midwife who urged her client to push too soon would not only exhaust the woman, but might make delivery difficult or even impossible.

¹⁶⁵ Sharp, p.207.

¹⁶⁶ 66-09, Msc 9; 88-281, C11355; C11371; C11378. As might be expected, there was more than one definition for this term. One of Elsie Drover's deliveries was a dry labour because the waters came after the baby. 88-281, C11373. Everyone agreed that dry labour was more difficult. Mexican women believe that sexual activity during pregnancy lubricates the birth canal, so a difficult labour, also called "dry labour," may be attributed to sexual abstinence. Kay, p.57.

¹⁶⁷ Until the cervix, the opening of the uterus, has dilated ten centimeters, the fetus cannot pass out of the uterus and into the birth canal.

Problems of this sort did occur. During Clara McGrath's first labour, she recalled that "an old woman half blind kept me kneeling by a chair for a day and a night almost tearing me asunder."¹⁶⁸ District nurse Margaret Giovannini encountered a similar situation near La Scie in 1940 when a midwife encouraged a woman to bear down by pulling on a sheet tied to the bottom of the bed from the beginning of labour. When the nurse arrived she administered a quarter grain of morphine and allowed the woman to rest so that the swelling could go down, an unusual step caused by these extreme circumstances. The child was delivered the next day.¹⁶⁹

Kneeling and pulling on a sheet tied to the bottom of the bed were intended for the delivery only. More skilled midwives kept the woman active to discourage the urge to bear down, and watched for signs that delivery was imminent. Internal examination of the cervix is the easiest way to ascertain when a woman is ready to push with her contractions. During Commission of Government and after, midwives were prohibited by law from doing this, as noted in Chapter Two. One woman who received public health training denied she had performed internal examinations in our first interview, apparently because

¹⁶⁸ 81-328, Ms p.7. It is possible that complications rather than inexperience might have caused this long delivery.

¹⁶⁹ 88-281, C11370.

of this prohibition. But in extended discussions it became apparent that she performed internal examinations when necessary. Aside from this, it is almost impossible to determine the impact of either obstetric system on the practice of performing internal examinations. For example, the midwife who Annie Power assisted did not "insert," although she had virtually no contact with medical practitioners.¹⁷⁰ On the other hand, Florence Noble was reluctant to perform internal examinations because of her brief nurses' training.¹⁷¹ When discussing internal examination, most midwives mentioned in the same breath the care they took to ensure cleanliness.¹⁷²

Newfoundland women gave birth kneeling on the floor or lying in bed. European women traditionally used different positions as well. Jane Sharp wrote

take notice that all women do not keep the same posture in their delivery; some lye in their beds, being very weak, some sit in a stool or chair, or rest upon the side of the bed, held by other women that come to the Labor."¹⁷³

There is no indication that Newfoundland women gave birth sitting. Birthing stools, so popular in Europe, were not used here nor did women deliver sitting in someone else's

¹⁷⁰ 88-281, C11372.

¹⁷¹ 78-415, Ms p.7.

¹⁷² 76-165, Ms p.12; 76-258, Ms p.14; 84-379, Ms p.6; 88-281, C11355.

¹⁷³ Sharp, p.199.

lap.¹⁷⁴ Neither did women give birth standing, a posture Shorter maintains was common in Europe.¹⁷⁵

If the woman knelt on the floor she leaned on a chair or was supported under the arms by other women, and might pull with her contractions on a cloth attached to the bed posts.¹⁷⁶ One woman recalled "all my babies were born on the floor and you know t'is a strange thing for me to say, but it was easier."¹⁷⁷ Many women who delivered in bed used a cloth attached to the foot of the bed to raise themselves into a semi-upright position during contractions. A few pulled on the rungs on the headboard.¹⁷⁸ One woman still sleeps in an iron bedstead that has a rung bent by her in the throes of labour.

Prior to this century, Newfoundland women may have regarded the bed as an appropriate birth place only if there were problems, as did Jane Sharp. Well into this century, women in Portugal Cove gave birth in bed only

¹⁷⁴ See Wertz and Wertz, pp.13-15 and Schnucker, p.641 for discussion of the sitting posture in childbirth.

¹⁷⁵ See Shorter, pp.55-56 for discussion of the standing position in birth.

¹⁷⁶ See 75-21, Ms p.14; 78-119, Ms p.23; 78-211, Ms p.85; 81-328, Ms pp.19-20. This birth posture was common among English puritans in the seventeenth century. Schnucker, p.641.

¹⁷⁷ 75-21, Ms p.14.

¹⁷⁸ Women in Northern Ireland were given a towel to pull on at the head of the bed during labour. This was not reported in Newfoundland. See Linda-May Ballard, p.66.

when complications developed.¹⁷⁹ But in the early twentieth century most women regarded both positions as normal and the decision was based on personal preference, comfort and habit. Sometimes the midwife would determine the birth posture. Nellie Powell always gave birth lying in bed except once, when she had a different midwife.¹⁸⁰ In other cases, the client decided. Mary Sweetapple usually attended women in bed but "when they wanted to kneel, I used to let them kneel. They thought it was better and I used to help them, you know."¹⁸¹

As women became aware of medical obstetrics, however, the kneeling posture began to disappear. As with other changes, shift in birth position was sometimes due to direct contact with medical obstetrics. Clara McGrath said

before 1935 I born the babies like this. I'd put a quilt or blanket on the floor. The woman would kneel by a chair and drop the baby into the blanket. After I had my [public health] training I had them use the bed.¹⁸²

But this change also occurred in advance of doctors and registered nurses in some places. Women in Deer Harbour moved from the floor to their beds well before

¹⁷⁹ 78-211, Ms pp.85-86.

¹⁸⁰ 88-281, C11376.

¹⁸¹ 88-281, C11378.

¹⁸² 81-328, Ms pp.19-20.

professional care was available to them. Elizabeth Marsh lived through the change but could not say why it occurred.¹⁸³ In some places, birth position was altered because of changes in attitude. One woman who was delivered in the kneeling position was told it was "Indian style," an indication that this European-derived custom was coming to be regarded as outlandish.¹⁸⁴ One midwife stated this more emphatically:

the way they had their babies was the reason they had to stay in bed so long and were so exhausted. They had their babies like animals, more or less. They knelt on the floor by the bedside instead of being in bed and comfortable.¹⁸⁵

Women in other areas of North America where medicalization occurred within living memory experienced changes in birth posture in a strikingly similar manner. Jesusita Aragon, a partera [midwife] from a Hispanic community in New Mexico, stated

so many things change over the years. Many things change in how we deliver babies. When I first be a midwife, some mothers give birth the old way; the way that's gone now. They squat down when they have their baby. They tie a little round stick [to pull on]. Oh, it helps. I like that way, and sometimes somebody hold her from the back. They hold her back against their legs so she doesn't fall over...I don't know why they stop

¹⁸³ 88-281, C11379.

¹⁸⁴ Class discussion, Folklore 3420, Grand Falls, Summer, 1984.

¹⁸⁵ 74-181, Ms p.48.

doing that way, why they start laying on their backs. I think because to squat down is an old-fashioned way.¹⁸⁶

Midwives sometimes pressed down on the fundus, the top of the uterus, to facilitate delivery.¹⁸⁷ On Long Island, Notre Dame Bay, a sheet was wrapped around the mother just above the fundus, and as she bore down with each contraction, two women on either side pulled on the sheet to apply extra pressure.¹⁸⁸ While the application of such pressure was probably useless, it was also part of medical obstetrics.¹⁸⁹ Eliza Jane Dawe did this at the direction of the doctor she assisted, and Agnes Kennedy, a nurse-midwife also worked with doctors who encouraged this practice.¹⁹⁰ As mentioned above, hot compresses were sometimes applied to the woman's abdomen and perineum to ease labour or to prevent perineal tearing.¹⁹¹ "Sweet oil," or olive oil was also used as a lubricant to

¹⁸⁶ Buss, p.63.

¹⁸⁷ 75-56, Ms p.15; 76-165, Ms p.13; 88-281, C11356; C11379. This practice was also common with Mexican midwives. Kay, p.58. Henriette Pelletier applied pressure to the fundus in difficult cases. Paradis, p.119.

¹⁸⁸ 75-211, Ms p.36.

¹⁸⁹ Obstetrician Dr. Craig Loveys believes that pressing on the fundus would have little impact on labour. 88-281, C11357.

¹⁹⁰ 77-247, Ms p.6; 88-281, C11353.

¹⁹¹ See 79-695, Ms p.12; 88-281, C11378.

prevent tearing.¹⁹² Many midwives supported the perineum during delivery and some cautioned the mother not to push too hard while the baby's shoulders were being delivered.¹⁹³ Annie Power said that women would "open with the pain [the contraction]" and should therefore only push with contractions.¹⁹⁴ Some midwives stretched the perineum to facilitate delivery.¹⁹⁵

Small perineal tears were kept clean and expected to heal like any minor cut. Lillian Wandling was the only empirically trained midwife to suture such tears, and only when a doctor was unavailable.¹⁹⁶ Several women complained about cervical tears. Many midwives had no problems with perineal tearing throughout their careers,

¹⁹² See 78-211, Ms p.89; 79-433, Ms p.14; 79-508, Ms p.5; 79-549, Ms p.14. Hispanic-American midwife Jesusita Aragon said, "when the lady is opening for the baby's head, I pour a little olive oil on the lady, on her perineum, by her vagina, so that part gets soft and smooth and tender, and it won't cut. So it won't tear when the baby's head come out." Buss, p.70.

¹⁹³ For support of the perineum see 76-255, Ms p.11. For reference to care in delivering the shoulders see 84-379, Ms p.8. Hispanic-American midwives also support the perineum. See Buss, p.70. Keyes found that all the midwives she studied in San Antonio, Texas, whether traditional Hispanic, or new age Anglo used olive oil and supported the perineum during delivery to prevent tearing. Keyes, pp.146-147.

¹⁹⁴ 88-281, C11371. Also see 80-229, Ms p.4.

¹⁹⁵ 78-211, Ms p.91; 88-281, C11356.

¹⁹⁶ 88-281, C11355.

however.¹⁹⁷ These women were extremely proud of the low incidence of perineal tearing in their practice, which they attributed to their patient, laissez-faire attitude.

Irene Bradley said

I never had a patient to break or crack, whatever you mind to call it. But I used lots of olive oil and put my better judgement to work and everything always worked out well for me, for which I thank God. I always believed that lots of olive oil and the patience to let the mother do it slowly gave better deliveries.¹⁹⁸

Midwives did not perform episiotomies. The idea of deliberately making an incision was foreign to traditional obstetric care and surgery of any kind, however minor, was not considered a possible resort. Empirically trained midwives and nurses believe the current high rate of episiotomy is unnecessary, perhaps even performed mainly for the doctor's convenience. Irene Bradley said

I don't think women should be cut unless it's a must to save a life. I think there's too much of that done and that people don't wait long enough for nature to do its work. They don't have patience any more. Now if one person makes a

¹⁹⁷ Today an incision in the perineum, called an episiotomy, is almost always performed on women having a first child to prevent perineal tearing and speed delivery. It is therefore reasonable to wonder if midwives were not simply protecting their own reputations with this claim. However, Brigitte Jordan found that perineal tearing was similarly rare among the Mayan midwives she observed. Jordan, p.25.

¹⁹⁸ 79-549, Ms p.15. Also see 79-433, Ms p.14; Porter, p.98.

mistake there's somebody else to repair it, where we had to trust to our own ingenuity and do it the best way we knew how to cause less trouble. Nowadays the hospitals are in too big a hurry to get it all over with and the mothers are being torn up.¹⁹⁹

Sometimes a child is born with part of the amniotic membrane covering the head. If this is not promptly removed the child may suffocate, but it does not appear to have caused problems.²⁰⁰ This was called a caul or veil and was considered good luck by most people.²⁰¹ Some Roman Catholics connected the caul with St. Veronica, who kept a towel used to wipe the face of Jesus at the time of his crucifixion, and a girl born with a caul was sometimes called Veronica because "she brought the name with her."²⁰² The caul was either dried or preserved in alcohol and was sometimes worn in a cloth bag around the neck to ensure the child's luck.²⁰³ Some Newfoundlanders

¹⁹⁹ 79-549, Ms p.15. Also see 88-281, C11353; C11370.

²⁰⁰ See 76-494, Ms p.8 for information about dealing with this problem.

²⁰¹ Jane Sharp was an exception. She stated "I know no wonders the Caule will work...The reason why some Children bring it with them on their head into the world is weakness, and it signifies a short life, and proves seldom otherwise." Sharp, p.213. In Newfoundland, one couple attributed their child's mental retardation to the fact that he was born with a caul and believed that all such children would suffer a physical or mental abnormality. 71-27, Msc 1.

²⁰² 75-21, Ms p.20.

²⁰³ 71-115, Msc 2; 72-62, MUNFLA transcript C1257, p.13; 73-07, Msc 2; 78-415, Ms p.13; 79-163, Ms p.6.

believed that a caul would protect whoever carried it from drowning, the most common belief connected with this object in Britain.²⁰⁴ Sometimes the ability to stop blood or ease pain was attributed to those born with a caul.²⁰⁵ Some believed that a caul foretold an exceptional life, and some Catholics of Irish descent felt such children would enter a religious order.²⁰⁶

After the child was born, the umbilical cord was cut. Some midwives waited until the pulsing stopped, but most did not. As noted above, the cord was tied in two places, a few inches from the child's navel, and cut between the two ties. The child was sometimes slapped to encourage breathing and the mucus was usually removed from the mouth and nose with a clean cloth or cotton batting. As soon as possible, the child was wrapped up and set aside, or given to one of the other women present.

²⁰⁴ See 69-27, Msc 24; 73-60, Msc 1; 73-161, Ms pp.11-12; 75-56, Ms pp.15-16. For British references see C. C. Baines, "Children Born with a Caul," Folk-Lore 61 (1950), 104; Leather, p.112. This belief is also found in Nova Scotia, see Creighton pp.144-145. One of my mother's brothers was born with a caul, which the midwife preserved. When the family immigrated from Scotland to Canada in 1929, the captain of the ship tried to buy the caul from my grandmother because he believed the ship would never sink if one was on board.

²⁰⁵ 73-07, Msc 7; 73-19, Msc 20; 74-181, Ms p.54; p.56.

²⁰⁶ See 66-02, Msc 14; 68-19, Msc 38; 70-13, Msc 10; 72-62, MUNFLA transcript C1257, p.13; 76-351, Ms p.20; 88-281, C11371.

The midwife then returned to the mother until the afterbirth was expelled. Little was done to hasten this process. Midwives did not pull on the cord, but some pressed on the fundus. As midwives learned that haemorrhage or infection could result if any afterbirth was retained, the delivered placenta was placed on a piece of clean paper and carefully inspected to ensure none was missing.

Some women believed that the number of knots or lumps in the cord would predict the number of children the mother would have. This belief was more elaborate in seventeenth century England. Jane Sharp, who discounted this idea, wrote

Midwives say these knots in number signifie so many Children, the reddish boys, the whitish girls, and the long distance between knot and knot, long time between child.²⁰⁷

Other methods of divining family size included counting the number of wrinkles in one's forehead, or counting the movements of a needle and thread suspended over the mother's abdomen during pregnancy.²⁰⁸ These were

²⁰⁷ Sharp, p.216. This belief was collected in England in the 1930s. See Barbara Newman and Leslie Newman, "Some Birth Customs in East Anglia," *Folklore*, 50 (1939), p.187. For the American Ozarks around the same time see Vance Randolph, *Ozark Magic and Folklore*, 1947; rpt., (New York: Dover Publications, 1964), p.192. For Newfoundland see 76-62, MUNFLA transcript C1257, p.5.

²⁰⁸ This latter method also could also predict the sex of the child. See 67-04, Msc 1; 67-05, Msc 6; 67-10, Msc 22; 67-21, Msc 1; 68-07, Msc 30; 68-10, Msc 28; 68-

amusements not directly associated with birth, but on a more serious level all such practices indicate how little control women had over family size.

The afterbirth was wrapped in paper, and usually burned though it might be buried or thrown into the privy.²⁰⁹ One collector was told that it was sometimes wrapped up and placed in the bed with the woman during confinement to help her regain her strength, but this was not common.²¹⁰ Some women believed that the afterbirth should be salted and burned so the mother would "dry up" properly and not haemorrhage, but one midwife rationalized the salting, saying that it was "to keep down the smell."²¹¹ Some midwives believed that the afterbirth was indecent, and considered its disposal an important part of their job. One said "it was all a very private affair. The burning was seen to by the midwife,

12, Msc 12; 68-13, Msc 39; 68-13, Msc 31; 69-16, Msc 32; 69-25, Msc 34; 69-27, Msc 26; 69-28, Msc 16; 70-12, Msc 10; 70-13, Msc 4; 70-21, Msc 2; 70-22, Msc 9; 73-135, Msc 1; 73-174, Msc 2. Needle and thread are also used in present-day England to predict the sex of an unborn child. David Clark, Between Pulpit and Pew: Folk Religion in a North Yorkshire Fishing Village (Cambridge: Cambridge University Press, 1982), p.120.

²⁰⁹ For burning see 79-417, Ms p.32; 80-229, Ms p.5; 84-379, Ms p.7; 84-383, Ms p.8. In Stanhope, Lily Clarke buried the afterbirth in summer, but in winter it was thrown into the privy to keep it from dogs. 88-281, C11356.

²¹⁰ 71-99, Ms p.4.

²¹¹ See 75-21, Ms p.14 and 78-211, Ms p.86 for this belief, and 83-312, Ms p.10 for the rationalization.

that was part of the performance. There was never a speck of anything to be seen. That wasn't done."²¹²

If complications threatened both mother and child, the mother was cared for first. Olive Bishop said,

of course, when you're alone and you've got a case like that, you haven't got a chance. Nobody bothered, as long as you could save the mother nobody would, nothing else mattered, and thank God I never lost a mother.²¹³

Doctors also considered the mother first, a fact made apparent in cases when a midwife managed to revive an infant set aside while the doctor tried to save the mother.²¹⁴ It is not surprising to find that the mother was considered more important than the child. The mother was invaluable in the emotional and economic life of the family and a child's chances of surviving infancy without a mother were extremely low.²¹⁵

Midwives who encountered no complications attended few women. Most dealt with some problems, and very active

²¹² 82-326, Ms p.13. Also see 72-62, MUNFLA transcript C1257, pp.15-16; 75-21, Ms p.20.

²¹³ 88-281, C11369.

²¹⁴ See 77-65, Ms pp. 22-23; Porter, pp.94-95.

²¹⁵ Unless another woman agreed to nurse an orphan, even the feeding a motherless infant posed considerable problems. Until tinned, evaporated milk was available, fresh milk was rare and even in many communities where cows were kept it was only available on a seasonal basis. Infant bottles and nipples were unheard of or unobtainable in many places. The problems of artificial feeding were many and the likelihood that an orphan would succumb to a gastric infection in the first year of life was high.

midwives saw many, varied complications. It is now assumed that empirically trained midwives were extremely limited in their ability to deal with complications of labour.²¹⁶ However, Newfoundland midwives handled many problems effectively.

Most midwives encountered babies who were "corded" or "collared" by the umbilical cord, which is hardly surprising as this occurs in about one in four births.²¹⁷ When this problem became apparent, the midwife took hold of the cord and eased it over the head to free the baby.²¹⁸ Annie Power, who witnessed this procedure several times, recalled it was difficult because the mother had to stop pushing while the midwife manipulated the cord.²¹⁹ Susan Everleigh, who must have done this many times in her 1,534 deliveries, said it "wasn't really a problem," but most midwives regarded cording as a serious complication.²²⁰ Olive Bishop was the only

²¹⁶ See Donegan, p.10; Peter Ward, "Introduction," Charlotte Fuhrer, The Mysteries of Montreal: Memoirs of a Midwife, ed. Peter Ward, 1881; rpt. (University of British Columbia, 1984), p.4; Shorter, pp.76-81. Shorter maintains "many granny midwives and helping neighbours simply did not know what to do if a mother ran into trouble, and so she would be left to die." Shorter, p.77.

²¹⁷ Paul and Paul, p.722. Paul and Paul quote an American government manual for midwives on this.

²¹⁸ 76-165, Ms p.16; 76-255, Ms p.11; 81-328, Ms p.25; 88-281, C11371.

²¹⁹ 88-281, C11371.

²²⁰ 76-165, Ms p.16.

midwife to clamp and cut the umbilical cord before the baby was born, which reflects her partial training as a nurse.

Many midwives saw breech deliveries, in which the child's bottom presents, or footling breech when the feet come first. Some midwives would allow such deliveries to proceed without intervention.²²¹ Clara McGrath described her approach:

all in all I didn't have no more than fifteen cases of them breech births. You'd have to let it be. The only difficult thing, everything is alright till you come to the neck. Then I would have to put my finger into the baby's mouth to pull out the head.²²²

She elaborated in her description of the most difficult breech birth she attended:

when I got there it was very cold and the woman was suffering with one [of the child's] leg[s] protruding down beyond the knee. Of course that was a doctor's case because I had no help whatsoever. Her husband had to go to Placentia for the doctor. That was twenty five miles away. All I could do to get the two legs was push back one leg until you get the two legs. Then the same thing applied when you came to the arms. Get one arm down then the other--that took eight hours with great difficulty before the head arrived. I remember it as well as if it was today. A few hours later the doctor arrived and considered it a miracle for the baby was born. Fortunately the doctor came when he did [because] the

²²¹ See 78-415, Ms pp.7-8; 76-165, Ms p.19; 80-229, Ms p.5.

²²² 81-328, Ms p.21.

woman started haemorrhaging.²²³

Like Clara, most midwives attempted to ease the limb back into the birth canal and send for a doctor if possible when a foot or arm presented. Some mal-presentations treated in this way resolved themselves.²²⁴ Other midwives performed either internal or external version, but there are unfortunately no detailed accounts of these manoeuvres.²²⁵ Hand presentation is a rare but extremely difficult complication which makes delivery physically impossible. Lily Clarke dealt with cases by "working" the hand back into the birth canal and turning the baby around.²²⁶ But some children died because of mal-presentation. One midwife delivered a child who presented an arm by lifting the mother's back. It is not stated if she first returned the arm to the birth canal,

²²³ 81-328, Ms pp.22-24.

²²⁴ 79-433, Ms p.14; 88-281, C11371.

²²⁵ Version, the turning of the infant before birth to facilitate delivery, may be accomplished by external or internal manipulation. It is by all accounts a difficult and painful manoeuvre, which has now been almost completely abandoned in favour of caesarian section. For reference to internal version see 75-21, Ms p.17; 78-211, Ms p.86. For reference to external version see 83-312, Ms p.10. Sometimes it is mentioned that a midwife performed version without elaboration. See 71-84, Ms p.2; 88-281, C11373.

²²⁶ 88-281, C11356. Unfortunately, when this interview was conducted in 1984, I did not know enough about obstetrics to question Lily more closely. She mentioned the need for gloves and may well have performed internal version.

but birth would have been impossible otherwise. The child was born with deformities and later died in a hospital.²²⁷ It has been asserted that empirically trained midwives routinely dealt with mal-presentation by pulling the child out by the presenting part.²²⁸ This was not true in Newfoundland. One midwife who pulled on infants' legs when they presented was held responsible for hip deformities of children she delivered.²²⁹ Such force was not considered part of good obstetric care.

Any variation in the child's position during labour can cause problems. If, for example, the forehead presents rather than the crown of the head, or the child travels down the birth canal with its back towards the mother's spine rather than her abdomen, delivery may be impossible without instrumental intervention. Newfoundland midwives did not use forceps to deal with such cases.²³⁰ A doctor or nurse-midwife was always sent for if possible. Otherwise, the midwife could only wait until the child was expelled naturally. This might take

²²⁷ See 79-379, Ms p.19.

²²⁸ Shorter refers to "a rich peasant tradition of tugging on whatever presented itself." See Shorter, pp.79-81.

²²⁹ 75-21, Ms p.18.

²³⁰ Dorcas Taylor was taught by Dr. William Roberts to use forceps to support the perineum during normal labour to avoid tearing, and did this routinely. 76-255, Ms p.12. This does not involve grasping the child's head with the forceps, which Newfoundland midwives did not do.

days, often costing the child's life and sometimes the mother's as well.²³¹

Embryotomy, dismemberment of the fetus to facilitate its expulsion, may be a last resort in difficult labour. Although Shorter refers to this as the only traditional obstetric operation, embryotomy was extremely rare in Newfoundland. Doctors are known to have performed embryotomy.²³² Unlike some European midwives, Newfoundland women never carried or used "crochets," metal hooks to pierce and evacuate the child's skull made popular by European barber-surgeons.²³³ One midwife called upon her husband to manually dismember a fetus as a last resort to save the mother's life.²³⁴ This is the only recorded instance of embryotomy in traditional obstetric care in Newfoundland. For most, embryotomy required too great a degree of vaginal intervention.

Haemorrhage may result if the afterbirth is not expelled because the uterus cannot contract. Some midwives asked women to blow into a bottle to encourage

²³¹ Olive Bishop described a case where labour lasted several days. When the dead child finally emerged the head was about a foot long, and only a few inches in diameter. 88-281, C11368.

²³² Shorter, p.81. For information on embryotomy see 88-281, C11357.

²³³ See Donegan, pp.42-45 for an account of embryotomy as practiced by male accoucheurs in eighteenth century England.

²³⁴ 75-211, Ms p.36.

expulsion of the afterbirth by contracting the abdominal muscles. This is a traditional practice in many places, but one midwife learned it from a doctor.²³⁵ Manual removal of the afterbirth is a truly dangerous undertaking which greatly increases risk of infection and haemorrhage. A few midwives active early in this century did this when necessary, and no problems are known to have resulted. One such midwife lived close to doctors whom she called for other problems.²³⁶ But midwives who became active later did not attempt this manoeuvre. Instead, they pressed on the mother's abdomen and sought professional help, an indication, perhaps, that the risks that midwives were willing to take declined as resort to professional help increased.

Virtually no herbs were utilized in childbirth in Newfoundland and midwives used no substances to stimulate uterine contractions, unlike women in other areas.²³⁷ Purgatives and enemas might strengthen weak contractions, but if labour ceased entirely little could be done. One midwife said

²³⁵ 76-258 Ms pp.9-10; 84-379, Ms p.7. See Hand, Frank C. Brown Collection, Vol. VI, p.13.

²³⁶ 88-281, C11379; C11380.

²³⁷ In many places, midwives used ergot, a fungus of rye which is highly effective in stimulating uterine contractions. See Luc Lacourciere, "A Survey of Folk Medicine in French Canada from Early Times to the Present," in American Folk Medicine, p.209; Shorter, p.78.

I'd sit down beside her, could do nothing but pray specially if the woman was bad. I['d] know I couldn't born it. Sometimes they'd lose their pains, then I'd have to go over the road with her, that is to the hospital.²³⁸

Haemorrhage and eclampsia were greatly feared. Haemorrhage may result from laceration during labour, incomplete separation of the placenta, exhaustion due to prolonged labour or loss of muscle tone in the uterus resulting from many, frequent births.²³⁹ Maternal nutrition is important as anaemic women are less able to withstand the shock of haemorrhage.²⁴⁰ In dealing with haemorrhage, emphasis was placed on preventative care during confinement rather than resort to the supernatural. Blood stopping charms were rarely employed. One man who was a blood stopper in St. Bernard's, Fortune Bay was called by a midwife if a woman haemorrhaged. He applied ribbons to the woman's arms and this charm was said to be effective.²⁴¹

Haemorrhage can be very swift, and unless a doctor or nurse was close by, a woman would likely bleed to death before help arrived. Women died of haemorrhage. One

²³⁸ 75-21, Ms p.13.

²³⁹ Clark and Affonso, pp.729-732.

²⁴⁰ Elizabeth Davis, A Guide to Midwifery: Heart and Hands (Toronto: Bantam Books, 1981), p.115.

²⁴¹ This information is from an unaccessioned survey card, submitted by Lana Johnston for Folklore 2300, Fall 1988. This man was active in the 1920s.

woman was advised by a doctor to deliver in hospital because "her blood was low." When she declined, the doctor asked Susan Everleigh not to attend her, but the midwife could not refuse to help. The child had been dead for some time, and the woman haemorrhaged and died. The midwife recalled "it was sad to sit and watch her bleeding to death, not being able to do anything about it."²⁴² Clearly, this complication was beyond the midwife's skills.

Lillian Wandling was taught that haemorrhage could be prevented by keeping the uterus in place, and she placed a small roll of cloth above the fundus before applying a binder to accomplish this.²⁴³ The uterus does rise when haemorrhage occurs, but only because it fills with blood, so this practice was probably ineffective.²⁴⁴ Other midwives were taught by nurses and doctors to pack the vagina when haemorrhage occurred and elevate the lower part of the woman's body but these measures had limited effect. Ergot, given to some midwives by health care professionals, was more effective in stopping haemorrhage.

Toxemia, also called pre-eclampsia, is a disease of

²⁴² 76-165, Ms p.17. This was the midwife's only maternal mortality.

²⁴³ 88-281, C11355. Abdominal binders are discussed in detail below.

²⁴⁴ 88-281, C11357.

pregnant women only, and an enigma still.²⁴⁵ The extreme stage, eclampsia, is characterized by kidney failure and convulsions which may prove fatal. The symptoms of toxemia include rapid weight-gain due to fluid retention (edema), high blood pressure, blurring of vision, headaches, and protein in the urine. These symptoms seem unrelated to people with no knowledge of modern medicine, and some of the most telling, such as high blood pressure and protein in the urine, are not readily observable. Because of this toxemia was not recognized as a distinct disease in traditional health care. Convulsions could not be predicted or prevented, and little could be done to treat them effectively, although they usually abate when delivery is complete if the mother survives.

One midwife treated convulsions by having the woman drink "a dose of salts" or baking soda in water, but most midwives let the convulsions take their course and sent for a doctor.²⁴⁵ In the early part of this century, when Elsie Drover's mother went into convulsions during labour, the midwife sent for a doctor and the Anglican clergyman who had some medical knowledge. They rolled the woman in blankets heated with hot water. This treatment had no effect the woman died, although the child lived to

²⁴⁵ See Clark and Affonso, p.678. Eclampsia remains a major cause of maternal mortality.

²⁴⁵ 79-695, Ms p.14.

adulthood. Another woman died of eclampsia in the community that year. Midwives learned to identify the symptoms of toxemia and refer women with them to doctors.

Traditional obstetric care had definite limitations, but Newfoundland midwives do not confirm Shorter's picture of women who intervened freely in normal deliveries, but were completely incapable of dealing with problems. Uncomplicated labour was approached as a natural process requiring minimal intervention. Midwives did not intervene aggressively in part because they regarded the internal workings of the body as being beyond their expertise. Mag Hibbs articulated this when asked how she would treat a woman if menstruation stopped. She replied, "they'd have to go to a doctor in a case like that. That's inside you, that's more than we could, you know."²⁴⁶ A laissez-faire attitude is also evidenced by reluctance to perform amniotomy and embryotomy, lack of instrumental and surgical intervention, and caution with internal examinations.

In Newfoundland, the two systems of obstetric care co-existed quite well. This was partly because the medical care that women received in Newfoundland in the early part of this century was by no means identical to current obstetrics. As noted above, some folk practices, blowing in a bottle for retained afterbirth for example,

²⁴⁶ 72-62, MUNFLA transcript C1257, pp.8-9.

were used by doctors. Intervention was also approached differently. Breech presentation, for example, is now routinely handled by caesarian section, whereas a generation ago doctors would attempt to perform version.²⁴⁷ Caesarian section was dangerous and impractical outside a hospital and was avoided until birth was institutionalized.²⁴⁸ Medical obstetric care was not characterized by aggressive intervention or heavy reliance on technology. One midwife recalled that a doctor she assisted at an instrumental delivery said "it's just as bad, you know, to start [intervention] too quick as not quick enough."²⁴⁹

There were some points of conflict however. Sometimes doctors were believed to intervene for their own convenience rather than the well-being of mother and child, as noted in the discussion of episiotomy above. When this happened, midwives were critical. Freida Guinchard related a narrative about such intervention to Cindy Turner:

F. G. Well, the way it is the doctor just
come there long enough to deliver the

²⁴⁷ 88-281, C11356; C11357.

²⁴⁸ For example, Agnes Kennedy, a registered-nurse midwife, recalled only one caesarian during her career in Newfoundland. In that case, the mother died of a stroke in her ninth month of pregnancy and a doctor performed the operation after her death to successfully deliver the live child. 88-281, C11353.

²⁴⁹ 82-166, Ms p.11.

baby and was gone again, that's all...I know Dr. _____ had words one night. I sent for him and he came and it was a bit early because the baby wasn't ready to pop into the world. He got mad. He said, "You shouldn't have sent for me." He wanted to give her a shot of something. I said, "Not yet."

C. T. She wasn't really ready to have her baby and you wanted to wait but it was sort of pressed for some reason?

F. G. Dr. _____ used to always hurry them along just the same.²⁵⁰

So blatant a challenge to a doctor's authority by an empirically trained midwife was rare, indicating how strongly this woman felt that normal labour should not be tampered with.

A high degree of intervention implies a sense of control over labour which was not present in traditional obstetric care. Newfoundland midwives managed childbirth by responding to circumstances as they arose. When complications developed midwives were not helpless, and with limited intervention successfully resolved many problems. But before medical obstetric care was available, some mal-presentations, haemorrhage and convulsions were simply beyond the midwife's control and mortalities caused by these complications were seen to be unavoidable. One midwife said,

if a woman was having a baby and the midwife couldn't deliver it or the baby died, through some fault of the midwife

²⁵⁰ 84-332, Ms appendix p.19.

or of the mother, they just accepted it as an act of God. You would just pick up the pieces and go on. They didn't blame.²⁵¹

Confinement

The treatment we got after the baby was born was something else. You got tea with bread and butter the first day. Then no more for three days, dry toast I lived on for three days. They wouldn't even give you a drink of cold water. You were not allowed to sit up in bed. You weren't allowed to comb your hair, not put your hands in cold water. The windows were not allowed to be opened. I don't know what way it was, but you had to go along with it. The midwife had the responsibility of you and the baby, and she was afraid you'd haemorrhage. They would let you up the fifth day just to sit in the chair. The tenth day, mother was coming down stairs and that was a big day. The blanket was put on the rocking chair and my husband would say "Don't open the doors, mother is getting up today." Then when you got up, you couldn't walk, you were practically starved to death.²⁵²

When delivery was complete, the mother was washed, changed into a clean nightgown and made comfortable in a freshly changed bed. At this time an abdominal "binder" or "wrapper," a band of clean cloth about six inches wide, was wrapped several times around the mother's abdomen.²⁵³ This supported the flaccid stomach. One woman

²⁵¹ 74-181, Ms p.66.

²⁵² 75-21, Ms p.23.

²⁵³ 75-21, Ms p.24; 77-247, p.6; 88-281, C11354; C11358; C11370; C11372.

said "when you got the band on you, you were in heaven, otherwise you were all abroad, because this band gave support, once it was tucked in nice and tight."²⁵⁴ Some women believed the binder helped the abdomen to resume its normal shape. Although part of traditional obstetric care, abdominal binders were also used in the Grace Hospital into the 1940s.²⁵⁵ Several women regretted the passing of the binder because it provided comfort.²⁵⁶

The midwife washed the newborn with soap and water or olive oil in the warmth of the kitchen. The stump of the umbilical cord was dressed with previously prepared burnt flour and scorched cloth. An abdominal binder called "a belly band" was also placed on the infant "to support and protect what remained of the cord."²⁵⁷ This

²⁵⁴ 75-21, Ms p.24.

²⁵⁵ Abdominal binders were used by women in early modern England, see Sharp, p.210, and early twentieth century Northern Ireland, see Linda-May Ballard, p.67. A Quebecois midwife in nineteenth century Maine also used binders. See Paradis, p.120. Hispanic-Americans call the abdominal binder a faja. Buss, pp.71-72; Kay, p.59; Keyes, p.37. For information on use of abdominal binders in the Grace Hospital see 88-281, C11377. They were also used in English hospitals into the 1940s. Personal communication, Dr. Kenneth Roberts, November, 1988.

²⁵⁶ 88-281, C11354.

²⁵⁷ 72-21, Ms p.21. Also see 76-142, Ms p.7; 76-351, Ms p.12; 76-494, Ms pp.7-8; 77-247, Ms p.6; 79-417, Ms p.34; 81-328, Ms p.28; 81-491, Ms p.9; 84-364, Ms p.5. This binder was changed with the diapers. Infant binders were also used in Northern Ireland, see Linda-May Ballard, p.66; by Quebecois settlers in Maine, see Paradis, p.121; and by Mexican and Hispanic-American women, see Buss, pp.70-71; Kay, p.59; Keyes, p.160.

was between four and six inches wide, also made of clean, used cloth and was kept in place at least until the stump of the cord fell off. Annie Power recalled it was always retained for five or six months in Branch, or even as long as a year.²⁵⁸ This band was to prevent umbilical hernia and support the child's back.²⁵⁹ If umbilical hernia occurred, a coin covered in cloth might be placed under the band to hold it in.²⁶⁰ The belly band was apparently never part of medical obstetric care in Newfoundland. Midwives were aware that health care professionals disparaged this practice, but still believed it was an important part of infant care.²⁶¹

The band in place, the child was dressed in a diaper, an undershirt, and a flannelet coat called a "barrow coat" in some places.²⁶² This was overlapped and tied at the side and was long enough to cover the baby's feet and overlap up, where it was secured with another, external band. The child was then wrapped tightly in a thick blanket. Dressing complete, the baby was placed in bed beside the mother to receive her warmth and be fed

²⁵⁸ 88-281, C11372.

²⁵⁹ 68-08, Msc 18; 73-31, Msc 3.

²⁶⁰ 69-9, Msc 19; 73-25, Msc 1.

²⁶¹ See 88-281, C11354; C11378.

²⁶² This term seems most prevalent in Irish Catholic communities.

with ease.

The application of these binders marked the beginning of a nine to ten day confinement period observed almost universally in Newfoundland. While there are practical reasons for use of the abdominal binder on the mother and belly band on the infant, the similarity of the two is striking. These almost identical abdominal dressings may have symbolized the identical danger faced by new mother and newborn. Confinement was a time of danger, when a woman might haemorrhage or develop "a chill."²⁶³ In 1671 Jane Sharp wrote "women are in as great danger if not more, after the young is born," an idea which persisted well into this century in Newfoundland.²⁶⁴ Freida Guinchard said,

to me this follow up care was more important than the delivery...Delivery was important too but the baby was going to come, everything was normal, the baby was going to come anyway. But anything can happen [after] especially on the third day. If anything was going to happen that's when you find the signs. Probably the woman would run a temperature, I'd check for that. The third day the milk would come into the breasts and that would give you a rise in

²⁶³ See 71-99, Ms p.4; 72-62, MUNFLA transcript C1257, p.3; 73-161, Ms p.15; 75-21, Ms p.23; 76-142, Ms p.7; 76-165, Ms p.22; 76-184, Ms p.27; 76-255, Ms p.13; 76-351, Ms pp.10-11; 78-119, Ms p.24; 79-433, Ms p.17; 79-509, Ms p.6; 79-662, Ms p.26; 79-695, Ms p.14; 81-328, Ms p.28; 81-474, Ms p.5; 82-166, Ms p.14; 83-312, Ms p.14; 84-364, Ms p.5; 84-383, Ms p.8; 86-254, Ms p.14; 88-281, C11354; C11356; C11358; C11372; C11373.

²⁶⁴ Sharp, p.217.

temperature too.²⁶⁵

Accordingly many precautions were taken, as illustrated by the quotation which opens this section. Some customs were not common in Newfoundland, not being allowed to comb one's hair for example.²⁶⁶ Restricted diet, concern with cold and complete bed rest were more widespread.²⁶⁷

Women were usually given very light meals such as tea and toast and not fed butter or anything greasy.²⁶⁸ Jane Sharp believed this was done because the newly delivered woman "may not use a full diet after so great loss of blood suddenly."²⁶⁹ By the early twentieth century, the rationale for restricted diet was unclear, and gradually women ate whatever they pleased or thought nourishing during confinement.

Tea made from juniper twigs and berries (*Juniperus communis*) was given to the mother as a purgative a few days after the birth to ease constipation and rid the

²⁶⁵ 84-332, Ms appendix p.19.

²⁶⁶ In early twentieth century Northern Ireland, Catholic women were not allowed to comb their hair until after they were churched. Linda-May Ballard, p.67.

²⁶⁷ See 73-161, Ms p.15; 77-247, Ms p.6; 79-405, Ms p.12; 83-312, Ms p.14; 88-281, C11371; 11376; Murray, pp.88-89.

²⁶⁸ 72-62, MUNFLA transcript C1257, p.17; 75-21, Ms p.23; 76-255, Ms p.13; 79-508, Ms p.6; 79-405, Ms p.11; 88-281, C11358; Rogers, p.2.

²⁶⁹ Sharp, p.211.

body of any "corruption."²⁷⁰ Juniper also helped afterpains and made the uterus contract. Castor oil could be given as a purgative instead. Infants were also purged with castor oil, as St. John's public health nurses reported.²⁷¹ This was not widely reported, perhaps because women are now aware of the dangers of this practice, but it seems to have been a common practice. Juniper was also sometimes given to infants with gas and colic.²⁷²

Warmth was extremely important during confinement.²⁷³ There was a pragmatic basis for this as the weather is rarely hot in Newfoundland. Concern with

²⁷⁰ 78-211, Ms p.95. Also see 70-15, Msc ; 70-35, Ms p.3; 79-662, Ms p.26; 84-364, Ms p.6; 84-379, Ms p.10; 86-254, Ms p.14; 88-281, C11373.

²⁷¹ See Rogers, p.2; Child Welfare Association Annual Report, 1929, p.14. For outports see 73-155, Msc 6; 84-379 Ms p.10. In nineteenth century England, "grandmothers of all classes, midwives and doctors agreed that the first aliment for new babies should be 'something of an opening nature.'" Midwives preferred butter mixed with sugar, but at least one medical man recommended castor oil. F. B. Smith, The People's Health, 1830-1910 (New York: Holmes and Meier Publishers, Inc, 1979), p.82. See Leather, p.112 for reference to use of butter and sugar around the turn of the century.

²⁷² 73-138, Msc 1. Juniper was also sometimes given to domestic animals following delivery, and was used for "urine trouble" and "to cleanse the body and ease pain." 84-363, unnumbered Msc.

²⁷³ See Kay pp.59-61; Keyes, p.164 for the dangers of coldness in the post-natal period among Mexican and Hispanic-American women; Linda-May Ballard, p.69 for women in Northern Ireland; Shorter, p.54 for eighteenth century Germany; Sharp, p.230 for seventeenth century England and Scholten, p.434 for early America.

the cold was more than mundane however. During confinement, for example, windows were kept closed even if the weather was hot. Perhaps this had symbolic significance, as windows were sometimes opened to allow the departing soul to escape after a death occurred.

Women who discussed the importance of warmth spoke interchangeably about taking a chill or catching a cold during confinement, but some were not referring to the viral common cold. Nellie Powell knew of a woman who handled cold cabbage after giving birth and died as a result.²⁷⁴ Elizabeth Marsh recalled a woman who, during confinement, was given clean clothes that had been dried outside. Because the seams were frozen she took a chill which caused her death.²⁷⁵ Post-natal complications were understood to be caused by coldness entering the body. Jane Sharp believed that a woman's unusual suffering after labour was caused by "the cold air that is got in by her sore travel in child-birth."²⁷⁶ Warmth was the only preventative measure traditional obstetrics could offer.

As noted above, Newfoundland midwives were quick to adapt as the value of cleanliness in prevention of

²⁷⁴ 88-281, C11376.

²⁷⁵ 88-281, C11379.

²⁷⁶ Sharp, who was familiar with anatomy, also blamed "sharp or clotted blood sticking in the womb," possibly retained afterbirth. Sharp, p.220.

infection became known. Post-natal care came to include daily washing of the vaginal area with cooled boiled water which sometimes contained disinfectant. The idea of dangerous cold was not negated by this new knowledge, however, and attention to warmth continued along with care about cleanliness.²⁷⁷

The same concern about cold may be seen in traditional infant care. Jane Sharp gave this as one reason for binding the navel:

when the Navel-string is cut off, apply a little Coten or lint to the place to keep it warm, least the cold get in, and that it will do if it not be hard enough bound, and if it do you cannot think of a greater mischief for the Child.²⁷⁸

Newfoundland women also believed the cold was harmful to infants, and this explains why babies were dressed in so many layers of clothing, although this also kept the baby (and the mother's bed) dry. One woman recalled that a district nurse assigned to her community after the World War II omitted the belly band and dressed infants in nightgowns open at the feet and back. The mothers "were shocked. They really thought that the children were going to die with the cold..." but they did not return to

²⁷⁷ One woman, who had a child in the 1970s, was expected to call her mother-in-law, who lived next door, every time she wanted anything out of her refrigerator after returning from the hospital with her child. Class discussion, Folklore 3420, Grand Falls, 1983.

²⁷⁸ Sharp, p.216.

traditional infant dress, a measure perhaps of their confidence in formal medical training.²⁷⁹

The barrow coat was overlapped to cover the feet until the child was about three months old. Then the mother "shortened" or "stumped" her baby by cutting the outer clothes so that they opened at the feet.²⁸⁰ Shortening the baby was a minor event, a cause for comment, part of the local news. It was also a vestige of a much longer confinement period of observed in former times, an idea returned to below.

Because of the dangers associated with confinement, the new mother was not expected, or even allowed to assume her regular chores. Housework was taken over by the husband, neighbours and relatives, or the midwife.²⁸¹ One collector states that a midwife

suspected some of the women of cheating a little and getting up before they should have, but if they did, it was only for a short time and they always went back to bed and waited for the proper time to get up.²⁸²

Bed rest allowed women to remain warm and was considered the best means of preventing haemorrhage, which helps to

²⁷⁹ 88-281, C11372.

²⁸⁰ See 71-18, Msc 1; 88-281, C11371.

²⁸¹ For references to husbands running the household during confinement see 75-21, Ms p. 25; 88-281, C11370; C11379.

²⁸² 84-364, Ms p.6.

explain why women were kept "on the broad of the back" for nine days. Doctors also connected activity after childbirth with haemorrhage. Women in the Grace Hospital were confined to bed for nine days following childbirth into the 1940s. Minnie Taite recalled that Cluny MacPherson encouraged women to walk from the delivery room to their beds. At first, other doctors "thought he was crazy," because they believed that this might cause haemorrhage.²⁸³

Confinement changed as childbirth was medicalized. Annie Power recalled that "before her time" two women stayed up to watch over the new mother for four nights "because they were afraid something would happen." When her children were born in the 1950s, this practice was laughed at.²⁸⁴ When Mag Hibbs's mother was active, around the turn of the century, women were confined to bed for nine days and kept "all covered up" but during Mag's time as a midwife this changed, and women would get out of bed briefly before confinement was over.²⁸⁵ When Elizabeth Austin began her work in the 1940s, women were confined to bed for ten days, allowed to sit up on the eleventh and permitted to go into the kitchen on the twelfth day

²⁸³ 88-281, C11377.

²⁸⁴ 88-281, C11372.

²⁸⁵ 72-62, MUNFLA transcript C1257, p.3. Mag Hibbs was active between 1929 and 1969. Also see 73-161, Ms p.15.

after giving birth. "After a while," this changed; the mother was permitted to sit up on the sixth day and the midwife's work was over after nine days.²⁸⁶

Such changes were sometimes due to the influence of health care professionals. Susan Everleigh, who was active from around 1919 to 1974, kept her clients in bed for nine days at the beginning of her career but at some point cut this time down to three days on the advice of a doctor.²⁸⁷ But this change often occurred without outside influence and seems to indicate a lessened sense of the dangers of childbirth.²⁸⁸ In the past and in other cultures women observed a much longer confinement of thirty to forty days.²⁸⁹ By the twentieth century, Newfoundland women limited confinement to nine to ten days, but vestiges of this older pattern are discernible. In Branch, for example, women were not allowed to touch anything cold for twenty days after confinement, and one woman's husband put sheep's wool over the handles of

²⁸⁶ 84-383, Ms p.8.

²⁸⁷ 76-165, Ms p.22.

²⁸⁸ A similar decline in perception of the dangers of childbirth been noted in eighteenth century America. See Wertz and Wertz, pp.24-25.

²⁸⁹ See Sharp, p.211 for seventeenth century England; Wertz and Wertz, p.4 for eighteenth century America; Richard Blum and Eva Blum, The Dangerous Hour: The Lore and Culture of Crisis and Mystery in Rural Greece (London: Chatto and Windus, 1970), pp.19-20 for twentieth century rural Greece; and Kay, p.59-60 for early twentieth century Hispanic-American practice.

buckets so she could carry water without touching the cold metal.²⁹⁰ On Long Island, Notre Dame Bay, women waited a month before resuming their full workload.²⁹¹ Retention of abdominal binders on mother and child for thirty days and the shortening of the baby were also vestiges of an extended confinement.

For many women, however, there was no sense of continued danger after nine to ten days. At the end of confinement, midwife Bertha Feltham said the woman could "get up and go on outdoors, all danger was over."²⁹² The end of confinement marked a return to normal life. Sometimes this was acknowledged with a secular celebration which has English antecedents.²⁹³ Known as a "groaning party" in colonial America, this celebration was sometimes called an "Up-sitting Day" in Newfoundland.²⁹⁴ This was usually only for the mother, midwife and other women who helped with the birth. Colonial Americans enjoyed a substantial meal, whereas in Newfoundland the Up-sitting celebration might be an

²⁹⁰ 88-281, C11371.

²⁹¹ 75-211, Ms p.37.

²⁹² 79-433, Ms p.17.

²⁹³ See Murray, p.91 for discussion of English antecedents.

²⁹⁴ See Wertz and Wertz, p.5 for the groaning party in colonial America. See 78-211, Ms pp.105-106 and Murray, pp.89-91 for Newfoundland.

afternoon tea. The "Groaning Cake," which could be a simple raisin bread or a dark fruit cake, was featured.²⁹⁵ In Portugal Cove, this event was given no special name and was a party for friends. The father would buy a gallon of rum to celebrate if there was extra money.²⁹⁶

Women who were not Catholic or Anglican ended confinement with no special religious rite. Women belonging to these two religions were administered the rite of "the churching of women" after giving birth. This was a rite of purification in the Catholic church, while the Anglican church stressed thanksgiving for a safe delivery. Some women were churched as soon as they could get out, while others waited a month or even a few months. In Newfoundland, churching was not as rigidly connected with the end of confinement as in England and other European countries in the past.²⁹⁷

Many women were not allowed to do any housework until they were churched, and there was a widespread prohibition against baking bread, although necessity

²⁹⁵ See 71-98, Ms p.21; 71-107, Msc 1; 78-211, Ms p.106; Murray, pp.89-90.

²⁹⁶ 78-211, Ms pp.106-107.

²⁹⁷ See Blum and Blum, The Dangerous Hour, p.19 for churching in rural Greece, and Keith Thomas, pp.59-60 for England during the Reformation. For Newfoundland see 73-161, Ms p.15; 76-351, Ms pp.10-11; 83-312, Ms p.14; 88-281, C11371; C11378.

sometimes caused these customs to be disregarded.²⁹⁸ In some places, it was also felt that women should not visit other households until they received this rite.²⁹⁹ One woman was not allowed to attend a wedding because she had not been churched.³⁰⁰ The folk rationale for churching varied. Dona Davis was told by an Anglican informant churching was performed because "it gave you back all the strength you lost in childbirth."³⁰¹ Another Anglican informant reported that during churching she was "thanking God for bringing me through [childbirth]," which is the official Anglican doctrine.³⁰²

The churching of women was sometimes connected with ritual impurity, an idea old at the time of the

²⁹⁸ 67-21, Msc 2; 71-23, Msc 6; 73-155, Msc 2; 73-179, Msc 3; 75-21, Ms p.34; 76-494, Ms p.14; 78-211, Ms p.113; 81-328, Ms p.29; 88-281, C11372; C11373; C11378. Dona Davis, p.68.

²⁹⁹ 88-281, C11380. Catholic women in Northern Ireland also refrained from visiting until after they were churchd. Linda-May Ballard, p.68. This belief is still current in at least one village in northern Yorkshire. David Clark, Between Pulpit and Pew: Folk Religion in a North Yorkshire Fishing Village (Cambridge: Cambridge University Press, 1982), p.115.

³⁰⁰ 88-281, C11358.

³⁰¹ Dona Davis, p.68.

³⁰² 88-281, C11364. For the official Anglican text of this rite see "The Thanksgiving After Child-birth, Commonly Called the Churching of Women," Book of Common Prayer (London: Eyre and Spottiswoode, 1947), pp.573-574. For Catholic doctrine see "Churching of Women," The Catholic Encyclopedia (New York: Robert Appleton Co. 1908), Vol. III, p.761.

Reformation.³⁰³ Some Anglicans believed that churching provided an opportunity for forgiveness as well as thanksgiving. The new mother was considered unclean and "pray[ed] that the 'Original Sin' with which every child is born be absolved" when she received this rite, though original sin is not mentioned in the Anglican prayer book.³⁰⁴ Some Roman Catholics also said "churching was done to cleanse the woman" after childbirth.³⁰⁵ One midwife stated "the old folks would say she wasn't clean till she got the rites."³⁰⁶

Although churching was associated with ritual purification well into the twentieth century in Newfoundland, this can hardly be described as the dominant view, and is now all but extinct. Older women would not discuss the connection between childbearing and ritual impurity unless specifically asked, and some denied the idea outright. This rite was dropped by the Catholic church in 1970.³⁰⁷ Churching is still maintained

³⁰³ Keith Thomas, p.38.

³⁰⁴ 78-211, Ms p.44; p.113. Also see 67-21, Msc 2; 71-23, Msc 6; 88-281, C11378. See "The Thanksgiving After Child-birth, Commonly Called the Churching of Women," Book of Common Prayer, pp.573-574.

³⁰⁵ 76-494, Ms p.14. Similarly, Catholic women in Northern Ireland believed that churching "was to clean you after producing the devil himself." Linda-May Ballard, p.69.

³⁰⁶ 81-328, Ms p.29.

³⁰⁷ David Clark, p.119.

as an official rite in the Anglican church, but is usually incorporated into the christening ceremony.³⁰⁸ Younger women, even those churching as part of baptism, do not relate childbirth to impurity.³¹¹

If there was any doubt about an infant's survival, he or she was baptized at birth by the midwife, or by a clergyman, lay reader, or even a school teacher if there was time to wait.³¹² The desire for baptism was most urgent among Catholics. In communities with a resident priest, even a healthy child would receive this rite within a few days of birth, before the end of the mother's confinement, so it was routine for a mother to be absent from her child's baptism. Catholic doctrine placed the soul of an unbaptized infant in limbo, but some people believed such children would go to purgatory, or even hell, which explains the haste.³¹³ Similarly, in one Protestant community where infants were baptized as

³⁰⁸ However, one woman who lived near St. John's in the late 1970s was churching at the insistence of an Anglican minister. The ceremony took place the same afternoon as the christening, but was separate. Personal communication, Dr. Kenneth Roberts, November, 1988.

³¹¹ Many of the Anglican students I taught in Grand Falls in the summer of 1983 had been churching when their infants were christened. None had ever heard of churching as purification, and some were extremely indignant at the suggestion.

³¹² 71-123, Msc 1; 73-160, Ms p.9; 76-142, Ms p.8; 76-351, Ms p.25; 77-139, Ms p.20; 81-328, Ms p.30.

³¹³ See 77-139, Ms pp.20-22; 79-163, Ms p.8.

soon as possible, it was said that an unbaptized child "would not go to heaven as the sins to the parents would be on it."³¹⁴

A child who died without being baptized was never fully a person. Like murderers and suicides, unbaptized infants were not buried on consecrated ground in many places, although some people placed them on the border of the cemetery, or in an unmarked corner reserved for this use.³¹⁵ Some Roman Catholics baptized even a miscarried fetus and placed it in consecrated ground. Protestants tended not to do this, which may reflect fundamental differences in ideas about when life begins.³¹⁶

Until a child was baptized, it was considered to be in danger and many women would not take the baby out of doors.³¹⁷ Elsie Drover said "take the baby out of the house? They wouldn't let you leave the cot, sure."³¹⁸

³¹⁴ 71-123, Msc 1.

³¹⁵ 73-153, Msc 17; 77-139, Ms p.22; 81-328, Ms p.31; 88-281, C11378. Similar practices are recorded in England. See David Clark, p.117.

³¹⁶ For information on Catholics see 88-281, C11372. For Protestants 88-281, C11379.

³¹⁷ 76-142, Ms p.8; 88-281, C11373; Class discussion, Folklore 3420, Grand Falls, Summer, 1983. Many married women in this class were advised not to take their infants out until they were baptized. The danger to the child was undefined but real.

³¹⁸ 88-281, C11373. In the north Yorkshire town David Clark studied, he found that unbaptized infants might be taken outside, but were not allowed in other people's houses. He attributes this practice to the

Infants were protected with silver coins around the neck, a hymn book or a prayer book if taken outside or left alone in doors.³¹⁹ Many people thought the fairies would take any child, but unbaptized children were a particular cause for concern.³²⁰ In the second half of this century these ideas began to decline. Some women born after World War II either kept their children at home before baptism without being able to define the danger, or ignored the advice of somewhat shocked relatives and took their babies out as they pleased.³²¹

When it was not performed in haste, baptism was a formal celebration marking the entry of the infant into social life, though not in all denominations.³²² This rite was felt to confer magical benefits as well as

belief that the infant is impure before baptism. David Clark, p.116. In Newfoundland, emphasis was on keeping the unbaptized infant within the safety of the home, and the concept of danger seems to have been stressed more than impurity.

³¹⁹ 65-10, Msc 1; 88-281, C11373.

³²⁰ 88-281, C11373. Some people spoke instead of "evil spirits," see 65-10, Msc 1. One woman spoke of the need to protect babies from the evil eye, brought on by the compliments of those who actually wished the baby ill. 79-163, Ms pp.4-5. This tradition is widespread in Mediterranean cultures but less common in those of Northern Europe. See Blum and Blum, Health and Healing, pp.124-36; 166-73; 183-87; and 207-11.

³²¹ Class discussion, Folklore 3420, Grand Falls, Summer, 1983.

³²² Evangelical denominations such as the Salvation Army and the Pentecostal church do not baptize infants.

religious ones. Some people believed that a child would not begin to grow until baptism, or would grow more rapidly after.³²³ A child who cried during baptism was thought to be assured of survival, whereas one who failed to cry might well die, and some God-parents pinched the infant during baptism for this reason.³²⁴ While this belief was not always taken seriously, it reflects the anxiety caused by high infant mortality.

In the dangerous post-natal period, confinement traditions provided preventative health care to protect the mother from haemorrhage, chill and infection and the newborn from less defined dangers which included the supernatural. Mother and child remained separate because they were both vulnerable and unclean. The rites which marked the end of this period purified mother and child, signified entry or reentry into social life and restored life to a normal state. These ideas changed in the twentieth century. As childbirth came to be regarded as less dangerous and less polluting, the necessity for extraordinary measures declined.

³²³ 71-128, Msc 1; 73-163, Msc 1. Keith Thomas traces these beliefs back to the Middle Ages, and notes they were still prevalent in early twentieth century England. Keith Thomas, p.37.

³²⁴ 68-07, Msc 31; 71-11, Msc 1.

Conclusion

The idea of danger was highly significant in traditional obstetric care. Each pregnancy required considerable effort to ensure a sound child well before labour began. Mortality from some causes was regarded as unavoidable, and the post-natal period was a time of danger. These ideas were not borrowed from medical obstetrics. They were deeply rooted in traditional obstetric care. In fact, childbirth was probably seen to be even more perilous in previous centuries.

Women in Newfoundland certainly viewed childbirth as a natural process, but their concept of nature did not preclude danger. In the early twentieth century, Newfoundlanders lived in a natural environment that was often fatal. Men went to sea to fish, or out to the ice to hunt seals and died without a trace. One out of every four infants could be expected to succumb to "natural causes" in the first year of life. Most families were directly touched by maternal or infant death, and it seems fair to characterize childbirth as natural but dangerous.

In Newfoundland, medicalization of childbirth was not forced upon women. Midwives and medical men shared identical practices such as the use of the abdominal binder on the mother and observation of a nine day period of confinement. Attitudes towards the potential dangers

of childbirth and the degree of intervention thought to be desirable in the early decades of this century also overlapped. Similarities in practices, ideas and attitudes would not ensure an easy transition from traditional to medical obstetric care however if both health care systems had been unyielding. Traditional health care systems in other cultures have been characterized as "open systems," readily incorporating aspects of other institutions within their societies and showing great flexibility when confronted with medicalization.³²⁵

The traditional obstetric system in Newfoundland was similarly open, changing even before the influence of medicalization was felt. The lengthy confinement observed in early modern times gave way to a shorter nine to ten day period, and in this it is possible to discern a lessened sense of the dangers of childbirth. As information about medical obstetrics became available, Newfoundland midwives changed the amount of equipment they carried, standards of cleanliness, posture of birth and number of attendants present. These changes often occurred before direct contact with doctors and nurses.

Midwives relied more on health care professionals as the century progressed. This change cannot be explained by access to practitioners alone. As noted in Chapter

³²⁵ See Press, "Urban Folk Medicine," p.72.

One, in 1935 there were some twenty-five percent fewer doctors in Newfoundland than in 1911.³²⁶ Nor can midwives be seen to have perceived childbirth as more dangerous. Medical anthropologists note the ability of traditional practitioners to relinquish authority over certain aspects of care to the medical system.³²⁷ In Newfoundland, this flexibility was rooted in what is best described as the non-authoritative quality of traditional obstetric care. Midwives had definite limits in recognizing, defining and coping with complications of pregnancy and childbirth, and they did not pretend otherwise.

Medical obstetrics offered solutions to some of these problems. With forceps, a doctor or nurse could deliver a child that might otherwise die. If the placenta had to be removed manually, ergot could stop the haemorrhaging that might easily result. Toxemia remained an enigma, but trained practitioners could at least identify women likely to go into convulsions, and with bed rest this might be averted.

In the middle decades of the century, dual use prevailed and the two obstetric systems complemented each other; midwives coped effectively with most cases, but

³²⁶ Rusted, p.4.

³²⁷ See Press, "Urban Folk Medicine," p.76.

relied on health care professionals when the demands of a birth exceeded their abilities. This period of dual use helped to ease the transition from traditional to medical obstetrics by providing women with the familiar comforts of midwives and birth at home while male doctors and their interventions became familiar.³²⁸

The final shift from midwife-attended home birth to doctor-attended hospital birth was accomplished in part because of the attitudes of midwives. Annie Power assisted her friend Fanny McGrath for many years. Although she would probably have become the midwife if traditional care continued, she declined public health training after a district nurse was stationed at Branch. She felt the work was too demanding, and the dangers too great. She said,

you know, but you have to be, I says [midwives] they have to be something special, people like that cause you're taking both mother and child's life in your hands, there's no doubt about it...³²⁹

Because of these attitudes, some midwives urged women to seek professional attendance. One midwife said

I told her I would do what I could but there was an awful lot I didn't know and the little that I did know about some things I would be afraid to take the

³²⁸ Press notes the importance of dual use during major transitions in health care. See Press, "Urban Folk Medicine," p.81.

³²⁹ 88-281, C11371.

responsibility of it. Every time I did anything I would ask them first to go to [the cottage hospital at] Springdale. If they didn't want to go, well I said, "It's your responsibility, not mine." And so they understood that...But if anything happened I would feel awful, but it would have been on their own heads, I couldn't do anything else.³³⁰

Most child-bearing women did not resist medicalization and many welcomed it. A new generation grew up accustomed to the idea of male medical practitioners and were aware that women in other parts of North America gave birth in hospitals under the care of professionals. But it would be inaccurate and simplistic to say that medicalization of childbirth was regarded as an unmitigated blessing. Some women who experienced the transition felt in retrospect they were happier at home. One said, "I preferred my own home to a crowded case room where you were just part of a herd. No one really bothered about you. With Aunt Ethel you were not just another fee."³³¹ Midwives shared the perception that quality of care at the emotional level was sacrificed. Clara Tarrant said

it's not the same thing now. No, no. Not the same at all. The mother is gone and when she comes back, brings the baby in and lays it down. No...I think there's a bit of something gone there...Something missing...the feeling is gone out of

³³⁰ 74-181, Ms p.65.

³³¹ 78-211, Ms p.130.

it.³³²

Another woman said of her daughter's delivery,

it t'was I who looked after her in the hospital. Now, you know, that wouldn't be nice to say outside. But if she was home with a midwife, she'd get better care than she got.³³³

Birth is a social event as well as a biological process. While women believed that medical care afforded greater safety for their children and themselves, they regretted the loss of emotional support and comfort provided by midwives, family and friends. Traditional obstetric care was without question superior in this regard. The same woman later added, "being with midwives, and seeing the care that they got, I'd prefer it any time to a hospital...the mother got more consideration."

³³² 82-326, Ms p.2.

³³³ 88-281, C11372.

Chapter IV

The Occupational Folklife of Midwives

I guess [I became a midwife] because the old midwife was deceased and the nearest one to Burlington was Nipper's Harbour and beside that, I worked with a nurse in St. John's in my teens. I guess somebody thought that I knew a little bit about it you see. So, one stormy night, April the nineteenth, 1944, I was called to a home to stay with the patient while the husband went to get a midwife. Finally, hours later he returned with the midwife but the baby was here, a big boy, ten pounds, all by myself. So the midwife said "You'll make a fine midwife in this place." I said, "No, no, not me my dear." (laughter)¹

In Newfoundland for much of this century, the occupation of midwife was governed entirely by midwives and women who gave birth. The way in which women were selected and trained for this role, and the attributes of a suitable candidate or a good midwife, reflect complex values of these women and their communities. This occupational folklife is the subject of this chapter.

Many Newfoundland midwives were isolated from other practicing members of their occupation. They did not regard midwifery as work but as part of being good women and good neighbours. Yet there are clearly discernible patterns of selection and training which demarcate an occupation. These women shared common attributes believed

¹ 84-383, transcribed from an as yet unnumbered tape. Elizabeth Austin is speaking.

necessary for midwives and common attitudes about their work. Further, the stories they told are surprisingly consistent in content and themes and bear strong resemblance to narratives told by members of other occupations.

Occupational folklife is defined by Robert McCarl as "the complex of techniques, customs, and modes of expressive behavior which characterize a particular working group."² McCarl has worked almost entirely with wage earners who have little control over the structure of their occupation, and this shapes his definition to some degree. More recently he described "workers' folklore" as "the informally passed means through which workers control techniques and information in the workplace," so those aspects of an occupation which members control or manipulate help to delimit occupational folklore.³ In most modern occupations, there are definite limits to workers' control. Entry into the occupation, for example, may be dictated by the employer who hires. But because midwifery in Newfoundland was not subject to such external controls, even the structure of the occupation was part of its folklife.

Occupational analysis in this chapter is based on

² Robert McCarl, "Occupational Folklife: A Theoretical Hypothesis," Western Folklore, 37 (1978), p.145.

³ Robert McCarl, "Letter to the Editor," The American Folklore Society Newsletter, 13:6 (1984), p.2.

information on forty-two women without professional qualifications who acted as midwives in Newfoundland. Some occupational and biographical features are tabulated in the appendix to this work. The midwives whose lives and work give substance to this chapter were born between 1857 and 1927, with the majority between 1880 and 1910. They lived in every part of Newfoundland (see Fig. 1) and were active between 1885 and 1979. Most information is available between 1915 and 1960. If the work of a particular woman was not discussed in detail, she is not included in the appendix, but might be referred to in this chapter if good information was collected about some aspect of her work. Thus, Annie Pilgrim does not appear in the appendix, but her narrative about travel in difficult circumstances is included below.⁴

It is unusual to find complete data on any single midwife, even where the collector made every effort to be thorough. Many midwives had no idea how many births they attended. Sometimes in such cases it can be deduced that a midwife assisted at many births. For example, Louisa Dove was only able to say she presided at the deliveries of six sets of twins, so she probably attended hundreds of births. In other cases it is impossible to guess how many births a midwife might have attended because

⁴ 76-481. This interview with Stan Kinden was the basis for "Annie Pilgrim: Midwife," Decks Awash, 5:5 (1976), 19-20.

population density and number of other midwives active influenced this as much as length of career. For example, Alexandra (Alex) Poole, who served several communities in an isolated part of the Labrador coast, attended only fifty-six births in thirty-six years. In contrast, Dorcas Taylor, who lived in a populous part of Conception Bay, attended 1,056 births in about twenty years, although at least four other midwives and one doctor were also active in the area. Some midwives could not remember how old they were when they began to attend births, or failed to make a distinction between when they began to train as a midwife and when they assumed the role. In spite of these problems, it is possible to create a detailed picture of the occupation of midwife.

Occupational narratives are a valuable source of information in this chapter. As Jack Santino notes "every job will have its own set of challenges, duties, skills, working conditions, and its own social milieu, and all of these will affect the narratives of that job."⁵ The occupational narratives commonly told by Newfoundland midwives include: "first delivery" (similar to the "first day on the job" narratives, an important part of any occupational folklore); travel in difficult weather; unusual and difficult deliveries; and interaction with

⁵ Jack Santino, "Characteristics of Occupational Narratives," Western Folklore, 37(1978), p.205.

health care professionals.

In such narratives, we see how midwives presented themselves to those around them. There is always the possibility in such presentation that the narrator will alter the facts to bring herself more closely in line with the occupational ideal. The aim of this chapter is to elucidate that occupational ideal. Questions of the degree to which individual midwives did in fact fulfill the requirements of the role can not be answered in retrospective investigation. However, as noted in the introduction, midwives' presentation of self is consistent with community views of midwives.

These narratives help define ideal attributes of the midwife, describe how the occupation was undertaken and learned, communicate work technique, describe the conditions these women faced in their work, and reveal underlying attitudes towards the women they helped and the work of midwifery.

Michael Owen Jones notes that folk healers' occupational narratives illustrate "the individual's temperament and...way of structuring reality," and adds that such stories are useful because they are "readily obtainable and seem to be a rather reliable indicator of the subject's perceptions and self-concepts."⁶ Many

⁶ Michael Owen Jones, Why Faith Healing? (Ottawa: National Museum, CCFCS Mercury Series 3, 1972), p.6.

assumptions and attitudes that might not come to light in direct questioning are apparent in these stories. Through them we gain insight into the fundamental nature of this occupation and those who prosecuted it.

Selection of Midwives

Newfoundland women became midwives as a result of fate and friendships, most often assuming the role because other women thought they should. Features of selection important to midwifery in other cultures, such as ascribed or inherited status, supernatural calling or self-selection had little or no impact on midwifery in Newfoundland.⁷ A few very religious women felt their skills to be gifts from God.⁸ But only one midwife referred to this work as a calling, and she spoke of laying out the dead in the same terms.⁹

In contrast, black midwives in the American South strongly felt they were called to their vocation by God,

⁷ See Sheila Cosminsky, "Cross-Cultural Perspectives on Midwifery," in Medical Anthropology, eds. Francis X. Grollig and Harold B. Haley (The Hague: Mouton Publishers, 1976), p.231. The term ascribed status is sometimes used to denote community involvement in the selection of a healer. In my work, ascribed status is used in the more orthodox sense to refer to standing achieved by accident of birth, sex or age alone. Community involvement is treated as a separate process.

⁸ See 76-258, Ms p.28; 79-508, Ms p.3.

⁹ See 73-44, Ms p.22.

often in a vision or dream.¹⁰ This established these women as charismatic leaders, and impeded medicalization as women selected and trained by public health officials who lacked this supernatural sanction were not accepted as midwives in their communities. Although many Newfoundland midwives were deeply religious, the concept of a calling from God is noticeably absent here. Women who assumed this role were not charismatic leaders, and the occupation lacked this built-in resistance to outside control.

In Chapter Three, it was noted that many Newfoundland women were passive bearers of obstetric traditions. Becoming a midwife was a process of moving from passive to active status. To borrow from the performance centered approach current in folklore studies, this process reveals a kind of audience response which allowed older midwives and childbearing women to select the most suitable and gifted member of the community to assume this role based on assessment of past performance at births.

The role of midwife conferred status and respect, a theme that will be dealt with in detail below. Yet family members sometimes objected or even tried to prevent women

¹⁰ See Molly C. Dougherty, "Southern Lay Midwives as Ritual Specialists," in Women in Ritual and Symbolic Roles, p.152; Mongeau, pp.51-52.

from becoming midwives. This was because midwifery was a difficult, physically demanding and sometimes even dangerous vocation which often infringed on the midwife's household and familial responsibilities. These objections do not negate the status conferred by the role.

In larger communities there was often one leading midwife, and several less experienced women who were semi-active. If the midwife was preoccupied with another woman, or ill, or prevented from travelling by bad weather, one of these less active women acted as midwife. When a new midwife was needed, often one of these semi-active women assumed the role, in ways described below.

Women could also become midwives after being selected by an experienced woman who wanted a companion in her work or was nearing the end of her career. I will refer to this as apprenticeship, though it was a much less formal process than the term usually implies. To be apprenticed simply meant that a woman agreed to accompany the midwife to confinements and assist her without pay. Some apprentices were quite young. Elizabeth Day was seventeen when she began to assist her aunt.¹¹ Alex Poole was also seventeen when she first accompanied an unrelated midwife.¹² Mag Hibbs was eighteen when she delivered her first child, the woman's eighteenth, while

¹¹ 73-44, Ms p.2.

¹² 77-237, Ms p.3.

the midwife, Mag's mother, was out of the room preparing for the birth.¹³ Unfortunately, it is not known whether these young women were married when they began to apprentice. It is highly unlikely that they had already borne children themselves however, as the mother of an infant would be unable to stay away from home for the many hours, or in some cases days, required of those who attended childbirth.

Although women who apprenticed were likely to become midwives, some did not. Annie Power did not, as noted in Chapter Three. Elizabeth Marsh also assisted the midwife in her home of Deer Harbour, Trinity Bay without assuming the role. In this case, the role of midwife's helper seems institutionalized; Elizabeth's mother also served in this capacity.¹⁴

Eighteen midwives discussed here were apprenticed by an older woman before assuming the role.¹⁵ Most of these worked with an aunt or an unrelated midwife. Four assisted their mothers and one, her mother-in-law.¹⁶

¹³ 72-62, Ms p.1.

¹⁴ 88-281, C11379.

¹⁵ In her investigation of Kentucky mountain midwives in 1923 Mary Breckinridge found that "practically all" of the fifty-three women she interviewed had "gone about with older women" before assuming the role. Breckinridge, p.12.

¹⁶ For women who trained with their mothers see 72-62, Ms p.1; 76-351, Ms p.30; 82-326, Ms p.8; 88-281, C11360. For reference to mother-in-law see 86-254, Ms

Another worked with related midwives, but the relation was not specified, and one assisted a number of midwives, but her relationship to them was unclear.

Unfortunately, there is virtually no information as to how women were selected by relatives. Compatibility, though rarely mentioned, seems important in the selection of an unrelated apprentice and probably influenced choice of a family member as well. Annie Power began to assist Fanny McGrath because she had been present at some of her cousins' confinements and because the midwife was a very good friend.¹⁷ The midwife who attended Elizabeth Marsh "picked it up from her nearest friend."¹⁸

It is noteworthy that most women apprenticed with an aunt or an unrelated woman. Few daughters of midwives were trained by their mothers. One of these, Clara Tarrant, was raised outside her mother's household by a childless aunt and uncle. Other women who were daughters of midwives also assumed the role without ever working with their mothers.¹⁹ Perhaps the bond between mother and daughter was too intense to allow for a good working relationship. Even though such women did not apprentice with their mothers, they were likely to acquire

p.10.

¹⁷ 88-281, C11371.

¹⁸ 88-281, C11379.

¹⁹ See 78-401, Ms appendix p. 10; 88-281, C11384.

information about midwifery while growing up. Blanche Coady, daughter of midwife Olga Smith, learned about childbirth by surreptitiously listening to her mother's conversations with pregnant women who visited the house and by looking at her mother's book on obstetrics, even though it "nearly frightened her to death."²⁰ Similarly, Linda-May Ballard spoke with one midwife's daughter in Northern Ireland who became a midwife without ever observing her mother at work. She "picked it all up" by listening to her mother talk about midwifery.²¹

It might be assumed women who were apprenticed became midwives willingly, but this was not always the case. A woman with desirable attributes and demonstrated skills who was known to be able to spare the time (at whatever cost) from her own household could find it difficult to refuse this role. Fanny Avery was selected by Jessie Dean an older, unrelated midwife to act as her assistant. When the older woman became too feeble to continue, members of the community began to call for Fanny, yet she became a midwife with reluctance. The collector reported "she said it was almost forced upon her as she didn't want to become a midwife. There was too much responsibility but since there wasn't anyone else

²⁰ 88-281, C11385. Blanche did not become a midwife, but left home at the age of seventeen to become a nurse's aid in hospitals.

²¹ Linda-May Ballard, p.65.

around she didn't have a choice."²² Fanny also said that she would not willingly become a midwife again, as the work was sometimes unpleasant and she would have liked more time for her own chores.²³ Such a negative attitude is unusual among Newfoundland midwives and may be related to this woman's personality or some aspect of her experience that made midwifery disagreeable.

Choice of an apprentice was not always the prerogative of a midwife alone. Alex Poole began to assist the midwife in her community when the older woman, who suffered from arthritis, could no longer work without assistance. But community consensus helped to select young Alex. A student collector was told "although there were five or six other married women in the community, they were reluctant to go along and felt that Mrs. Poole was more capable than any of them."²⁴

A number of women not apprenticed were drawn into midwifery by clients who identified them as good candidates for the role. Jane Ann Emberly began her career as a midwife in 1923 because a woman in labour called for her and refused to have anyone else:

Constable _____ came...and said, "You got to go over, Ida wants you." So I on with the clothes and went on. I knowed 'twas

²² 75-56, Ms pp.22-23.

²³ 75-56, Ms p.24-25.

²⁴ 77-237, Ms p.3.

probably something about the baby and when I went in, I took a look at her and said, "Me woman, you'm on the way. You better send for who ever you'm going to have. "I'm not going to have no one," she said, "You'm going to do it." She knowed I knowed about it. "No I'm not going to do it." I said. "Yes you is," she said, "And you can do it too." Well I didn't know what to do. I got the pan of water, and put it on the hall stove and told her to get in bed. I put the things I needed on the chair beside me and went to work and borned the baby.²⁵

Jane was chosen on the basis of her experience and knowledge of obstetric care and the client's response to her past performance ("she knowed I knowed about it"). Three days later another woman in labour sent for her and refused to take no for an answer. This was the beginning of a career that lasted about thirty years and saw 323 births.

Community consensus played a powerful role in many narratives women told about becoming midwives and was a main alternative to apprenticeship in the selection of midwives. Client selection of midwives worked at a number of levels. Like Jane Ann Emberly, other midwives discussed here began their careers with an emergency delivery and found themselves placed in the role of midwife by those around them.²⁶ Louisa Dove delivered her sister's child while the midwife was on the way and "the

²⁵ 73-160, Ms p.6.

²⁶ See 77-345, Ms p.8; 78-401, Ms p.28; 78-415, Ms pp.6-7; 79-674, C5206; 84-379, Ms p.6.

news spread around, and from that time on people started coming after her to deliver their babies."²⁷ This type of selection was once a feature of midwifery in other Anglo-American areas. Catherine Scholten found "by the end of the eighteenth century, physicians thought that the 'greater part' of the midwives in America took up the occupation by accident, having first been caught, as they express it, with a woman in labour."²⁸ If Newfoundland circumstances are at all typical, the women "caught" in this way were those most capable of coping.

In Newfoundland, other women were asked by a neighbour or relative to be with them during pregnancy as a companion or to assist the doctor during labour.²⁹ Although not specifically asked to act as midwives, they eventually assumed the role. Doctors played a part by encouraging such women to continue to assist them, but the initial selection was by the client, and community consensus confirmed the choice. Marita House assisted a doctor at one delivery and "from this point on, nearly every woman [in the community] called Mrs. House when her baby was due."³⁰ Rhoda Maude Piercey recalled how she became a midwife under similar circumstances in 1954:

²⁷ 84-379, Ms p.6.

²⁸ Scholten, p.430.

²⁹ 77-247, Ms p.2; 76-142, Ms p.9; 76-258, Ms p.5.

³⁰ 76-258, Ms p.8.

my first experience was with a neighbour of mine. She came to me in the store one day and asked if I would help the doctor with the delivery of her baby. It was like a shot out of the blue. I was reluctant at first but decided to help because the doctor would have no one else to depend on. The family was poor and couldn't afford the fees of a professional nurse and because of caring for an invalid mother-in-law the woman was unable to go to the hospital. The delivery was a difficult one and I had to be on my toes at all times. I didn't have time to think about getting scared because there were too many other things to do. After the difficult time had passed and both mother and baby were out of danger the doctor said, "You did an excellent job. I think I can trust you from now on to help me out." Those words meant a lot to me because that was the first time I ever did anything like that. News spread quickly throughout the community over night.³¹

For women who became midwives as a result of an emergency or client selection, such first delivery narratives were extremely significant. In contrast, narratives of this type were absent in accounts of women who were apprenticed or began to practice after receiving formal training, unless the circumstances of the first delivery were unusual. The prominence of this type of narrative among midwives who began with an emergency or were selected by clients is partly because the first delivery was a memorable turning point in the life of the informant, with the dramatic qualities of a good story.

³¹ 78-116, Ms pp.5-6. Also see 76-142, Ms p.9 for another version of this narrative.

But these accounts have a deeper occupational meaning as well. Apprenticeship indicated the approval of an established midwife. Women who were selected by clients did not have this implicit occupational blessing. First delivery narratives may be seen as a kind of alternate charter to assume the role of midwife. Approval of a midwife or doctor after the first delivery was accomplished is a frequent feature in these narratives, as Rhoda Maude Piercey's story illustrates above. Similarly, in Elizabeth Austin's narrative, which opened this chapter, the older midwife said "you'll make a fine midwife in this place."³² Inclusion of such statements may be seen as an effort to bring the midwife's circumstances in line with the more usual occupational tradition of apprenticeship. Implicit in such narratives as well is a statement of the qualities that made these women desirable midwives, a topic returned to below.

Given that women in Newfoundland did not traditionally put themselves forward for this role, these narratives also enable the midwife to disclaim self-selection, partly by asserting that the initial success was endorsed by community consensus. Rhoda Maude Piercey ended one version of her first delivery narrative by stating "news soon spread and this community...had a new

³² 84-383, transcribed from a tape as yet unnumbered.

midwife overnight."³³ Louisa Dove stated "so from that they started coming to me."³⁴

Rhoda Maude Piercey was reluctant to assist the doctor. She was swayed by the fact that her neighbour and the doctor needed help, so the listener may infer that she was motivated by altruism. Elizabeth Austin laughed at the midwife who encouraged her to assume the role. Jane Ann Emberly refused at first to act as midwife for her neighbour, and argued briefly with her. Such refusal to display talent that a person is known to possess is related to attitudes about assuming a leadership role in Newfoundland, a topic returned to below. This type of refusal was also a feature of folk singing in northeastern North America.³⁵ In such situations, initial refusal places responsibility for an appropriate response on those who urge the person to perform.

By becoming a midwife, a woman tacitly agreed to take responsibility for a process that was regarded as dangerous for both mother and child, over which she had limited control. When the midwife was selected by her clients in spite of a display of reluctance, and urged by them to assume the role, part of this responsibility was

³³ 76-142, Ms p.9.

³⁴ 84-379, transcribed from a tape as yet unnumbered.

³⁵ See Edward D. Ives, "Lumbercamp Singing and the Two Traditions," Canadian Folk Music Journal, 5 (1977), p.20.

lifted from her shoulders and shared by the community of childbearing women in general. In the context of midwifery, appropriate response may well have included implicit agreement to accept the occasional misfortune in birth without criticism of the midwife.

Self-selection was rare. Three midwives discussed in this chapter are known to have selected themselves, and all sought formal training. Clara McGrath was a former school teacher who lived in Patrick's Cove, Placentia Bay. Her first labour, mentioned in Chapter Three, and her criticism of the care she received, helped to explain why she selected herself:

my first baby was born on July 28, 1918.
Well I had such a hard delivery...that I
vowed if I got over it, I'd try and learn
all I could about midwifery.³⁶

She described herself as "well trained in my own right" by 1928, though it is unclear how she acquired her training.³⁷ That year she sought instruction from the doctor in her area and in 1935 she travelled to St. John's for public health training. Clara McGrath was the only midwife discussed here to relate her interest in midwifery to her own difficult labour.

Olga Smith of Gooseberry Cove, Trinity Bay was not so clearly self-selected; she was urged to become a

³⁶ 81-328, Ms p.7.

³⁷ 81-328, Ms p.8.

midwife by a nurse in her area. But she decided to assume the role against her mother's wishes and was remarkably active in seeking education. She took a three year correspondence course from the Chicago School of Nursing, and received public health training at the Grace Hospital in St. John's and the Come by Chance cottage hospital.³⁸ Another midwife decided to train at the Grace Hospital in 1949 because women in her community did not like their midwife.³⁹

Some women who selected themselves sought formal training because they were oriented towards modern medicine. Clara McGrath reacted against the care she received in childbirth, and both she and Olga Smith actively sought as much medical information as possible. Self-selection could also allow a woman to circumvent usual occupational traditions and become a midwife without the approval of an older woman. This was not common.

Community participation in the selection of midwives was obviously desirable from the point of view of childbearing women as it helped to ensure the most acceptable women assumed the role. To take a more

³⁸ 77-328, Ms p.37. In spite of the correspondence course, Olga never received formal qualifications. 88-281, C11385.

³⁹ 77-139, Ms pp.13-14. This unusual case will be discussed in more detail in Chapter Five.

negative approach, it may be that the work of midwifery was so stressful and time-consuming that most women could not be expected to undertake it of their own volition. One self-selected midwife indicated this, saying most women were "nervous of the work."⁴⁰

It is apparent, however, that many women became midwives out of genuine interest in obstetrics and a desire to help others. Rhoda Maude Piercey said meningitis "forced [me] to abandon the one thing I had always set my heart on" when the illness caused her to give up nursing school.⁴¹ Becoming a midwife later in life allowed her to pursue this interest. Clara McGrath said "...I loved the work. I loved when a little baby was delivered. You'd be feeling so happy. When you'd see the little baby, you wouldn't mind facing the whole thing again."⁴² Clara Tarrant recalled, "it was a grand feeling to think you helped someone into new life. I really liked the work."⁴³ Freida Guinchard said "I really enjoyed it. I never regretted a day even though I almost died some nights from want of sleep."⁴⁴ Beatrice Wheaton, in the understated style of Newfoundlanders said "I was kept

⁴⁰ 81-328, Ms p.8.

⁴¹ 76-142, Ms p.9.

⁴² 81-328, Ms pp.42-43.

⁴³ 82-326, Ms p.17.

⁴⁴ 84-332, Ms appendix, p.16.

busy, I'll tell you, but I didn't mind the work."⁴⁵

The prominence of community consensus is related to the egalitarian nature of Newfoundland communities noted by ethnographers.⁴⁶ James Faris states

leadership and the exercise of authority involve taking decisions which may be binding to others, and in Cat Harbour anything which in this overt way may infringe on another, is considered aggression and a serious breach.⁴⁷

Childbirth required someone to oversee care and make decisions if complications arose; to assume a leadership role, even though this was contrary to community values. Under such circumstances, it is hardly surprising to find that women rarely put themselves forward as midwives. A high degree of client involvement in selection was a means of gaining a leader without seeming to, thus ensuring that the egalitarian ethic was maintained.

It is reasonable to wonder if self-selected midwives did not incur hostility by contravening these values. Because their medical knowledge was valued, these women probably did not. Olga Smith was respected because she

⁴⁵ 82-166, Ms p.14. Also see 75-21, Ms p.35; 76-165, Ms p.29; 77-247, Ms p.3; 79-508, Ms p.9; 84-364, Ms p.9.

⁴⁶ See Dona Davis, pp.97-98; John Szwed, Private Cultures and Public Imagery: Interpersonal Relations in a Newfoundland Peasant Society (St. John's: Institute of Social and Economic Research, 1966), pp.85-86.

⁴⁷ James C. Faris, Cat Harbour: A Newfoundland Fishing Settlement (St. John's: Institute for Social and Economic Research, 1973), p.103.

worked tirelessly as a general nurse for the surrounding area without pay. Her early death was attributed to this work. Midwives who put themselves forward to usurp another woman may have been regarded less favorably, but this was never stated.

These traditions of selection began to alter first in St. John's with the establishment of the Midwives' Club in 1919, although women in the city also continued to rely on neighbours chosen in the ways described above into the 1930s. Some women came to the Midwives' Club on their own initiative. But, like Lillian Wandling, many members of the Midwives' Club were selected by doctors.⁴⁸ Genevieve Hiscock also recalled local clergymen often approached her mother to suggest women who were in financial need, but of good character, as appropriate candidates for the Midwives' Club.⁴⁹ Some women who were acceptable midwives by traditional standards seemed less than desirable to those who ran the Midwives' Club. Evelyn Cave Hiscock "weeded out" some very old midwives interested in the training because of age. One of these was over eighty and had "borned" 2,500 children.⁵⁰ With the advent of formal training in St. John's, selection of midwives passed from the hands of existing members of the

⁴⁸ 88-281, C11355.

⁴⁹ 88-281, C11359.

⁵⁰ 88-281, C11359.

occupation and the women they served. Midwifery became an occupation of the deserving poor, and women were often chosen for the role by clergymen and doctors who would never receive their care.

Those who took public health training during and after Commission of Government were often selected by doctors or district nurses, though it is unlikely that any woman who desired this training would be refused. As the century progressed, doctors seem to have played a more active role in selecting midwives who they trained themselves. Many women selected in this way were not significantly different from midwives selected by community consensus. Irene Bradley of Eastport is a good example. The daughter of a midwife, with an interest in nursing the sick and in obstetrics, Irene attended a number of births in emergencies before she was approached by the nearest doctor to assume the role of midwife.⁵¹ She was a passive bearer of obstetric traditions who met with community approval. But such shifts in decision making were significant. When midwives were chosen by a health care professional, the traditional selection process broke down. The midwife chosen in this way was often the last to serve her community. However, because of the high value placed on medical knowledge, this change was not resisted.

⁵¹ 79-549, Ms p.11.

Training

Occasionally, a midwife began her work never having observed a birth and without the guidance of a more experienced person. One such midwife, Annie Fizzard, recalled the first birth she attended:

Now me brother's wife she was in the family way, she was going to have a baby. So there blowed a storm of wind and they couldn't get out of the harbour. Now me mother-in-law, she went over. Me mother [a midwife] was dead then, my mother. And she [her mother-in-law] went over and then she said to I, she said. "Oh!" cause she was, you know nervous, she like didn't like to born them, see and she said, "Now Annie," she said, "You'll have to take it." And me brother come to the window and he said "You have to do the best you can," he said. Because I said it is blowing a storm of wind...and I said "We can't get after nobody." And she said, "Well Ann," she said, "You'll have to take it." "Oh my," I said, "What, what, I never borned a baby in me life," I said, "And I got to take the job?" And "Yup" she said...She come down there and the woman, you know, she was swelled, God love you and she called me out of doors and she said "Nancy," I said "What Mam?" She said "I don't know what we're going do with that woman." She said, "How we going [to] handle her. Well I suppose I said "I got to do the best I can." So when she got sick I said to come after me, come over. They never come after me cause I went over me self. I said, "Well I got to go over," I said, "and see how Liz is." I said like that. Now Grannie, me Grannie, that is Grannie Fizzard, I used to call her, (me mother-in-law) I said, "Well," I said, "I got to go over and see what is going ahead over there." I[d] like to be like I was then. And so I went over, so she said, "Hove it in," and said "Mam

you'll have to take it." And I said "Oh my God, what next are you going [to] do?" I said "Grannie," I said, "Oh my God, I never seen a baby borned yet." God Almighty put it in me head, God love you, and I had the best of luck with all I borned.⁵²

Although her deceased mother was a midwife, Annie had never seen a birth. She told the collector that she "had to learn it all on me own."⁵³ This situation was hardly ideal. The midwife was deprived of the knowledge and skills of a more experienced woman and had no opportunity to learn before taking full responsibility for a birth. Such cases were the accidental result of low population density and geographic isolation rather than a deliberate cultural pattern. As noted above, it was more usual for women to observe the births of relatives and friends or apprentice over a long period of time, which provided greater continuity of beliefs and practices and allowed time to become accustomed to the stresses of midwifery before assuming full responsibility.

The process of becoming a passive bearer of obstetric traditions was gradual and even apprenticeship was often not undertaken with the object of becoming a midwife, so empirical learning was not usually remembered, and is difficult to reconstruct. It is clear,

⁵² 78-401, Ms appendix pp.10-12. This event occurred in 1916.

⁵³ 78-401, Ms p.6.

however, that the communication of technique in an apprenticeship situation was highly informal. When Lily Clarke, who assisted her aunt in the 1920s, was asked about her duties she replied:

well they'd call me out to go come with this lady [the midwife] see and I'd go with her and do things and help her eh? get things for her if she...wanted, get something for the labouring woman I'd go and get a cup of tea for her or a drink or whatever she'd want and help her and make her beds.⁵⁴

During births she was given no verbal or hands-on instruction and asked no questions; learning was a matter of direct observation. Mary Sweetapple recalled an almost identical apprenticeship during the 1940s. Obstetric knowledge was communicated non-verbally partly because midwives had an ethic which required them to keep from women in labour anything which might upset them.⁵⁵ But it was also the result of a more general tradition of empirical learning in Newfoundland. Elliot Merrick states "people here [in Labrador] don't explain anything. They think that words are only for sociability. You learn by

⁵⁴ 88-281, C11356.

⁵⁵ This idea was common but not universal. Gambo midwife Bertha Feltham, active from 1931 until about 1950, told a collector "she always believed in telling the mother exactly what was going on during the birth; if there were complications, she told her that as well." 79-143, Ms p.15.

watching or you don't learn at all."⁵⁶

Although most of the technique of midwifery was communicated through direct observation of childbirth, there were other means of learning. Occupational narratives, including those about first and difficult deliveries, communicated obstetric information to any woman who heard and remembered them. Women who assisted midwives sometimes found themselves in special learning situations as well. Lily Clarke recalled learning from her aunt during her own deliveries, stating "and when she'd tend on me herself I'd know what she used to do."⁵⁷ This is the only recorded instance of this practice in Newfoundland. Some apprentices also talked about the delivery with the midwife after a birth. Annie Power and Mary Sweetapple recalled such conversations.

By the twentieth century, few midwives were trained in these purely traditional ways alone.⁵⁸ Many women

⁵⁶ Elliot Merrick, Northern Nurse (New York: Scribner's, 1942), p.138. Also see Murray, p.27 for an example of non-verbal learning of wool processing and knitting by a young child.

⁵⁷ 88-281, C11356. Similarly, Mary Breckinridge spoke to one midwife who "learned from how it was done when her own babies came." Breckinridge, p.13.

⁵⁸ This is true in other cultures as well. Carol P. McCormack states "'traditional' midwives often do not fit unambiguously into a category opposed to 'trained' midwives. Some have been given brief training courses that link them with a primary health care system [and] they may use manufactured drugs..." C. P. McCormack, "Biological, Cultural and Social Adaptation in Human Fertility and Birth: A Synthesis," in Ethnography of

with empirical training received formal training later in life and were educated through the Midwives' Club or the Department of Public Health and Welfare, or had incomplete nurses' education.⁵⁹ Some worked with doctors on a regular basis and all had some contact with doctors or district nurses even if only in emergency situations.

As noted in Chapter Three, relations between midwives and health care professionals were generally good, and many physicians contributed informally to the education of midwives. Marita House, who was active from 1935 to 1957 mentioned no contact with other midwives at all. She appears to have been trained entirely by the doctors she assisted. Eliza Jane Dawe began her work as a midwife by assisting a Dr. Walsh, who lived nearby in Manuels, and continued to work closely with him. The collector was told "he was very anxious to help informing Mrs. Dawe and [other midwives in the area] about the work they were doing."⁶⁰ Freida Guinchard worked with seven doctors over a period of twenty-nine years.⁶¹ Rhoda Maude Piercey acted alone if the doctor in her area was

Fertility and Birth, p.11.

⁵⁹ See 73-44, Ms p.5; 75-285, Ms p.15; 76-142, Ms p.9; 76-351, Ms p.31; 78-415, Ms p.3; 78-211, Ms p.99; 79-433, Ms p.12; 82-326, Ms p.8; 86-254, Ms p.26; 88-281 C11354; C11365; C11385.

⁶⁰ 77-247, Ms p.3.

⁶¹ 84-332, Ms appendix, p.13.

unavailable. If complications requiring the doctor arose and the weather was bad, he advised her over the telephone.⁶² Such continued contact and informal training encouraged medicalization.

Some midwives also relied on medical books or pamphlets about obstetrics.⁶³ Charlotte Carberry showed the collector, her niece, a "well-worn" book called Help for Midwives, which was dated 1934.⁶⁴ Irene Bradley had an obstetric book used by her mother before her.⁶⁵ At the beginning of her career, Nellie King borrowed a "doctor's book" from a neighbour who was also a midwife. She told the collector she "read through it mostly learning from the pictures. Even the pictures, she said, were 'hard to look at.'"⁶⁶ None of these women attended midwifery courses.⁶⁷ Olga Smith obtained an obstetric book by mail.

⁶² 78-116, Ms pp.14-15.

⁶³ In most places such books could only be obtained from a public health official, by mail, or from someone who travelled abroad.

⁶⁴ 80-229, Ms p.2.

⁶⁵ 79-549, Ms p.11.

⁶⁶ 79-417, Ms p.28.

⁶⁷ Mary Breckinridge found only four of the Kentucky midwives she interviewed had such books. She also reported a high degree of illiteracy among her midwives; only twelve out of fifty-three could read and write. This literature seems to have been more common in Newfoundland. The island was less isolated from external influence, in spite of obvious disadvantage of location. Folksong collector Maud Karpelles, who worked in the Appalachians and Newfoundland in the 1920s, found

Such books were greatly valued. When Olga died, her book was passed on to Fanny Avery.⁶⁸

Popular literature was also mentioned, and probably played a role in making Newfoundland midwives aware of medicalization of childbirth in other parts of North America. In the early decades of this century, considerable interest among women in the changing circumstances of childbirth was reflected in American women's magazines.⁶⁹ In Newfoundland, popular periodicals of all kinds that were received by mail or brought by people who travelled were passed from house to house. Margaret Giovannini recalled when she was a district nurse "the [news] papers I received were eagerly sought after by the people and I always passed them on after reading them."⁷⁰

Lillian Wandling remembered reading articles about childbirth in magazines.⁷¹ Olive Bishop noted that one

Newfoundland singers were influenced by popular music to a much greater degree than their Appalachian counterparts. See Carole Henderson Carpenter, "Forty Years Later: Maud Karpeles in Newfoundland," in Folklore Studies in Honour of Herbert Halpert, eds. Kenneth S. Goldstein and Neil V. Rosenberg (St. John's: Memorial University of Newfoundland, 1980), pp.111-124.

⁶⁸ 88-281, C11385.

⁶⁹ Many articles in periodicals such as Ladies Home Journal and Good Housekeeping are listed in the extensive bibliography of Litoff's American Midwives, pp.160-172.

⁷⁰ Giovannini, p.6.

⁷¹ 88-281, C11355.

midwife in her district "who used to read a lot" revived a child using mouth to mouth resuscitation after reading about this technique.⁷² As knowledge of medical practices became common, a midwife could be criticized for failing to acquire such information. One woman was present at a breech delivery in the 1950s. The midwife successfully delivered the child, but he was not breathing and she made no attempt to revive him, so the informant took action herself:

I was talking to her afterwards [after the birth] and I asked her how the baby was and she said "Oh he's born okay but not for long though." I went in and saw the baby. He was right short and chubby but he was blue. I had often heard people say that when they are not breathing to draw on their nose and that's what I done. I only drew a couple of times and he screeched. The midwife ran in and she said "My God, what did you do?" I said "Nothing." I never told her to this day. She didn't know anything but you know she borned some three hundred babies and only lost a few. She never had anything to do with my three babies. ⁷³

Many women who received formal training brought printed material back to their home communities. Women in Portugal Cove who attended public health training in St. John's in the 1950s brought a "textbook" back with them.⁷⁴ Elizabeth Austin kept the mimeographed sheets

⁷² 75-285, Ms appendix, p.7.

⁷³ 71-84, Ms p.2.

⁷⁴ 78-211, Ms p.99.

which she received during her public health training in the 1940s.⁷⁵ Obviously, women who sought formal training could be expected to be receptive to academic medical practice. However, even those who did not take such courses were eager to learn as much about medical obstetrics as they could.

A number of women who became midwives had early contact with the medical system. Olive Bishop and Rhoda Maude Piercey both trained briefly as nurses in St. John's but were forced to quit because of illness.⁷⁶ Florence Noble attended three months of a year long midwifery course in Boston which she did not complete for unspecified reasons.⁷⁷

Less formal contact with academic medicine also had bearing on who assumed this role. At the age of fourteen, Susan Everleigh went to the hospital at St. Anthony to have her tonsils removed. She stayed to work as a helper in the kitchen for three years and observed several births during that time.⁷⁸ Alex Poole was sent to the hospital at Battle Harbour when she was thirteen and was treated for tuberculosis there for three years. When she

⁷⁵ Personal communication, Sidney Morris Chipp, Grand Falls, July 1984.

⁷⁶ 76-42, Ms p.9; 88-281, C11368.

⁷⁷ 78-415, Ms p.3.

⁷⁸ 76-165, Ms p.3.

returned to her home community she showed an aptitude for and interest in medicine by caring for a lame chicken the summer before she began to help the local midwife.⁷⁹ Elizabeth Austin worked for a nurse in St. John's before she married, probably as a domestic, although this was not made clear. In her first delivery narrative she explained "I worked with a nurse in St. John's in my teens. I guess somebody thought that I knew a little bit about it you see." Women who had incomplete formal training or even casual contact with formal medicine were considered attractive candidates for the role of midwife.

Such informal contact with health care professionals often provided basic medical information useful in attending childbirth. When Alex Poole assisted the older midwife in her community for the first time, she noticed that the child's leg was deformed. So

with the consent of both parents she made a splint of heavy cardboard and put it on the baby's foot. The greatest danger she feared was having the splint too tight and cutting off the blood circulation. However, she used the splint and every time the baby's diaper was changed, the splint would be slackened and the foot turned a little.⁸⁰

This was the correct treatment for club foot, and the deformity was diagnosed as such by the district nurse who reached the community a few days later. In her choice and

⁷⁹ 77-237, Ms p.4.

⁸⁰ 77-237, Ms p.4.

management of treatment, especially in the care she took to prevent restriction of the child's circulation, Alex showed good basic knowledge of medicine. This story also emphasizes this woman's intelligence and her ability to use practical knowledge and empirical observation to the best advantage.

Formal training was so greatly valued that those who possessed it were sometimes compelled to attend women in spite of genuine reluctance. Agnes Kennedy, a nurse-midwife trained in New York city, was prevailed upon to act as midwife when she moved to an outpost with her husband in the 1930s, although she had a two-month-old baby and did not wish to work.⁸¹ When Minnie Taite returned to visit her home community of Bonavista North after completing maternity nurse training she was required to travel to a nearby island to assist a woman in childbirth although an experienced midwife was in attendance and she did not want to go.

Established midwives also used occasional contact with health care professionals to increase their knowledge of formal medicine. This point was made by a former district nurse who recalled that traditional obstetrics gave her "many shocks," and that the customs she encountered were "rather frightening," indicating she was not unusually sympathetic to traditional practices or

⁸¹ 88-281, C11353.

midwives.⁸² In describing a case when she was called by an empirically trained midwife to deal with convulsions due to eclampsia she said:

the midwife...had the new experience of seeing a precipitate labour of which she had no previous knowledge. This midwife was a middle-aged woman, younger than the usual run of midwives, and she was very alert and intelligent. She was determined that day to obtain all the information she could gather about the cases that were not so normal.⁸³

This nurse apparently felt an older midwife might be less interested in learning about medical obstetrics. There are, however, no grounds for this opinion.⁸⁴ This information confirms the picture of traditional obstetrics which emerged in Chapter Three. Newfoundland midwives were extremely receptive to information about medical obstetric practices. There was a real hunger for this knowledge and for the benefits that this system could provide among midwives and the women they served.

Attributes of the Midwife

⁸² 78-166, Ms p.23; p.26.

⁸³ 78-116, Ms pp.28-29.

⁸⁴ A similar attitude towards formal medical knowledge has been noted among empirically trained midwives in other cultures. In Jamaica Sheila Kitzinger found "if nanas [the midwives] have an opportunity, they are eager to watch how trained midwives conduct deliveries. They are also eager to read, or have read to them, midwifery textbooks from Britain. They are highly motivated to learn as much as they can..." Kitzinger, p.189.

Because community selection was so important, women chosen as midwives possessed attributes which made them desirable for the role. Some qualities not related to personality were shared by many of the women discussed here. Most were married, had themselves borne children, and were past childbearing when they became independent midwives, though many raised young families while assisting an older midwife. In Newfoundland, as in other Anglo-American areas, midwives were sometimes called "granny women" and the title "granny" or "aunt" was often used as an honorific, Aunt Fanny Avery for example. But such titles were not reserved for midwives. In many outports some older people were called aunt or uncle regardless of kinship, and Dona Davis found the term "granny" was at one time applied to all older women in the community she studied.⁸⁵

The term "granny woman" conveys the stereotype of the midwife as an old woman, but this is an oversimplification. This point was made in a 1965 community medicine study of empirically trained midwives in the Appalachians of Kentucky. The authors found that

being a grandmother or "granny woman" is incidental to and not an integral part of the midwife's role of a lay health specialist. It is not a strictly enforced or socially sanctioned prerequisite to taking

⁸⁵ Dona Davis, p.69. In Annie Fizzard's narrative above, she referred to her mother-in-law, who was not a midwife, as Granny Fizzard.

up the role of a lay midwife or actively entering into the practice of midwifery.⁸⁶

If Newfoundland women did not become midwives until their childbearing years were over, this was the result of practical considerations rather than cultural norms. Most women still bearing and raising children could not spare the time required for midwifery. Olga Smith was able to become a midwife when her youngest child was just one year old because she had both a servant and her mother in her household, but her circumstances were not typical.⁸⁷ Then too, apprenticed midwives might not begin to work regularly as independent practitioners until the woman who taught them was ready to step aside out of respect for her senior position, and this probably delayed the beginning of many careers.

Some women became midwives before having children and some, like Olga Smith raised young families while they worked. A number of the midwives referred to here attended births while in their twenties.⁸⁸ Lily Clarke delivered babies while she was pregnant. This did not interfere with the running of her household because she

⁸⁶ K. Osgood, D. Hochstrasser and K. Deuschle, "Lay Midwifery in Southern Appalachia," Archives of Environmental Health, 12 (1966), p.766.

⁸⁷ 88-281, C11385.

⁸⁸ 72-62, Ms p.1; 73-160, Ms p.4; 76-165, Ms p.3; 77-328, Ms p.38; 79-674, Ms p.23; 80-229, Ms p.3; 82-156, Ms p.10; 88-281, C11355.

served a small community.⁸⁹ Mag Hibbs was an independent midwife in her early twenties.

Newfoundland midwives tended to be women who had experienced pregnancy and childbirth, but childless women were generally rare here. Tradition did not preclude the possibility of a childless midwife, however, perhaps because apprenticeship could begin before marriage when a woman's fertility was unknown.⁹⁰ The aunt who apprenticed Lily Clarke was a childless married woman, as was the midwife who attended Mary Sweetapple.⁹¹ Single midwives are not documented until formal training became available.⁹² This may be due to the fact that single women were extremely rare in Newfoundland.⁹³ But, as training became available, some single women did assume this role; Beatrice Torraville and Olive Bishop never married or bore children, yet both were accepted as midwives after receiving formal training.

⁸⁹ 88-281, C11356.

⁹⁰ Women without children were not excluded from acting as midwives in other Anglo-American areas. Mary Breckinridge found two midwives who were married but childless out of the fifty-three she interviewed. Both were in their seventies at the time. Breckinridge, pp.14-15.

⁹¹ 88-281, C11356; C11384.

⁹² Similarly, all of the midwives interviewed by Mary Breckinridge in Kentucky in 1923 were married women. Breckinridge, p.10.

⁹³ See Dona Davis, p.61; Faris, p.54; Szwed, p.63.

Preconceived notions did not restrict selection of midwives to any segment of the population, except to limit the role to women. Practical considerations aside, a woman's position in her own childbearing career had little bearing on the practice of midwifery; both childbearing and post-menopausal women acted in this role. No taboos prevented either pregnant or childless women from becoming midwives. Attributes such as age, marital status and fecundity were irrelevant if a woman showed suitable personal qualities. Finally, while this discussion deals with attributes in a general way, it should be noted that some qualities were given more weight in some communities than others. For example, in some places midwives were expected to treat all aspects of childbirth discreetly, whereas in other areas they talked quite freely with other women about their work.

Formal education of any kind was one desired attribute not related to personality. As noted above, some contact with formal medicine, however casual, made women likely to be considered for the role of midwife. Only two of the midwives referred to here were said to be illiterate, and both lived in areas where there were no schools.⁹⁴ Others were noted to be literate in spite of obstacles. Alex Poole, for example, was taught to read and write by her mother because there were no schools in

⁹⁴ 76-165, Ms p.3; 79-508, Ms p.3.

her area.⁹⁵ Nora Ellsworth also lived in a community without schools. She was educated by a woman who began to employ her as a domestic when she was nine years old. Clara Tarrant was the only girl of her age to finish high school in her community. This was possible because she was raised by a childless aunt and uncle who urged her to get an education as a means of bettering herself.⁹⁶

From references to the writing of letters and exams, the use of books and because some women were teachers, worked in the post office or trained as nurses, it is apparent that many other midwives were literate.⁹⁷ The ability to read was of course an asset to women with obstetric books and probably necessary to those who sought formal training, but it was more than that. Although literacy was the result of opportunity rather than an indicator of native intelligence, formal education was valued because it was seen as a sign of personal traits such as industry or intelligence or upward mobility: the desire to "make something" of one's self.

⁹⁵ 77-237, Ms p.9.

⁹⁶ 82-326, Ms p.5.

⁹⁷ See 70-15, Ms p.23; 75-56, Ms p.6; 75-285, Ms p.13; 76-141, Ms p.3; 76-255, Ms p.6; 77-139, Ms p.14; 77-328, Ms p.37; 78-211, Ms p.99; 78-415, Ms p.3; 79-417, Ms p.28; 79-549, Ms p.11; 80-229, Ms p.2; 81-328, Ms p.4; 82-166, Ms p.10; 84-364, Ms p.10; 84-383, Ms p.2; 86-255, Ms p.91.

Even before the importance of cleanliness in obstetric care came to be recognized, a dirty midwife was regarded as a bad one and scrupulous cleanliness was an important virtue. Elsie Drover described Mary Margaret Drover as "a wonderful clean woman," and recalled the aprons she wore while working as a midwife were "as white as a lily."⁹⁸ These large aprons were traditionally worn by midwives in their work.⁹⁹

Attention to cleanliness is important in obstetric care, but this trait, like formal education, was probably considered a sign of desirable personal qualities as well. Indications are that women who became midwives were extremely careful about cleanliness in their daily lives even before assuming the role. Agnes Horwood's granddaughter Helen Porter comments on the attention given to cleanliness in her grandmother's household in Below the Bridge.¹⁰⁰ In the everyday life of Newfoundland women, cleanliness was (and remains) an important virtue. Dona Davis was told that "Newfoundland women are the cleanest in the world."¹⁰¹ Davis also notes the importance of a woman's ability to live up to rigorous standards of housekeeping in maintaining her status in

⁹⁸ 88-281, C11373.

⁹⁹ See Fig. 5 for women dressed in such aprons.

¹⁰⁰ Porter, p.25-26.

¹⁰¹ Dona Davis, p.102.

the community.¹⁰²

Seemingly impersonal factors such as formal education and personal cleanliness were apparently desirable for what they conveyed about a woman's character. Personality was most important in determining who became a midwife. To be chosen as a midwife's assistant, appropriate attributes were necessary. Elizabeth Marsh said

...oh no they wouldn't pick up everybody. They'd want somebody that was like theirself, and 'tis a kind of a secret thing, you know like? Yes. You didn't want everybody talking. No, no, my dear, they'd want somebody which was, they could rely on.¹⁰³

As she suggests, many women who became midwives felt a need for discretion in their work. While obstetric information might circulate in a narrative, a woman who discussed her clients' private lives would not be regarded as a good midwife. Many midwives maintained confidences which would have made wonderful gossip. During World War II, Elizabeth Day was called to the home of a young woman whose husband returned from overseas only months before. Ostensibly she was called because the woman was having "terrible pains in her stomach." The midwife immediately recognized the signs of labour, and in time a full-term child was born. Later in the day she

¹⁰² Dona Davis, p.104.

¹⁰³ 88-281, C11379.

was praised by a relative of the mother who stated "she brought along the baby this morning--a four month baby--and it's still living!"¹⁰⁴ The midwife did not correct her. Catherine Reegan never revealed to her family the identity of a woman whose child she raised as her own.¹⁰⁵ When Mary Margaret Drover attended a woman who gave birth to a deformed baby that died, the midwife's daughter-in-law, with whom she lived, only learned of the child's deformity from the bereaved mother.¹⁰⁶

Midwives related stories about the mundane discomforts of their work which stress the need for stoicism. Annie Le Moine recalled sometimes sleeping on the floor with her coat wrapped around her while staying with poor families.¹⁰⁷ One midwife occasionally returned from a confinement with lice because she had stayed in an infected household.¹⁰⁸ Many midwives worked in spite of occasional or chronic health problems. Alex Poole suffered from asthma, and once had to be carried to a woman because of this.¹⁰⁹ Annie Fizzard was required to attend a woman while ill because no one else would act as

¹⁰⁴ 73-44, Ms pp.11-12.

¹⁰⁵ 72-49, Ms p.5.

¹⁰⁶ 88-281, C11373.

¹⁰⁷ 84-307, Ms p.8.

¹⁰⁸ 79-508, Ms p.7.

¹⁰⁹ 77-237, Ms p.7.

midwife, and fainted just after the child was born.¹¹⁰ One of Annie Power's grandmothers continued as a midwife in spite of varicose ulcers.¹¹¹ Near the end of her career, Susan Everleigh was called upon to attend a woman who gave birth while en route to the hospital in Corner Brook. Because the midwife's "legs were bad" she was supported by two women as she worked.¹¹² Nora Ellsworth continued to serve as a midwife after developing diabetes and gangrene of the foot. She carried on after her leg was amputated by having women come to her home for their deliveries and once in an emergency travelled to a community five miles distant.¹¹³

The dedication of these women is implicit in such accounts. Clients of midwives also noted this attribute. One woman stated the midwives in her community "never refused supposing if they dropped down with the tired."¹¹⁴ The many narratives about travel in bad weather also stress this commitment to attend any woman in need. Only one midwife told of circumstances which required her to refuse to attend a birth. She was caring

¹¹⁰ 78-401, Ms appendix, p.16.

¹¹¹ 88-281, C11371. Because of her problem, the post-natal tasks often performed by midwives were taken over by other women in the community.

¹¹² 76-165, Ms p.20.

¹¹³ 78-199, Ms p.33.

¹¹⁴ 75-21, Ms p.11.

for a sick grandchild when called to a woman in labour and could not go. The collector states "this was a shocking blow to her as she knew she was needed. That night she even cried."¹¹⁵ This contributed to her decision to give up midwifery shortly after. Some empirically trained midwives in other areas of North America were equally committed to their occupation. One North Carolinian midwife said "I went if I had to crawl."¹¹⁶ But this ethic was apparently not universal. West Virginia midwife Opal Freeman said, "one time it was raining so hard my husband said, 'You're not gonna go.' So I didn't. He was the boss, you know."¹¹⁷

Husbands of Newfoundland midwives did not hold such power, though many were less than enthusiastic about the role their wives assumed. One collector was told by Elizabeth Day

at one point her husband became increasingly exasperated by the frequent awakenings in the wee hours of the morning...[and] exhorted her, half-seriously, to 'turn that certificate into the wall until after I'm dead'.¹¹⁸

When Susan Everleigh recalled "those days were fun..." her husband replied "they were good for her but there

¹¹⁵ 76-258, Ms p.27.

¹¹⁶ Wigginton, p.286.

¹¹⁷ Judith Gibbs, "Nature Always Worked: Opal Freeman, Moatsville Midwife," Goldenseal, 10 (1984), 22-26.

¹¹⁸ 73-44, Ms p.10.

were a good many nights I had to sleep alone."¹¹⁹ Such comments were typical.¹²⁰

Husbands complained partly because they were deprived of the company and comforts provided by their wives. Myrtle Atkinson's husband cared for the children while his wife acted as midwife if he was not away in "the lumberwoods."¹²¹ Elizabeth Wells' husband disliked his wife's work "for the simple fact that he was fishing and there was no one to cook his meals and wash his clothes."¹²² But husbands also worried about the discomforts these women faced in their work. Irene Bradley recalled "I had to work under some hard conditions, sometimes nearly freezing to death myself. Sometimes in the winter I'd walk up to my waist in snow. My husband didn't like it very well."¹²³ Husbands could be supportive of their wives in spite of grumbling. Agnes Horwood's husband tried to persuade her to give up midwifery as she grew older, but often accompanied her to a confinement if the weather was bad and once carried her

¹¹⁹ 76-165, Ms p.29.

¹²⁰ For other examples see 76-494, Ms p.8; 79-508, Ms p.7.

¹²¹ 84-364, Ms p.8.

¹²² 79-508, Ms p.7.

¹²³ 79-549, Ms p.18.

on his back during a snow storm.¹²⁴

Regardless of their attitudes, husbands of midwives apparently had little control over their wives' activities. Only one midwife said she gave up midwifery partly because of her husband's attitude, but she also cared for the children of a working daughter.¹²⁵ As noted in Chapter One, another midwife did not assume the role until after her first husband's death because he had not wanted her to take up the work.¹²⁶ Because many of these women could only call upon a health care professional in a life-threatening situation, the ability to think independently was an important attribute. Such women were unlikely to assume a meek and dependent role in their personal lives, and few did.¹²⁷

Perhaps the most important attribute of midwives was "good nerve," an emic term denoting physical courage and the ability to remain calm in childbirth, and sometimes in the face of direct danger to the midwife as well. To

¹²⁴ Porter, p.97.

¹²⁵ 76-258, Ms p.28. This is the midwife mentioned above who refused to attend a birth because she had to care for her sick grandchild.

¹²⁶ 88-281, C11378.

¹²⁷ In her study of the song repertoire of a Newfoundland woman contemporary with many of these midwives, Debora Kodish notes the importance of independence as a female virtue. See Debora Kodish, "Fair Young Ladies and Bonny Irish Boys: Pattern in Vernacular Poetics," Journal of American Folklore, 96 (1983), p.139.

be considered for the role of midwife, it was vital that a woman demonstrate good nerve. Fanny Avery stated this when she recalled she was selected because she had "a good nerve and a bit of education."¹²⁸

The importance of this quality is also revealed in occupational narratives. First delivery narratives illustrate the midwife's ability to cope with a stressful situation, and in doing so confirm the narrator's suitability for the role. The following example of this narrative type was told by Florence Noble about events which occurred in the Bay of Islands in 1921:

I delivered a baby when I was only twenty-six and 'twas me first cousin up from the Labrador and 'twas a living storm. When we knowed, the husband went for the doctor or the midwife. And where he was a stranger from the Labrador he didn't know where to find a midwife. And...a living storm, down in old Mrs. Sweetland's home 'twas...and she [the woman in labour] told me what to do...and...it seemed like everything left me when I knew what I had to do. I knew I had to save life. And I told the children to stay, don't come out of the room. I got the scissors and I sterilized 'em and I got the cotton and I twist it up and I sterilized that. And I sterilized my hands, and I sterilized the sheet that went under--laid it in the oven, just turned it warm, you know, enough to sterilize the sheet underneath her. She told me what to do and everything turned out all right. But I was exhausted though, after it was all over. And when her husband came with the nurse (he found her after two hours) the baby was born two hours. He couldn't believe his eyes,

¹²⁸ 75-56, Ms p.6.

his ears. He said, "That baby, is she alive?" I said, "Yes, she's alive." And after they came, then she went into a coma. Whatever the heart condition was. But she was all right. She came out of it. But she was a long time, she was a day or two.¹²⁹

To directly state the personal qualities that made a woman a good midwife would have seemed inappropriately boastful. Such occupational narratives provided an indirect means of stating why a midwife was suited to her role. In this story, Florence Noble stressed the importance of cleanliness in obstetric care through her description of sterilizing and preparing equipment. Such detail implicitly asserts that she was clean and therefore a good midwife. She also indicates her good nerve, saying "it seemed like everything left me when I knew what I had to do. I knew I had to save life." The entire narrative stresses her ability to deal with crisis in a calm and capable manner.

Other first delivery narratives reveal similar attributes. Annie Fizzard implicitly contrasted herself with her mother-in-law, who was "nervous" because she did not like to "born babies."¹³⁰ She also told the collector "I['d] like to be [now at age ninety-two] like I was then," emphasising her positive qualities without boasting. Annie impersonalised her skill by stating "God

¹²⁹ 78-415, Ms pp.6-7.

¹³⁰ 78-401, Ms appendix, p.10.

Almighty put it in my head," which is not only a statement of belief in a higher power, but a means of remaining modest about her own abilities.

The tone of such narratives also conveys the midwife's courage. Stories about first deliveries, travel in bad weather, and difficult births describe dramatic and even life-threatening situations. Yet the narrator is always calm, sometimes even humorous, giving the listener the impression that she would not be frightened by anything. Clients also recalled the calm and courage of their midwives. One woman said,

the midwives were great women, they never lost heart, never gave up and wouldn't let you give up either. I remembers one time saying to the midwife "You're hurting me." and she said, "No that's your baby hurting you." They knew just what to say. They were as brave as lions, you know, they never got upset and wouldn't let you get upset either.¹³¹

As this woman indicates, good nerve was required so that the mother was not upset during labour. The importance of remaining calm for the sake of the client was noted by several women. Annie Power said of Fanny McGrath "I knew lots of times inside that she must be really keyed up and that her heart was pounding, expecting what situation..." but she never let this show.¹³² The collector who interviewed Ida Linehan stated

¹³¹ 75-21, Ms p.15.

¹³² 88-281, C11371.

"she never once felt afraid during a birth. She said she remained calm so as not to frighten the mothers."¹³³

To "lose nerve" during a delivery was a serious breach on the part of a midwife. None of the women discussed here admitted to having done this themselves, although one recalled that the midwife she assisted did once. In this case the baby was deformed and died at birth. When the older midwife felt sick and turned away, her apprentice recalled "I slapped her and said, 'Now you do it,' because I felt that I shouldn't be left alone to do such a birth."¹³⁴ The urgency of the situation apparently allowed for such a disrespectful action. It also seems this loss of nerve was such a serious departure from the expected behaviour of a midwife that it allowed her assistant similar disregard for social conventions.

Midwives needed good nerve outside the birthing room, as occupational narratives about travel in bad weather show. The following narrative is more dramatic than most, but otherwise typical. The narrator, Annie Pilgrim, was a midwife at Griquet on the Northern Peninsula for fifty years. The events described below took place when she was seventy. A man came from Quirpon Island, the northernmost tip of the island of

¹³³ 79-159, Ms p.33. Also see 76-142, Ms p.5.

¹³⁴ 79-379, Ms pp.22-23.

Newfoundland, to bring her to a woman in prolonged labour. Before beginning this narrative Annie said she was called because the midwife in the community, "a girl...[who] was trained in the hospital," was "afraid to take it on."¹³⁵ This may reflect Annie's feelings about the superiority of her own empirical training. It also contrasts the younger woman's inexperience and fearfulness with the narrator's skill and courage, setting the scene for her account.

A. P. I remember one morning I was going to prayers and I see a man coming...so I went and met him and I said, "What is it?" There was mountains of sea. He said, "I come for you Mrs. Pilgrim, to go to Cape Bauld." (You knows where Cape Bauld is to?) "My blessed Lord," I said, "You knows I can't go down, this morning. She had a right to be in the hospital. Such a sea as this, I'm afraid the sea." "Oh," he said, "We'll take care of you." Alright, come back and get my clothes and went on, and when I got down to Fortune, (You know where Fortune is to?) we changed a boat there the boat we had, and we got another boat and the sea was mountains, like mountains. Went down to Quirpon and got down to Quirpon and we changed again in another boat a bigger one. Know where Quirpon is to?

S. K. Yes Mam.

A. P. You know where [] Rocks is to? Covered right over, we had to go out there when we go down to [] before we got down to Cape Bauld, couldn't see nothing only sea going up the hills.

¹³⁵ 76-481, MUNFLA transcript C2969, p.7.

"Mrs. Pilgrim," he said, "Do you think you could go up over the cliff on a ladder?" "Goodness," I said, "I don't know," but I said..."I'll try it." And went down to the place where I had to go and we had to go right down where the ladder was to. "Mrs. Pilgrim," he said, "Do you think you'll catch the ladder when the boat goes in?" Mountains of sea there was. One man and he said, "Mrs. Pilgrim be sure you catch the right cable. There is a cable on the ladder come down the middle." And I turned around and said to the man, "Is it safe up over on the landing?" "Yes mam," he said, "It is safe there. Whatever you does, don't look back." I said when I gets part of the ways up I'm going to look and see that man, see what he's like.

S.K. You had a good nerve.

A.P. Oh, I had a good nerve, more than I got now....Yes I went on and I looked behind and he was coming behind me and see the man down in the boat he looked about the size of that. Regard a looking, the sea going over him. So, alright I got up on that, and "Watch out about the landing," he said, "Everything is perfect," he said, "There is a big piece of iron concreted into the rock. There is no fear no danger when you swings in," he said, "And no one don't catch you, don't catch a man, still hold the rope." I said, "Yes, I'll still hold the rope." A little afraid when he said that. So when she swung they never caught me, and the next time when I swung in around the rope a old man caught me around the neck. I said, "I got you hold brother." "Yes," he said, "You're safe Mrs. Pilgrim." So he took 'em down on the concrete and we went on and when...

S.K. Was that a high cliff?

A.P. Yes, I was going to ask Ambrose how

much it was high. I would like to know...how high it was. It was as high as the cape out here they said.

S.K. And you had to climb?

A.P. I climbed right up to the top, put me foot on the landing.

S.K. Were you afraid?

A.P. No, not a bit. The only thing though I had to come down the next day over the face. Yes I did so.

S.K. ...How far did you have to walk then?

A.P. Not very far. There was three women coming to meet me, three Catholic women was there, and they almost lugged me in the house. And I could hear the woman groaning upstairs....I went in and I said to her, "How are you my dear?" She said, "I'm going to die." I said, "No indeed, you're not going to die. What you're going to die for?" And she smiled and twenty minutes from that her baby was born, eight pound boy.¹³⁶

Narratives like this were certainly told for dramatic effect, but this does not diminish the significance of the narrator's positive attributes. In this story, Annie admit to being afraid, but the narrative emphasises her fearlessness, detailing how she travelled about twenty kilometres in rough seas, swung out from the boat on a rope to be caught by men waiting for her, and then climbed a ladder up a sheer cliff face. To stress her bravery, she recalls deliberately looking

¹³⁶ 76-481, MUNFLA transcript C2969, pp.4-7.

back to see the men in the boat when she was told not to. In this case, the midwife probably risked her life, travelling far beyond her own community for those who were "Catholic, but they were good people," indicating that the midwife's dedication to her work extended beyond her own community and people.¹³⁷

In this narrative, Annie's role in childbirth is recounted very briefly, but is nevertheless significant. Here we see the midwife calmly joking with the terrified woman. It is implied that this relaxes the woman, who is delivered without problems shortly after. The ability to inspire confidence by a show of good nerve is directly related to the midwife's efficacy as a birth attendant. This is a fundamental reason why good nerve was so important.

Virtually every midwife told narratives concerning travel in bad weather. Newfoundlanders face difficult weather on land and at sea, and the ability to persevere in the face of such conditions is an important part of their identity. But narratives about travel in bad weather had occupational significance as well. Women did not normally travel in such difficult circumstances. These events and the narratives told about them functioned to demarcate members of this occupation from ordinary women by stressing the unusual conditions of the

¹³⁷ 76-481, MUNFLA transcript C2969, p.7.

midwife's work. Such narratives also confirm the importance of stoicism, commitment to those in need, and good nerve. In occupational narratives of all kinds midwives emphasized the discomforts of the work and their dedication. This emphasis may have served to relieve any hostility resulting from the assumption of leadership role by assuring others that these women were not gaining status at their expense.¹³⁸

Another quality valued in Newfoundland midwives is best characterized as sympathy, which included treating a woman gently in childbirth and showing some knowledge of, and compassion for her temperament and circumstances. During childbirth, Annie Power and Fanny McGrath held the woman's hand and told her she would forget the pain when she held her baby.¹³⁹ One woman recalled,

the midwives were a real source of comfort. I really depended on them women. As long as they were there everything would be okay. Whatever they told me, I did without grumbling. They were like a mother to you.¹⁴⁰

¹³⁸ In Guatemala, Lois Paul found "in the eyes of their society...Pedrano midwives ameliorate the social ascendance of their role by genuine displays of compassion and emphasis on the hardships of their office." Paul, p.143. Newfoundland culture has been regarded by a number of ethnographers as similar in structure to the Redfieldian peasant societies of Central and South America.

¹³⁹ 88-281, C11371. Also see 78-211, Ms p.131 and 88-281, C11376, both quoted at the end of Chapter Three.

¹⁴⁰ 84-332, Ms p.9.

Helen Porter's portrait of her grandmother reveals that a midwife's sympathy extended beyond her role in birth. As Agnes Horwood grew older, she tried to retire:

..."I'm giving it up," she'd say to the next woman who came to her and half-shamefacedly confessed that she was "in the family way" again. "Oh Mrs. Horwood, wait till I'm finished," the woman would beg and Nanny would shake her head and say, "Sure, you'll never be finished," but then would agree to take "Just this last one." Time after time she found a reason to take "one more case." It would be, "She's such a good friend, how can I refuse?" Or, "Poor Mary, she's so shy, I couldn't let her have a stranger," or, "You know that family haven't got any money. They just can't afford to get a doctor or a trained nurse," or, most frequent of all, "She said she wouldn't know what to do without me."¹⁴¹

Agnes' compassion was part of her deep understanding of her clients' personalities and economic circumstances.

Although sympathy was an important attribute it is not a quality that midwives chose to emphasize in narratives about their work. Rather, statements about the sympathetic nature of these women is most prominent in the accounts of clients and assistants of midwives. Perhaps midwives chose to stress good nerve above all else because this attribute was often displayed in dramatic situations from which good stories were made. But it is also true that sympathy for those giving birth was common among women, whereas good nerve was less so.

¹⁴¹ Porter, p.97.

Good nerve was also emphasized because it had direct bearing on the outcome of labour, and was a definitive attribute. A woman without nerve would simply not be considered for the role.

These two attributes, good nerve and sympathy, are not always compatible, for it is difficult for a woman who must display unlimited calm and courage to also be tolerant of panic in others. It is therefore not surprising to find that midwives were sometimes less than sympathetic. One midwife, called to a woman who was already the mother of four children, heard the woman screaming as she approached the house. She said, "I stood no nonsense with her. I said, 'Either you stop that nonsense or home I goes.'" This threat apparently quieted the woman who was delivered without problems about half an hour later.¹⁴² Another midwife would tell any woman who began to overreact "not to be so childish," and once threatened "to shove a blanket down [the woman's] throat" if she could not regain her composure.¹⁴³ Such displays of temper were less than ideal, but were apparently acceptable because women were expected to be stoic during labour, especially after the first child, and because maintaining calm during labour and delivery was an important part of the midwife's job.

¹⁴² 79-405, Ms pp.15-16.

¹⁴³ 76-258, Ms p.16.

Conclusion

The role of midwife was assumed in accordance with occupational traditions, but no rigid restrictions limited selection to any particular type of women. A high degree of community participation in selection of midwives allowed women to assume a position of authority without compromising egalitarian ideals. This also ensured that responsibility for the outcome of childbirth did not rest with the midwife alone, protecting her from harsh criticism.

Newfoundland women shared a very clear occupational ideal, which midwives communicated in narratives about their work. These women tended to portray themselves in accordance with that ideal, and were expected to conform to it by the women they attended. Midwives were to be careful about cleanliness and some formal education and knowledge of medical obstetrics were desirable. Personal qualities such as good nerve, independence, stoicism, sympathy, the ability to maintain confidences, and a strong commitment to helping others were most important in determining who would assume this role.

In the outpost she studied, Dona Davis found "a 'good woman' is one who has worked hard all her life and stoically endured or surmounted the hardships of 'the old

days when we were all poor.'"¹⁴⁴ From narratives told by and about midwives, it is apparent that the attributes of a good midwife were fundamentally the qualities of a good woman, except perhaps that the midwife, in the best of circumstances, exemplified these qualities to a greater degree than most.

¹⁴⁴ Dona Davis, p.144.

Chapter V

Midwife as Healer and Neighbour

This chapter considers healing duties not related to childbirth that were routinely undertaken by many midwives and compares midwifery with other healing roles. The social position of midwives in their communities is considered through examination of the relative social standing of women who assumed this role and the ways in which midwifery affected their positions. As birth attendants, midwives were not healers in the strictest sense. A midwife oversees a normal biological process which proceeds without need for intervention in the majority of cases, whereas a healer intervenes in a pathological process to effect a cure and restore a normal state of health. When the role of midwife is compared to other traditional healing roles, especially those involving supernatural powers, some fundamental features of midwifery as practiced in Newfoundland become apparent. The aim of this discussion is to place women who became midwives in the context of traditional health care and their communities, and to further explain how community values helped to shape this role.

Other Duties

She's the same way at death as she is at

life. She is able to stay until the last breath goes out and she is able to bring life into them.¹

In most outport communities until very recently people were groomed and dressed for burial by members of the community, placed in homemade coffins and waked in their own homes.² In Newfoundland, preparing people for burial was known as "laying out the dead," and no special name was given to those who performed this service. The dead person was usually laid out by someone outside the family. Many midwives, though not all, assumed this role.³ Some only prepared infants who died near the time of birth, but most who acted in this role served the community at large.⁴

Some midwife-entrepreneurs received money for this service. Lillian Wandling was paid for laying out the

¹ 84-379, Ms p.15. The speaker is Donna Dove, granddaughter of Louisa Dove.

² See Anna Kay Buckley, "The Good Wake: A Newfoundland Case Study," Culture & Tradition, 7 (1983), 6-16; Gary R. Butler, "Sacred and Profane Space: Ritual Interaction and Process in the Newfoundland House Wake," Material History Bulletin, 15 (1982), 28-29; and Murray, pp.136-140 for Newfoundland burial customs.

³ See 72-62, Ms p.1; 73-44, Ms pp.13-14; 75-56, Ms pp.25-26; 79-159, Ms pp.30-33; 79-163, Ms pp. 9-12; 79-417, Ms pp.38-39; 84-307, Ms p.11; 84-364, Ms p.10; 84-379, Ms p.15; 84-383, Ms p.3. Kevin Major, ed., "Interview with Kenneth and Irene Bradley," Stagehead II, 1 (1976), 14-15. 88-281, C11355; C11375; unrecorded information, Thompson interview.

⁴ For information on a midwife who only prepared infants see 76-258, Ms pp.25-26.

dead by Barrett's, a firm of St. John's undertakers, when people were still waked in their homes in the city.⁵ But laying out the dead was usually an act of charity, performed without thought of payment, and in smaller settlements all funeral preparations were made by members of the community. In Eastport, for example, Irene Bradley laid out the dead and made the distinctive shroud found in that area, and her husband built the coffin.⁶

The task of laying out the dead was also taken on by other members of the community, male and female.⁷ It was most usual for people to lay out members of their own sex only, although some midwives prepared men for burial.⁸ The combination of midwifery and laying out the dead was known in Victorian England, as evidenced by Dickens' infamous Sarah Gamp who "went to a lying-in or a laying-out with equal relish and zest."⁹ Recent oral evidence from Britain and Northern Ireland indicates that this

⁵ 88-281, C11355.

⁶ The shroud was made of white cloth, folded over several times and cut with scissors into a "snowflake pattern." 88-281, C11375. An example is housed in the Salvage Fishermen's Museum, not far from Eastport.

⁷ A number of informants who were not midwives had also prepared the dead for burial at some point.

⁸ See 73-44, Ms p.14; 75-56, Ms pp.25-26.

⁹ Charles Dickens, Martin Chuzzlewit, quoted in Margot Edwards and Mary Waldorf, Reclaiming Birth: History and Heroines of American Childbirth Reform (Trumansburg, New York: The Crossing Press, 1984), p.147.

dual role was common.¹⁰ Mormon midwives also laid out the dead during the first exodus to Utah in the 1840s, as did Nova Scotian midwives in the early twentieth century.¹¹

Preparation of the dead seems at odds with the midwife's main duty as birth attendant. But the possibility of death was present at every birth in the past and if the occurrence of death was infrequent, it was certainly not unknown. When an infant died, it was a logical extension of the midwife's role to wash and dress the corpse in preparation for burial, much as she would had the child survived. These two roles also required some common attributes such as a willingness to aid others and the courage to deal with a stressful situation. Fanny Avery said,

people said I had a good nerve but I don't know if it was nerve or not but I didn't mind shaving and dressing [them] after they died. The way I looked at it is if they didn't do anything to me when they were alive they wouldn't do anything now.¹²

If death was caused by an infectious disease, this

¹⁰ Elizabeth Roberts notes "when there was a death only a certain few women were called upon to lay out the dead. They were often the same women who delivered babies until the training of midwives became compulsory." Elizabeth Roberts, p.189. Also see Mary Chamberlain and Ruth Richardson, "Life and Death," Oral History, 11 (1983), 31-43; Linda-May Ballard, p.64.

¹¹ For Mormon midwives see Noall, p.89. For Nova Scotia see Kuusisto, p.27.

¹² 75-56, Ms pp.25-26.

combination of roles might pose the threat of communication of disease from a dead person to a mother or child. In most outports the chances of any woman laying out a corpse and attending a birth in a single day was low. As the twentieth century progressed, disinfectants were used both at births and in the preparation of the dead, and midwives washed their hands and discarded the materials used to prepare the corpse. Though these measures might seem primitive by present day standards, they served to lower the chances of cross-infection. There are no recorded cases of a midwife having infected a client as result of laying out the dead.

Midwives also acted frequently as general nurses in their home communities.¹³ Such domestic nursing was not exclusive to the midwife but was primarily women's work. Within the family, women were responsible for nursing the sick and curing minor ailments. As part of their routine duties, women also provided food, performed household chores for, and visited with people who were unwell.¹⁴ When heavy work such as cutting firewood was necessary men also helped.

¹³ See 70-15, Ms p.24; 76-165, Ms p.24; 76-351, Ms p.34; 77-328 Ms p.40; 77-345, Ms p.3; 78-119, p.12; pp.43-45; 78-415, Ms pp.14-17; 79-405, Ms p.4; 82-326, Ms p.17; 84-307, Ms p.10; 84-379, Ms pp.11-15; 86-254, Ms pp.16-20.

¹⁴ 88-281, C11372; C11379; C11385; Murray, p.136.

In each community, a few women undertook more specialized domestic nursing, providing first aid, caring for people through long illnesses and keeping watch at deathbeds. In some places these duties were assumed by the midwife and other women as well. In other communities, the midwife concerned herself with obstetric matters only and others took over domestic nursing. This division was determined by demands on a midwife's time and interest in the work. Like midwives, other women who undertook such nursing had an interest in caring for people and specialized knowledge and skills necessary to first aid and curing. Because domestic nursing was unpaid, and at times unpleasant, time-consuming, and even dangerous in the case of infectious diseases, this was considered an act of charity and women who undertook it were motivated in part by altruism and a sense of responsibility.

The line between infectious and non-infectious complaints was not always clearly drawn in the past, and domestic nursing involved both.¹⁵ Tuberculosis was the most pervasive infectious disease in Newfoundland well into this century. Large and small communities alike also

¹⁵ Elizabeth Marsh recalled a case in Deer Harbour of a man with a visible cancer who was nursed through his illness by a neighbour who routinely cared for the sick. The man's family would not tend him because they were afraid of contracting the cancer. The woman who did the nursing took precautions to ensure that she would not contract or spread the disease. 88-281, C11379.

experienced periodic outbreaks of measles, whopping cough, chicken pox, influenza and other infectious diseases. Occasionally, very serious diseases such as small-pox, diphtheria and typhoid occurred, though these disappeared in this century.

When dealing with diseases thought to be communicable, many women took precautions to prevent the spread of infection. Elizabeth Marsh recalled that the midwife who nursed people through an outbreak of small-pox early in this century in Deer Harbour, Trinity Bay, wore a mask and a special suit of clothes which she kept away from her home and other people.¹⁶ Nora Ellsworth did this as well when she nursed people during a diphtheria epidemic in the 1930s, and as an extra precaution she was vaccinated for the disease by a visiting doctor. But the combination of midwifery and domestic nursing could be dangerous to the midwife's clients. Olive Bishop recalled a case in Hermitage Bay when a midwife nursing a girl with small-pox inadvertently passed the disease on to a woman whom she attended in childbirth. The new mother subsequently died as a result.¹⁷

Other complaints looked after in the course of domestic nursing include boils, constipation, earaches,

¹⁶ 88-281, C11379.

¹⁷ 88-281, C11369.

indigestion and intestinal parasites.¹⁸ First aid was given for nosebleeds, cuts, sprains, burns and frostbite. For more serious problems, broken limbs or serious cuts for example, most people would seek a doctor or district nurse if one was available. Some midwives with formal training undertook such major problems. For example, Olga Smith set dislocated hips and shoulders.¹⁹ There were also individuals who could set broken bones in many communities. In Newfoundland, bone setting, like domestic nursing, was considered a skill rather than a power.²⁰

Mary Margaret Drover of Upper Island Cove, Conception Bay is one example of a midwife skilled in domestic nursing.²¹ She became a midwife after apprenticing with her mother-in-law and was active from about 1920 until her death in 1945. Mary Margaret prevented infection by applying a bread poultice to

¹⁸ See, for example 70-15, Ms p.24; 77-345, Ms p.3; 78-119, Ms p.12; 78-415, Ms p.14; 79-404, Ms p.4; 82-326, Ms p.17, 84-307, Ms pp.10-11.

¹⁹ 77-328, Ms p.40.

²⁰ 88-281, C11372. In Branch, two brothers who acted as bone setters also sutured cuts when weather prevented doctors from reaching the community and removed splinters. Their bone setting activity was regarded as part of domestic healing. Also see 78-219, Ms p.14.

²¹ Information about Mary Margaret Drover comes from 86-254, and two interviews with her daughter-in-law, Elsie Drover, 88-281, C11373; C11380.

wounds.²² She also used laundry starch and linen to cure blood poisoning, though such cases were referred to doctors. When one man came to her with blood poisoning and refused to see a doctor she reluctantly opened his hand with a sterilized straight razor and drained and dressed the infected area.

On another occasion she bandaged a child who cut her head on an iron post. The child was then sent by train to hospital in St. John's, and Mary Margaret later received a letter from a doctor stating that her work probably saved the child's life. This midwife also treated jaundice using loaf sugar, pineapple juice and egg whites in spring water; "sheep saphrin" [sheep manure tea]; and senna tea.²³ This was said to work within nine days.

Nora Ellsworth also acted as a domestic nurse in Carmanville and the surrounding area. She treated toothache using flour poultices or massage and a solution made from burnt paper and water. She also stitched minor cuts with an ordinary sewing needle and thread which were sterilized in boiling water. She treated sore throats, minor skin infections, and pneumonia, as well as more

²² Bread poultices were more commonly used in Newfoundland to draw the infection out of a boil or abscess.

²³ Sheep manure tea is made by steeping sheep manure in water. Hand notes eleven American states and two Canadian provinces where the drinking of sheep manure tea is part of folk medical practice. Hand, Frank C. Brown Collection, Vol. VI, p.233.

serious infectious diseases as noted above.²⁴

These other duties, laying out the dead and domestic nursing, illustrate the varied skills of women who became midwives. They also indicate the willingness of midwives to provide care for others and undertake difficult or unpleasant tasks without personal gain. The relationship between midwifery and domestic nursing raises questions about the place of midwives in the broader context of traditional healing.

Midwifery and Traditional Healing Roles

In addition to midwives and domestic nurses, healers with supernatural powers were fairly common in Newfoundland. These three categories of healers were not always separate. As noted above there was a substantial overlap between midwifery and domestic nursing. In general however it seems that the line between natural and supernatural healing was a fairly distinct one. A few people who were wart charmers or blood stoppers also did some domestic nursing, but many people possessed of supernatural powers provided no other medical services. Domestic nursing might also involve resort to charms for nosebleeds and warts. Nora Ellsworth tied a green ribbon around a person's neck to prevent nosebleed, for example, a common charm in Newfoundland. But this was the only

²⁴ 78-119, Ms pp.14-20.

charm she relied on in all her healing activities, midwifery included.²⁵ Like some wart charms, this charm for nose bleed could be performed by anyone and did not indicate a special personal relationship with the supernatural.

Our knowledge of healers with supernatural power and especially their role in communities is slight; at present there is only one published study of such a person in Newfoundland.²⁶ The subject of supernatural healing is at least as complex as midwifery itself, and on the whole beyond the scope of this work. However, a brief comparison between midwives and supernatural healers is worth inclusion here as it helps to place midwives in the broader context of traditional healing roles.

People who could charm warts, cure toothaches by touch alone, stop blood, or cure skin diseases were believed to derive their power from the supernatural. Men were as common in these healing roles as women. In fact, in many places it was believed that such power could only be passed to a person of the opposite sex. In contrast to

²⁵ 78-119, Ms p.21.

²⁶ Michael Owen Jones, Why Faith Healing? This work was researched in Newfoundland. Though Jones chose not to identify the location in his publication, Why Faith Healing? has been included for many years in Philip Hiscock's "Newfoundland Folklore and Language: A Selected Bibliography," [mimeograph], (St. John's: MUNFLA, 1981), p.5.

midwifery and domestic nursing, those who assumed these special healing roles were frequently ascribed their status. Seventh sons or daughters, or the seventh child of a seventh child, a child born with a caul or a posthumous child, born after its father's death, were most frequently ascribed this role.²⁷ In some places, priests or ministers became healers with special powers as well. Supernatural healing powers could also be passed from one person to another, as indicated above.

In some cultures, midwifery is similarly ascribed. In Guatemala, for example, Mayan midwives are believed to be born with a sign of their vocation, often a caul. A woman who ignores this and refuses to accept her calling may become ill or even die.²⁸ Guatemalan midwives also have a pronounced supernatural role. In Newfoundland, such ascribed status was not necessary to midwifery, and is almost never found. Although seventh daughters had special healing powers, birth position did not influence who would become a midwife. One midwife was a posthumous child and a woman in her community said "the healing was in her."²⁹

Another midwife was born with a caul. She was aware of its significance, saying, "they say it is for healing,

²⁷ See 78-219, Ms pp.2-3.

²⁸ Paul and Paul, pp.710-712.

²⁹ 78-211, Ms p.48.

that you have the gift of healing."³⁰ But when asked if she had healing powers because of this, she described how a neighbour with an injured hand was sent to her when she was a child. She was frightened, but her grandmother said, "Jesus, Father and Holy Ghost," while compelling the child to make the sign of the cross over the hand. The pain subsided after.³¹ This was the only type of healing this midwife related to her caul. Significantly, her work as a midwife was not seen to be connected with this gift.

In Newfoundland, midwifery was not regarded as a supernatural role, although midwives sometimes came into direct contact with the supernatural in the course of their work. For example, one version of an international narrative, well known in Britain, which is sometimes called "the fairy midwife," has been collected in Newfoundland.³² In this narrative, the midwife is called

³⁰ 74-181, Ms p.54.

³¹ 74-181, Ms p.56.

³² This narrative is type ML5070. See Reidar Christiansen, The Migratory Legends: A Proposed List of Types with a Systematic Catalogue of the Norwegian Variants, FF Communications No. 175, (Helsinki: Suomalainen Tiedekatemia Academia Scientiarum Fennica, 1958). Also see Lady [Isabella] Gregory, Visions and Beliefs in the West of Ireland: With Two Essays and Notes by W. B. Yeats, 1920; rpt. (Gerrards Cross, Buckinghamshire: Colin Smythe, 1979), p.206 and W. Y. Evans Wentz, The Fairy-Faith in Celtic Countries, 1911; rpt. (Gerrards Cross, Buckinghamshire: Colin Smythe, 1988), p.54.

to attend a woman she does know at a poor home. While there, some water touches one eye and she sees the family is really quite wealthy. She is given a bundle for her work, and told not to open it for a certain amount of time, but does not wait and the bundle only contains dead leaves. Some time later she meets the husband of the woman she attended, and greets him. He asks her which eye she can see him with, and strikes her blind in that eye.³³ This was told to the informant in the first person by a midwife. However the midwife is not an agent of supernatural powers in this narrative.

Other beliefs found in the British Isles connect midwives more directly with supernatural powers. For example, in East Anglia many people believed "that the nurse or midwife has certain powers which enable her in emergencies to arrive in time for the birth without having recourse to the ordinary means of transport," even in the twentieth century.³⁴ Irish midwives are said to have boasted of the ability to transfer the pains of labour to any man they chose, "particularly...old bachelors."³⁵ There are no indications that Newfoundland midwives claimed or were believed to possess such powers.

As there was little relation between midwifery and

³³ 72-95, Ms pp.33-35.

³⁴ Newman and Newman, p.182.

³⁵ Black, p.179.

ascribed status, personality was the key factor in determining who would become a midwife in Newfoundland, as noted in Chapter Four. In his study of a Newfoundland folk healer, Michael Owen Jones also considers how personality influences the assumption of healing roles. Jones posits two personality types which are, as he states, polar opposites:

Type I is the nonaggressive, supportive, task-oriented individual who commonly is motivated by a desire for social service, although other motivations may also be evident on specific occasions...
Type II is the aggressive, self-oriented individual whose principal motivation for choosing the occupation had to do with self-aggrandizement, although there may also be involved...the motive of altruism.³⁶

"Jim Gallagher," the healer Jones studied, cured skin diseases and sometimes stopped blood and cured toothaches by touch. He was a seventh son, so the role was ascribed to some degree. His ability to cure various skin conditions was documented and he was widely believed to be possessed of supernatural power. Jones believed this man was of the second personality type; an aggressive, self-serving individual who at times violated community standards. He was thought to "work the black heart" by cursing those who conflicted with him and he arranged his healing activities so that he gained financially from them, in direct contravention of

³⁶ Jones, Why Faith Healing? p.12.

tradition.

Traditional safeguards usually worked to prevent such manipulation of a healing role by unscrupulous individuals. Ideally, such people were expected to view themselves not as powerful in their own right, but as instruments of a higher power.³⁷ It was also widely believed that a healer with supernatural powers should not be paid or even thanked, and if money was received the power to cure would be lost. But such safeguards could be ignored or circumvented, as the subject of Jones' study discovered.³⁸

It would certainly be wrong to assume that most healers with supernatural powers resembled Jim Gallagher. Many who assumed this role heeded traditions which curbed the use of their powers, and like midwives, were motivated by a desire to help others.³⁹ The point is that

³⁷ This attitude has been noted among burn charmers in North Carolina. See James W. Kirkland, "Traditional Medical Information Systems in Deep Run, North Carolina," North Carolina Folklore Journal, 30 (1982), p.46.

³⁸ This healer tried to "sell" his power by charging money, and discovered that, contrary to tradition, his ability remained. His mother, wife or daughter requested a "contribution" of ten or twenty dollars from those he treated, allowing the healer to profit financially without taking money himself. Jones, Why Faith Healing? pp.21-22.

³⁹ For an example from England see Martin J. Lovelace, "The Life History of a Dorset Folk Healer: The Influence of Personality on the Modification of a Traditional Role," (M. A. thesis, Memorial University of Newfoundland, 1975).

the role of supernatural healer was open to manipulation by an aggressive individual who wished to gain financial and personal power at the expense of others. Ascribed status made such healers difficult to replace, and implied selection by a higher power. Tangible healing abilities confirmed the person's right to this role, and power to cure could easily be subverted into power to harm.

Many features of supernatural healing roles are absent from midwifery in Newfoundland. The role of midwife was not ascribed, and because midwives were selected from a fairly large pool of potential candidates well known within their communities, someone likely to use this position primarily for self-aggrandizement would probably not be chosen to begin with. The skills midwives developed made them invaluable, which could provide opportunities for the domination of others. But, unlike the healer in Jones' study, midwives endured travel in difficult circumstances, long and irregular hours, discomfort and sometimes hard physical labour in the course of their work. And, although the ability to endure difficult circumstances was status enhancing, it is unlikely that an individual primarily interested in self-aggrandizement would be drawn to midwifery. This role was not as susceptible to manipulation by a self-serving individual as was that of supernatural healer and most

Newfoundland midwives can be placed in the category of Jones' first personality type with some degree of confidence.

The overlap between midwives and those with special healing powers was slight. Polly Oliver of Gull Island, Conception Bay and Louisa Dove of Chanceport, New World Island, both midwives, were also wart charmers.⁴⁰ Unfortunately, we do not know how they acquired or used these special powers.

Most midwives did not claim supernatural powers. One was cast in the role of toothache charmer in spite of herself. The collector, a granddaughter, reports

there are about three families in _____ Cove who believed that she had a charm to stop toothaches. They would always tell her the name of the child having the toothache and she would just say okay and walk away forgetting about it. Even today the children of those families are phoning her about their children's toothaches. She answers the phone, says, "Okay," or "Alright child," hangs up, walks away and never does a single thing about it. She hasn't admitted to them that she can't stop toothaches because they believe she can.⁴¹

The midwife's reaction is interesting. When this role was thrust upon her, she did not deny it, but neither did she attempt to cultivate such power. This midwife said she did not believe in charms, although she added that

⁴⁰ 78-297, Ms p.6; 84-379, Ms p.11.

⁴¹ 79-695, Ms pp.15-16.

another woman successfully charmed the "extreme bleedings" of the midwife's daughter.⁴² In spite of her skepticism, she was reluctant to deprive these people of access to healing they found effective, and probably wished to avoid embarrassing them as well.

Supernatural power may be used in harmful as well as helpful ways, and is likely, by its very nature, to inspire fear unless a practitioner carefully presents it and herself in a non-threatening manner. This explains why so many safeguards were built into supernatural healing roles in Newfoundland. On this topic, Jack Santino notes

healers--especially those operating more fully in the magico-religious or supernatural domain--are people who have power. People who have power are often viewed ambivalently by members of their society. When power is in the area of health, or is set in the supernatural domain, it can be threatening.⁴³

The opposite of benevolent curing is of course witchcraft, the deliberate use of supernatural powers to harm others. Although witchcraft belief remained strong in Newfoundland, midwives were rarely seen as witches.⁴⁴

⁴² 79-695, Ms p.14. Although the collector was unclear, the term "bleedings" may refer to menstruation.

⁴³ Jack Santino, "On the Nature of Healing as a Folk Event," Western Folklore, 44 (1985), p.159.

⁴⁴ For information about witch beliefs in Newfoundland see David J. Hufford, The Terror That Comes in the Night: An Experience Centered Study of Supernatural Assault Traditions (Philadelphia: University

In the francophone community of La Grand Terre (Mainland) on the west coast, children moved to the homes of relatives during childbirth were told the baby came during a battle between "la chasse femme" [the midwife] and the "old witch." The old witch brought the baby and the midwife's role was to protect the mother and take the baby from the witch. Children were told the midwife remained at the house for three days after a birth to ensure the old witch did not return to steal the baby, and the mother remained in bed for seven days because she had been hit on the leg by the old witch.⁴⁵ However, during extensive fieldwork in the Port au Port area, Gerald Thomas was told by some that the midwife was the old witch who brought the baby.⁴⁶ This indicates those not involved in childbirth may have very different ideas about the role of midwife from those directly involved.

In another case where midwifery was related to witchcraft, a collector was told

the witch [the informant] knew of was a
midwife of which many people were afraid.

of Pennsylvania Press, 1982), and Peggy Martin, "Drop Dead: Witchcraft Images and Ambiguities in Newfoundland Society," Culture & Tradition, 2 (1977) 35-50.

⁴⁵ 79-658, Ms p.16. Geraldine Barter, a native of La Grand Terre who teaches French at Memorial University, confirmed this was the common explanation of childbirth given to children in her community. "Chasse femme" is a local dialect term for the more usual sage femme. Personal communication, February, 1987.

⁴⁶ Personal communication, Gerald Thomas, October, 1988.

Being the only midwife in the community at the time, women were forced to rely on her to deliver their babies. If she didn't get paid for her labours, she would cast a spell on the baby and it would die.⁴⁷

In his study of witchcraft in New England, John Demos found that accusations of witchcraft grew out of long term conflict.⁴⁸ In this Newfoundland case, money was clearly a focus of conflict. As noted previously, Newfoundland midwives were expected to work without pay whenever necessary. If this woman demanded payment, she violated this expectation. Although the power she was believed to have over life and death must have placed her in an important position, her control was challenged in the form of counter-magic. The collector was told

they drew out her picture on a board and they shot at her. She fell down and broke her leg. That really happened, owing to them shootin' at her I don't know, but she fell down.⁴⁹

James Faris also connects midwifery with witchcraft in Cat Harbour, stating all midwives in Cat Harbour not native to the community were regarded as witches by his informants because "in former times, children born malformed or in some way deficient, were often put to

⁴⁷ 79-341, Ms p.24.

⁴⁸ John Demos, Entertaining Satan: Witchcraft and the Culture of Early New England (New York: Oxford University Press, 1982), p.86.

⁴⁹ 79-341, Ms p.4.

death on the spot by the midwife."⁵⁰ But such infanticide is not true witchcraft, since no supernatural power was involved and however misguided such actions might seem, they were apparently not motivated by malice.

It is entirely possible that some Newfoundland midwives committed infanticide under such circumstances.⁵¹ Faris supports the assertion of infanticide by stating there were no people with birth defects in Cat Harbour. This in itself does not prove infanticide. Many defects are sufficiently serious to cause death at or shortly after birth unless considerable medical intervention is undertaken. For example, some types of mental retardation may carry other deformities, of the digestive system for example, which cause death unless prompt corrective surgery is performed. In such

⁵⁰ Faris, p.136.

⁵¹ In Britain, the connection between midwifery and infanticide is much stronger. My great grandmother was said to suffocate a deformed child as it was born by pushing the mother's legs together, though this was not discussed openly. Jean Donnison states "poor themselves, ordinary midwives were not...likely to be convinced of the value of a new arrival to the harassed and ill-fed mother of a large family, and were in consequence often less than conscientious in seeing that the child lived. As evidence to the Select Committee on Infant Life Protection had shown [in 1902], some were quite willing to arrange its early demise, and even at a late period a midwife's 'churchyard luck' could be an important recommendation in the eyes of her clientele." Donnison, p.103. In Newfoundland a large family remained an asset well into this century and there are no indications that such attitudes prevailed.

cases, infanticide might be rumoured where none occurred.

The connection between midwifery and witchcraft has received attention in recent years, some of it poorly grounded in fact.⁵² In North America, the correlation between these two roles does not prove strong when empirical evidence is carefully considered. In John Demos's examination of 114 cases of witchcraft in colonial New England he found only two instances in which a midwife was thought to be a witch. He adds

otherwise the witches were not midwives, at least in a formal sense. It is clear, moreover, that scores of midwives carried out their duties, in many towns and through many years, without ever being touched by imputations of witchcraft.⁵³

However, Demos did find that a number of women accused of witchcraft in New England possessed supernatural healing powers.⁵⁴ He concludes there was

a key association between efforts of curing, on one hand, and "the black arts" of witchcraft on the other. Opposite though they may seem in formal terms, in practice they were (sometimes) tightly linked. "Power" in either direction could be suddenly reversed.⁵⁵

Richard Wertz and Dorothy Wertz found midwifery to be relatively free of supernatural practices in the

⁵² See for example Ehrenreich and English, and Forbes.

⁵³ Demos, p.80.

⁵⁴ See Demos, pp.80-84.

⁵⁵ Demos, p.84.

Protestant areas of colonial America.⁵⁶ This may help to explain why New England midwives were seldom thought to be witches.

Demos believes that witches were primarily people whose troubled personalities brought them into continued conflict with their neighbours. Because of the traditions of selection discussed in Chapter Four, Newfoundland midwives were unlikely to have contentious personalities, and it is not surprising to find the connection between midwives and witches in Newfoundland was not strong.

If healing is viewed as a continuum between natural and supernatural medicine, Newfoundland midwives fall decidedly on the mundane side of the spectrum. Ascribed status, important in roles involving powers, played a negligible part in determining who would become a midwife in Newfoundland. There were no taboos to govern who would assume this role. Refusal to accept payment or thanks, a feature of supernatural healing roles, was also lacking. Most Newfoundland midwives were fully prepared to work without payment, but they were not averse to accepting money and there was certainly no occupational sanction to prevent them from doing so.

Midwives were the only traditional healers who received money for their services, and midwifery was the only service for which most were paid. Perhaps this was

⁵⁶ Wertz and Wertz, p.23.

so because midwifery demanded more time and effort than other types of health care, except perhaps domestic nursing in cases of chronic illness. Then too, it may be that payment was a means of discharging what would otherwise seem an unreasonably large debt of gratitude towards a midwife. It is also possible that acceptance of payment was a way for midwives to distinguish themselves from healers with supernatural powers, a topic returned to below.

As noted in Chapter Three, recourse to magic in childbirth was slight, even when complications developed. On one occasion when blood stopping was used during labour, the power came from a man who was a blood stopper rather than the midwife. Religion played an important role during labour and delivery, but in this the midwife was an ordinary supplicant, not a special agent. Even when midwives performed baptism they acted as any lay person might.

Although midwifery was not often connected with witchcraft, the suspicion that a midwife might somehow harm those she served cast a shadow on the role. Such suspicions were an occupational hazard for those who oversaw the dangerous process of birth. There are indications that midwives were aware of this problem, and sought to reassure others by measures mentioned in Chapter Four, encouraging the presence of witnesses for

example, and assuming an attitude of self sacrifice.

Suspicion of harm may also explain the conspicuous lack of resort to magic in midwifery, and reliance on formal religion. Although midwives were seen by some to have power over life and death, they did not regard themselves in this light. A midwife who claimed a special relationship with the supernatural would be even more powerful, hence more vulnerable to suspicion when misfortune occurred. The distance midwives placed between themselves and the supernatural may well have been an unconscious attempt to assert benevolent intentions in the face of such unspoken fears.

The Midwife as Neighbour

People in small outports were unquestionably close. One woman said, "in an outport I suppose you know too much and you nearly know what somebody has for breakfast."⁵⁷ Although this created intense, life-long friendships, it could also encourage conflict. Midwives were unlikely to have contentious personalities, as noted above, but they could not be expected to go through life without ever conflicting with those around them.

Ideally, midwives served anyone who called upon them. This occupational ideal was usually met, as noted in Chapter Four, but not always with grace. One woman

⁵⁷ 88-281, C11372.

insulted a midwife's grandchild because he was born out of wedlock. When this woman went into labour the midwife at first refused to come when called for. "After enough pleading and begging had taken place," she finally agreed to attend the birth. When the child was born she handed it to her assistant and walked away without having said a word.⁵⁸ On another occasion, a midwife demanded a woman with whom she had quarreled "get down on her knees and beg forgiveness" before assisting at her difficult labour.⁵⁹ Events such as this were probably rare, as midwives were usually portrayed as more compassionate and companionable. But such occurrences indicate that midwives did not always subjugate their personal feelings to the demands of their occupation.

There was no prohibition to prevent midwives from attending family members, and many delivered their own grandchildren and great-grandchildren.⁶⁰ Some women found this difficult. One midwife said, "the hardest thing for me was to born a baby for my own daughter. I could hardly see for tears."⁶¹ Another midwife dreaded attending a daughter because her expectations always exceeded the

⁵⁸ 76-494, Ms p.4.

⁵⁹ 76-494, Ms p.4.

⁶⁰ 76-165, Ms p.22; 79-549, Ms p.19; 79-695, Ms p.10; 88-281, C11355; C11374; C11375.

⁶¹ 84-383, Ms p.6.

care this woman was able to provide.⁶² But most women felt that mothers were good midwives for their daughters and granddaughters because they provided emotional support and understanding.

Religion, which played such an important role in other aspects of Newfoundland social life, had little effect on midwifery.⁶³ Only in one area of the north shore of Conception Bay was religion said to have shaped the practice of midwifery. This area in general experienced particularly intense religious conflict in the nineteenth century. The communities of Gull Island and Burnt Point had one Catholic and one Protestant midwife. The Catholic midwife usually attended Catholic women only, and the Protestant midwife cared for Protestants, but neither would refuse to attend any woman if called for. After the Protestant midwife was called to a Catholic home, the Catholic midwife blessed the house with holy water, and insisted that the child be baptized immediately.⁶⁴

⁶² 88-281, C11372.

⁶³ See Wareham, "Harbour Buffet: Growth and Decline," in Victor Butler, pp.144-147 for discussion of the role of religion in outpost social life.

⁶⁴ 78-297, Ms pp.8-9. The collector suggests that the midwife "went through all this fuss to show the people that they would have been better off had they called for her" because she was jealous of the competition, implying that occupational pride rather than religion was the real source of her annoyance.

Such an overt display of religious prejudice was extremely unusual among Newfoundland midwives. Most did not openly express any negative feelings they may privately have held about people of other denominations. Another midwife, who lived not twenty kilometres from Gull Island, expressed the more usual attitude, saying

I went to everyone that came looking for me. It made no difference to me. If they didn't care about religion, I didn't neither. Everyone was alike. I never done no different for them than for me own kind. Never had to do a thing different, not one single thing. And they was as good as gold to me. Could never be better...We was all alike when it come to that [birth]. 'Twas only when they was dying they done different than we did.⁶⁵

Within outport communities, the role of the midwife may be understood in relation to a similar role in male culture: that of the skilled craftsman. These craftsmen are primarily fishermen, like other men in their communities, but are prevailed upon by virtue of their special talents to perform skilled tasks such as boat and house building. This analogy has limitations of course because the personal attributes so important in midwives have little relevance to craftsmen. In spite of this, there are some significant points of similarity.

In his study of such part-time craftsmen in a southwest coast outport, Louis Chiaramonte asked four

⁶⁵ 73-160, Ms p.9. The midwife, who was Anglican, was referring to Catholic customs associated with death such as lighting candles.

boat builders why a man would take time away from fishing, his main source of income, to perform a task for others with minimal financial reward. All answered "because you can't refuse a man in need. You have to do what needs to be done."⁶⁶ Chiaramonte feels that such a statement

suggests that the man who has the expertise to do a task in a community where there are no full-time specialists must--if he wishes to maintain amiable ties--accept the job. When his expertise becomes apparent, he cannot refuse.⁶⁷

As we have seen, a woman who demonstrated her skills as a midwife was prevailed upon to fill the role when the need arose, and, like the skilled craftsman, her ability to decline was limited. Annie Power indicated this in response to the question "why did women become midwives?" stating:

why did women work as midwives, that's one thing I often wondered myself. Automatically they had to do, they didn't have to, but they delivered one baby, well then the next they couldn't refuse a friend. They delivered the next baby, so it was drawn into gradually, it was never planned, but when then people found out that Mrs. McGrath was delivering, everybody [asked her] then, that's the way it happened.⁶⁸

Comparison of the advantages of being a craftsman in

⁶⁶ Chiaramonte, p.28.

⁶⁷ Chiaramonte, p.28.

⁶⁸ 88-281, C11372.

outport Newfoundland reveals further similarities. Chiaramonte states the principal advantages of being a craftsman:

(1) the personal satisfaction gained from doing a job; (2) the status achieved through being a craftsman; (3) the monetary remuneration...and (4) the relative ease with which his social network can be extended.⁶⁹

The question of midwifery and status will be considered below. For midwives, personal satisfaction was also derived from the task itself. These women were skilled and intelligent, and assisting at childbirth was an intellectual challenge. This work was also rewarding for the bonds of affection developed between midwives and the women and children they cared for.

Chiaramonte places monetary reward relatively low on the list of advantages of being a craftsman. For the midwife, this aspect of reward was probably lower still. The craftsman expected to be paid for his work; the midwife did not. This difference was perhaps because a craftsman's client could control his material needs to some extent, or attempt to perform the work himself, whereas the midwife's client had little control over her reproductive life, and midwifery was regarded as an essential service. Also, as altruism and willingness to extend charity were important to the midwife's role,

⁶⁹ Chiaramonte, p.29.

these women could be expected to work without pay.

In Newfoundland, expansion of social networks seems to have been more significant to men than women. Chiaramonte found the men he studied did not tend to form strong bonds of friendship outside the nuclear family and men were loath to feel indebted to others.⁷⁰ Opportunities to expand social networks were therefore limited and welcome. In contrast he found

within the community, women are socially more mobile than men...The visiting pattern of women appears to be much more active when contrasted with the infrequent visiting of the men...The female social network is more relevant for the delineation of a neighbourhood than the male. Women interact more frequently within the spatial boundaries of a neighbourhood than do men...⁷¹

Women were necessarily dependent upon their neighbours for support when childbirth occurred at home, and this in itself helps to explain the why women might form close friendships more freely than men. While women did not require any special process to enable them to expand their social networks, those who became midwives probably had wider contacts than the average woman.

People who extended such services to others developed strong reciprocal ties. Annie Power was not only a midwife's assistant, she was married to a skilled

⁷⁰ Chiaramonte, pp.12-18.

⁷¹ Chiaramonte, p.14.

carpenter who often helped others without payment, although he worked outside the community and was frequently away. Annie said there was hardly a person in Branch they had not helped in some way. During her husband's illness and after his death, the people in the community reciprocated these acts of kindness. Annie's husband's normal chores such as chopping firewood and clearing snow were always done by neighbours without any request from her.

Midwives sometimes performed household chores, cared for older children and did laundry for their clients. Because of this, it has been suggested that they were specialized domestics.⁷² To determine if this is an accurate assessment of the role, it is useful to examine the social position held by women before becoming midwives, the position midwives occupied within their communities, and the effect of becoming a midwife on relative social status.

This is a difficult undertaking for a number of reasons. Dona Davis suggests that the income and social status of people in smaller outports was often more or less equal. In places without resident merchants, clergymen or doctors, most men and women performed essentially the same work according to traditional

⁷² This idea was suggested by Cecila Benoit in an address, "Newfoundland Midwives," presented to the Newfoundland Historical Society, October, 1987.

divisions of labour by gender, and relative standing was determined by individual competence.⁷³ It is also difficult to comment on social standing in retrospect. The egalitarian ethic which prevails in Newfoundland often ensures that those more financially secure than average will not draw attention to this. By the same token, some people hesitate to report extreme poverty.

In spite of these problems, there is good information on the social position of a number of women who became midwives. A few were employed before marriage as domestics.⁷⁴ As noted above, this was a common job for young unmarried women. Other women worked in a profession. Sophia Anstey operated a small lobster cannery which employed five men.⁷⁵ Clara McGrath was a school teacher prior to her marriage in 1917 and Beatrice Wheaton was the post mistress in her community for several years before she began to help an older midwife.⁷⁶

Some midwives also held significant social positions in their communities before beginning their obstetric work. Irene Bradley belonged to a leading

⁷³ See Dona Davis, p.113.

⁷⁴ 73-160, Ms p.4; 77-139, Ms p.9; 78-119, Ms pp.5-6; 84-379, Ms p.5; 86-254, Ms p.9.

⁷⁵ 77-345, Ms p.3.

⁷⁶ 81-328, Ms p.5; 82-166, Ms p.10.

family in her home community of Eastport. Her father, a farmer, was known as "the rich man of Eastport."⁷⁷ When she was approached by Dr. Gerald Smith to act as midwife in her area her reply indicates her position in her community:

I told him that I had eight children of my own, that the teacher stayed with us and that I liked to provide meals for people travelling by train from St. Brendan's (free of charge of course) so that I was kept busy. Also whenever the priest was in our part of the parish he stayed with us.⁷⁸

Olga Smith's family owned a hardware store in Gooseberry Cove, Trinity Bay.⁷⁹ Her husband's family operated a similar business in the nearby community of Southport. After their marriage, they took up residence in the seven bedroom home which had belonged to Olga's parents. Like the Bradley family, the school teacher boarded with the Smiths, and the Anglican priest stayed with them on his regular visits to their community. The fact that Olga charged no fees for midwifery or healing is a reflection of her family's affluence.

Rhoda Maude Piercey's father was captain of his own schooner. At a time when most children played with homemade toys, she owned two china dolls, although she

⁷⁷ 88-281, C11375.

⁷⁸ 79-549, Ms p.11.

⁷⁹ This information is taken from an interview with Blanche Coady, Olga Smith's daughter, 88-281, C11385.

was rarely allowed to play with them. When she was ten, her father purchased a small organ so that she could take music lessons. As noted in Chapter Four, she began to train as a nurse at the Grace Hospital at the age of twenty in 1929 but quit due to illness after four months. After she was married in 1935, her husband was forced to seek work outside their home community of Winterton, Trinity Bay. To prevent long separations, she bought a small store with their savings which they operated together until retiring in the 1970s.⁸⁰ She was also organist and choir leader at the local Anglican church.⁸¹

Olive Bishop was the daughter of a music teacher and an Anglican clergyman stationed at Hermitage Bay. Her father died when she was a child, and her mother eventually married the merchant at Pass Island. Olive's stepfather was wealthy by Newfoundland standards and kept three servants in his household. Olive began nurse's training at the General Hospital in St. John's in 1915, but was forced to discontinue her studies after six months because she developed a neurological disorder and heart trouble. After a year in hospital she returned to Pass Island to recuperate, eventually teaching school for four years.

Olive began healing activities because people knew

⁸⁰ 88-32, Ms p.81.

⁸¹ 78-116, Ms p.20.

of her training and called upon her for advice and care. When the mobile clinic the Lady Anderson came to Pass Island, she found herself in the role of unpaid district nurse, screening patients for the doctors on board and administering medicines they left. In 1939, after serving the area for about nineteen years, the Department of Public Health and Welfare appointed her part-time district nurse for Hermitage Bay. Shortly after she was sent to St. John's for the public health course in midwifery and began to work as a midwife upon her return.⁸² Olive Bishop is not typical of empirically trained midwives in this regard, but in spite of official recognition she never acquired formal nursing qualifications. Like many empirically trained midwives, she was prevailed upon by members of her community to assume the role of nurse and finally midwife. These women are probably not typical. Most Newfoundland midwives were likely to be more similar in economic and social status to those they attended. But this information indicates that the role of midwife was compatible with a high social position. Such women had no motivation to accept a role that conferred the status of a domestic servant.

Agnes Horwood was not so clearly different in social standing from those around her as the women described

⁸² This information is taken from 75-287, and an interview with Olive Bishop, 88-281, C11368; C11369.

above, but because her granddaughter Helen Porter wrote about her community and family she can be placed in the context of her neighbourhood on the South Side of St. John's. This was a small community, consisting of a line of houses squeezed between the harbour, with its warehouses and small factories, and the South Side Hills, which rise steeply less than a hundred metres from the waterfront. Southsiders were predominantly Protestant, and most residents attended St. Mary's, a stone Anglican church located in the middle of the community. There were also some Catholic families. The Ebsary family was Methodist and the Horwoods joined the United Church. Many families lived on the South Side for several generations, and neighbours provided help for one another in times of crisis. Aside from a few shopkeepers and small landowners, people who lived on the South Side were working class. Some men worked in the warehouses and small cooperages near their homes, while others were longshoremen who worked intermittently. During the Depression of the 1930s, many families were without regular income for long periods of time.

In contrast to many of their neighbours, both Frank Horwood and his son-in-law Bob Fogwill had "what southsiders called, with a mixture of respect and disdain, a steady job."⁸³ By community standards the

⁸³ Porter, p.19.

Horwood family was always comfortable, though they would not be described as affluent. They were more financially secure than many of their neighbours, and were able to extend charity to both friends and strangers during the Depression.⁸⁴ Like Agnes Horwood, most neighbourhood midwives were probably similar in social standing and income to those they attended. However, as the ability to extend charity and work without pay was important to the role, they were unlikely to live in financial need.

Some midwives in St. John's certainly took up midwifery as a means of providing for their families. Outside the city, a few widows may have been able to support themselves by working as midwives, especially during the post-war period when fees increased. But in one case only are we given the impression that an extremely poor woman undertook midwifery solely as a means of increasing her income. There were five children in this woman's family and her husband earned twenty-five cents an hour as a labourer in a quarry. The collector was told that they found it hard to support themselves. This woman made moonshine to supplement her family income prior to becoming a midwife. She selected herself for the role and took public health training in the 1940s. This caused some disruption of her family, as the children had

⁸⁴ See Porter pp.19-23 and pp.32-38 for examples of charity extended by the Horwood family.

to be left with her mother, but the collector reported that "[her] husband made no objection. He was quite proud of her."⁸⁵ This contrasts with comments that most husbands of midwives made about their wives' work as noted in the previous chapter. This man may have been proud of his wife because she enhanced her status by undertaking this role, and because she showed a good deal of initiative in attempting to improve her family's lot. Since these events took place after the Department of Health and Welfare began to set fees for midwives, it is possible this woman made a significant contribution to her family's income through midwifery.

Because there was little relationship between midwifery and profit for most women, the role of midwife is best understood as a form of charity. Sometimes midwives explicitly stated they viewed their work in this way. Louisa Dove told the collector that "she didn't look on it [midwifery] as a job but as a way of helping others."⁸⁶ Relatives of Elizabeth Wells said "she was not doing it for money but for love of it and the need [of her clients]."⁸⁷

Midwives often mentioned charity in reference to payment. Irene Bradley stated "I didn't always get paid

⁸⁵ 77-139, Ms p.15.

⁸⁶ 84-379, Ms p.14.

⁸⁷ 79-508, Ms p.9.

in dollars and cents but that sort of thing brought its own reward."⁸⁸ Beatrice Wheaton attended a poor woman more than once without payment "because they didn't have it. I wasn't in need of it and I could do without."⁸⁹ Louisa Dove told the collector that she was still owed money for her work, but "she doesn't want it now because she has lots of her own."⁹⁰ Such statements affirm the charitable nature of these midwives, and indicate their financial security.⁹¹

Midwives extended other kinds of charity to the women they assisted in childbirth. Helen Porter recalled her grandmother often took food from her own cupboards while caring for some women so that the family would have enough to eat.⁹² When Sophia Anstey attended her first confinement, she found the family in such poverty that she returned with food collected from her own and neighboring households.⁹³ Jane Ann Emberly once tore up her petticoat to make diapers for a child born into a

⁸⁸ 79-549, Ms p.13.

⁸⁹ 82-166, Ms p.14.

⁹⁰ 84-379, Ms p.6.

⁹¹ For similar statements see 76-165, Ms p.22; 76-258, Ms p.11; 76-494, Ms p.5.

⁹² 88-281, C11360.

⁹³ 77-345, Ms p.9.

house where there were none.⁹⁴ Midwife Catherine Reegan far exceeded the bounds of ordinary charity in 1945 when she brought an infant home a few days after his birth to raise as her son.⁹⁵

The relationship between midwifery and charity is vital to an understanding of the role of the midwife in her community. Charity was a Christian virtue. The ability to extend charity to those who needed it was probably status enhancing in itself, provided it was done without ostentation. The fact that these women were capable of giving their time, skills and sometimes material goods without payment tacitly proclaimed their personal virtue and underscores the fact that many were at least as financially secure as those around them. In fact, the question of whether a woman would be able to aid her neighbours without payment may have been a factor in the selection of midwives, although this was never mentioned. In light of this information it is safe to conclude that the midwife was not regarded as a kind of domestic servant, but rather a woman whose affluence and generosity enabled her to extend charity to others.

⁹⁴ 73-160, Ms p.7. This narrative passed into oral tradition in her home community; Joyce Nevitt collected it in the course of researching White Caps and Black Bands. Nevitt, p.145.

⁹⁵ 72-49, Ms p.5.

Women who became midwives were respected.⁹⁶ One collector, who wrote from personal experience as a client's husband, recalled that the midwife was treated as a special guest when she attended women:

the father always made a special effort...in trying to get special foods that would please Miss Beatie [the midwife]. Moose steaks, or rabbit soup, or bakeapple jam and fresh cream, or bottled turrs, were something special and even the poorest home and the poorest fare were given special attention for Miss Beatie.⁹⁷

Some women who became midwives achieved important social positions as well. Like Irene Bradley and Olga Smith, Alex Poole became the person in her community who hosted visiting civil servants and clergymen. From 1968 to 1972 she was a member of the local committee for the Labrador East Integrated School Board and served four consecutive terms with the Anglican Church Women's Association. She also operated the radio telephone and later, the Bell Telephone system in Fox Harbour.⁹⁸ Fanny Avery was active in her women's church group. She was president for many years probably, as the collector was told, because "she had more education than any of

⁹⁶ For comments about respect see 76-351, Ms pp.36-37; 78-119, Ms p.39; 78-211, Ms p.93; 78-401, Ms p.6; 79-405, Ms pp.14-15; 79-508, Ms p.7; 86-301, Ms pp.6-7.

⁹⁷ 70-15, Ms p.24. This midwife was trained at the Grace Hospital, but the collector reported that she "stayed to help with the housework whenever she could."

⁹⁸ 77-237, Ms p.2.

us."⁹⁹ It is possible these women would have occupied the social positions that they did without becoming midwives, but their standing in their communities appears to have been enhanced by becoming birth attendants.

There are also indications of the affection people felt for midwives. Many of these women were chosen as God-parents for children they assisted into the world. Mag Hibbs, who attended about 300 births, was a God-parent to 152 children.¹⁰⁰ After Nora Ellsworth's leg was amputated in 1946, members of her community took up a collection to pay for an artificial limb.¹⁰¹

Midwives were rarely at odds with their communities. Because of this, such material deserves special attention when it comes to light. Midwives thought to be witches and the few dirty midwives mentioned in previous chapters did not meet occupational expectation about cleanliness and charity. Another midwife who was considered unacceptable by many women in a community around the time of World War II was a "Jackie tar."¹⁰² The collector

⁹⁹ 75-56, Ms p.27.

¹⁰⁰ 72-62, Ms p.25.

¹⁰¹ 78-119, Ms p.38.

¹⁰² "Jackatar" or "Jackie tar" is the term for people of mixed French and Micmac Indian heritage. See "Jacktar," DNE, p.272. While considered a racial slur today, in the past it appears to have been used by many without malice. See Victor Butler, p.93 and Wareham's accompanying note, p.101.

states that women of the community did not wish to

be left in the mercy of a Jackie Tar whom they did not trust. [The midwife] came from a different community and her skin was dark. They did not want this type of woman borning their babies.¹⁰³

It is easy to assume that the woman's skin colour was the point of conflict here, but that cannot be stated with any degree of certainty.¹⁰⁴

It may also be that this midwife was mistrusted because she was a stranger, like the Cat Harbour midwives who were considered witches. But both this case and Faris' are unfortunately fragmentary. A vital piece of information lacking in both instances is whether the women in question were selected and trained as midwives in the communities where they were mistrusted. I would suspect they were not. Many midwives examined here also married into communities. They were selected and trained as midwives in their adopted homes, however, and are indistinguishable from midwives who practiced in their home communities. It may well be that a woman who came into a community as a practicing midwife would incur a certain amount of mistrust because clients lacked the security normally provided by apprenticeship with an

¹⁰³ 77-139, Ms p.14.

¹⁰⁴ Other women of mixed Micmac and French descent practiced successfully as midwives in Newfoundland. One informant had such a midwife in Stephenville around the same time as the events described here. 88-281, C11375.

older midwife or client selection.

If this was in fact the case, it seems reasonable to wonder if women who sought formal training outside their communities were also regarded with suspicion. On the whole, they were not. This was partly because many of these women were passive bearers of obstetric traditions prior to seeking such training, and well on the way to becoming midwives through traditional channels in their home communities. The high degree of respect for medical obstetrics also helped to legitimize such women as midwives.

The Jackie tar midwife was replaced when another woman in the community went to St. John's to seek training as a midwife. She later recalled that after returning,

I took over that other woman I was telling you about, that Jackie tar....She was cut out completely. Well she did get a few patients, but not too many. But I was new and probably on the first of it you know [women were] kind of scared to have me. After I went to one patient, then to another, well I got all the calls after that. Everyone called on me.¹⁰⁵

In fact, there was a three month gap between the time this midwife returned from St. John's and her first delivery. This was probably an unusually long delay; Mary Sweetapple was called to assist a woman the same day she returned from St. John's. Because it was extremely

¹⁰⁵ 77-103, MUNFLA transcript C2975, pp.4-5.

unusual for a novice to supplant an active midwife, this delay may reflect hesitance of women in this community to ignore an established midwife, regardless of their misgivings about her. Without access to formal training it is unlikely that one woman would be able to replace another in this way, though the mistrust that women felt for the outsider might give rise to the kinds of rumours Faris recorded.

Many studies of traditional healers, especially those with supernatural powers, stress the marginal social position and personalities of those who assume such roles, and view the healing role as a kind of adaptive therapy which allows a maladjusted person to serve a useful purpose.¹⁰⁶ While this is certainly valid for many types of traditional healers, it does not apply to Newfoundland midwives. These women were not marginal to their communities, they were central. Many came from leading families, and in adulthood many assumed leadership positions.

In other parts of North America where medicalization was slow to occur, the last midwives were decidedly "other," immigrant women, members of racial minorities, or rural poor. Because of this, those in authority did

¹⁰⁶ See, for example, David Hufford, "Folklore Studies and Health: An Approach to Applied Folklore," (diss., University of Pennsylvania, 1974), Chapter Three, "Stress and Belief System in Traditional Healing and Prophylaxis;" and Jones, Why Faith Healing?

not feel compelled to treat these women with respect.¹⁰⁷ In fact, ethnic and racial prejudice was used against midwives in some campaigns to eliminate their practice in the United States.¹⁰⁸ Under such circumstances, midwifery could be legislated out of existence, and midwives dealt with in a punitive manner. The fact that Newfoundland midwives held such a position of respect within their communities helps to explain why this approach was never taken in Newfoundland.

Conclusion

Negative feelings about Newfoundland midwives were rare. Women who became midwives were usually well liked and the prevailing attitude was one of gratitude rather than resentment. Midwives were respected but they were not feared. In his analysis of threatening figures in Newfoundland, John Widdowson found 105 instances in which doctors were used to frighten children, and seventeen references to nurses in this role. Yet a midwife appeared in this capacity only once. In this case, the midwife found two older children difficult to control during

¹⁰⁷ See Dougherty, "Southern Lay Midwives," p. 156 and Mongeau, for black midwives in the American South; Eugene Declercq and Richard Lacroix, "The Immigrant Midwives of Lawrence: The Conflict Between Law and Culture in Early Twentieth-Century Massachusetts," Bulletin of the History of Medicine, 59 (1985), 232-46, and Fiorenza for immigrant women in the industrial Northeast.

¹⁰⁸ See Wertz and Wertz, pp.215-217.

their mother's confinement. She removed her false teeth and told the children these teeth would bite them if they did not behave. Thereafter, the mother always invoked the midwife as a threatening figure.¹⁰⁹ This midwife assumed the role of threatening figure of her own volition. In general, however, midwives were not authority figures used to threaten children.

Midwives could have been regarded differently. The close association of these women with life and death gave them at least the appearance of power over matters of great importance. Midwifery also involved the necessary assumption of a leadership role in a culture which maintains a spirited dislike of authority, and at least some of these women were drawn from affluent families. These factors could easily have worked to make midwives feared or disliked.

But within the community the midwife occupied a position of respect as a person who served a necessary function without regard for personal gain. These women rarely inspired fear in part because midwifery was not associated with supernatural power. In fact, midwives may have unconsciously chosen to disassociate themselves from the supernatural and stress the importance of formal

¹⁰⁹ John D. A. Widdowson, If You Don't Be Good: Verbal Social Control in Newfoundland (St. John's: Institute of Social and Economic Research, 1977), pp.261-266.

religion as a means of assuring others of their benevolence. These factors helped to ensure that the midwife was liked and respected by those she assisted in childbirth.

Chapter VI

Conclusion

At the beginning of this century, most women in Newfoundland were attended in childbirth by empirically trained midwives. Outside of St. John's especially, most midwives worked for minimal payment, serving their neighbours as a form of charity. Although neighbourhood midwives were found in St. John's as well, there were also midwife-entrepreneurs in the city who supported themselves through this work. Both types of midwives were capable of acting as independent birth attendants.

Midwifery was not subject to any kind of controls until the 1920s, when the first efforts to train and licence women began in St. John's. At this time, two approaches to the midwifery question were apparent. Some St. John's doctors favoured the professional approach, the complete elimination of midwives as soon as possible. Other doctors and some nurses used the public health approach, providing education and seeking to secure licences for suitable women.

Even after efforts to train and control midwives were expanded to the outports during Commission of Government, the public health approach remained dominant in Newfoundland. Although the government did little to recognize midwives as individual practitioners and public

health training was inadequate, efforts to encourage women to take this training and become licenced continued until women could no longer be interested in becoming midwives. Also, because health care facilities and professional practitioners were in short supply for most of the century, empirically trained midwives were regarded as valuable allies of rural doctors rather than competitors. In contrast to the United States in the twentieth century, Newfoundland midwives were part of mainstream society. They were not poor, immigrants or members of racial minorities, and this helps to explain why the occupation was not eradicated by law, and why midwives were not treated harshly by public health officials.

Newfoundland had a complex system of traditional obstetric care providing beliefs and practices which allowed some influence over the uncertain processes of gestation and childbirth. Prenatal beliefs and practices show that gestation was regarded as a process which could not be relied upon to produce a healthy child without considerable human effort. Traditional prenatal care provided guidelines for the behaviour of the mother and those around her to ensure the well being of the child. Midwives dealt effectively with normal deliveries and some complications using traditional obstetric skills. But birth was regarded as a potentially dangerous event

and some complications, such as haemorrhage, eclampsia and many types of mal-presentation were simply beyond a midwife's control. The post-natal period of confinement was regarded as a time of danger to both mother and child, and precautions were taken against natural and supernatural threats. However, in the twentieth century it is possible to discern a lessening sense of danger in confinement.

Midwives were eager to incorporate aspects of medical obstetrics into their practice. They began to carry more equipment, made an effort to sterilize their equipment, reduced the number of women present at births and abandoned the kneeling posture in delivery as they learned about medical obstetrics. These changes often occurred in advance of direct contact with doctors and nurses.

Prior to this informal medicalization, obstetric information was part of the everyday knowledge of many women. Each community had a number of passive bearers of obstetric traditions from which the next generation of midwives was chosen. As the number of women present at births declined, obstetric information was shared by fewer women, the number of potential midwives dwindled and knowledge of obstetric traditions declined.

Midwives willingly ceded control over many complications of childbirth as access to health care

professionals became available. This led to a situation of dual use of traditional and medical obstetrics in rural Newfoundland in the middle decades of this century. Midwives dealt with normal deliveries in the homes of their clients, calling upon health care professionals when the demands of a birth exceeded their skills. This period of dual use eased the transition from traditional to medical obstetrics. Because childbirth was regarded as potentially dangerous and midwives were not financially dependant on this work, many urged their clients to seek medical attendance as it became available. Traditional patterns of selection gave way to public health training, and finally, as older women died or retired, no one stepped forward to replace them. As a new generation of women grew up accustomed to male doctors and aware of trends in other parts of North America, medicalization of childbirth came to be viewed as a natural progression, and was accomplished with little conflict. The shift from midwife-attended birth at home to doctor-attended birth in hospitals was not forced on women by the government or health care professionals. Nevertheless, many women regretted the loss of the personal attention and emotional support which was an important feature of traditional obstetric care.

This health care system also provided traditional ways of selecting and training midwives, and clear

occupational standards for those who assumed this role. The occupation of midwife was based on a system of selection and training which helped to ensure that the women who assumed this role were those deemed most suitable by the women they served. Midwives did not select themselves, partly because of attitudes toward leadership roles in Newfoundland. Self-selection may also have been avoided as a means of distributing responsibility for the outcome of childbirth among childbearing women in general.

In spite of these traditions of selection, the role of midwife was a leadership role which conferred respect and was compatible with high status. Because of this, and because midwives assumed responsibility for life and death matters, it was entirely possible that those who assumed this role would incur the hostility of others. Many features of the occupation worked to relieve such tensions. Apprenticeship supplied security in the form of approval of an older, trusted woman, and the benefit of her experience. Client selection inspired confidence of another kind as it allowed considerable control in the selection of midwives. Women prevailed upon to assume this role often displayed some reluctance because the monetary rewards were slender and the work involved personal sacrifice. In occupational narratives, midwives often stressed negative aspects of the role; the

hardships and self-sacrifice involved. Women selected as midwives were also likely to be those who conformed closely to shared concepts of womanly virtues: cleanliness; stoicism; personal courage; independence; sympathy for others and willingness to extend charity. Accordingly, midwives were most often regarded in a positive light by others in their communities. And, although they were respected, Newfoundland midwives were not usually feared or regarded as threatening figures.

The practice of midwifery ceased in part because of the structure of the occupation. Midwives were not charismatic leaders with a divine calling, but ordinary women performing a necessary service sometimes at personal sacrifice. Midwives also regarded childbirth as a potentially dangerous process over which they had little control, readily recognizing the limits of their own obstetric skills. There was therefore no built in resistance to change in traditional obstetrics.

During the twentieth century, resort to the supernatural in childbirth was extremely slight. Midwifery was a skill rather than a power and midwives were definitely not regarded as supernatural practitioners. The role of midwife was achieved rather than ascribed and there were no taboos to limit practitioners; childbearing women, childless women and post menopausal women were all found in this role.

Often leading members of their communities, midwives identified with the formal institutions of church, government and the medical system, and many rejected ideas they felt to be at odds with these institutions or old fashioned. In their work, they relied on formal religion and help from health care professionals rather than charms and powers. In placing distance between themselves and the supernatural, Newfoundland midwives were perhaps unconsciously attempting to assure others of their good intentions as well. Given this situation, it is not surprising to find that these women were liked and respected by those they served.

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APPENDIX

CHART I: OCCUPATIONAL DATA SUMMARY (ONE)

NAME	DATE OF BIRTH	RELIGION	AGE AT FIRST DELIVERY	YEARS ACTIVE	MARITAL STATUS
Annie Andre	1910	RC	39	1949-1976	M
Sophia Anstey	1857	uk	38	1885-1939	M
Myrtle Atkinson	1904	uk	na	1944-	M
Elizabeth Austin	1913	uk	31	1947-1976	W 1947
Fanny Avery	1889	uk	34	1923-1958	M
Olive Bishop	1896	ANG	about 45	1939-1948	S
Irene Bradley	1899	ANG	uk	1940-1974	M
Dora Butt	1902	uk	uk	1930-uk	M
Charlotte Carberry	1901	uk	29	1929-1979	uk
Lily Clarke	1899	SA	uk	1920s-uk	M
Eliza Jane Dawe	1900	ANG	about 46	1946-1966	uk
Elizabeth Day	1894	ANG	uk	1920s-1945	M
Alice Devereaux	1890	RC	about 27	1917-1957	M

Codes Used: uk- unknown; na- not applicable.

Abbreviations: ANG- Anglican; RC- Roman Catholic; SA- Salvation Army; UC- United Church. MARITAL STATUS: M- married; S- single (never married); W- widowed, and year if known. c- circa

CHART I: OCCUPATIONAL DATA SUMMARY CONTINUED

NAME	DATE OF BIRTH	RELIGION	AGE AT FIRST DELIVERY	YEARS ACTIVE	MARITAL STATUS
Lousia Dove	1906	uk	31	1937-1972	M
Mary Margaret Drover	1872	ANG	uk	1920s-1945	W 1918
Lenora Ellsworth	1877	SA	uk	1930-1950	M
Jane Ann Emberly	1884	ANG	28	1923-1950s	M
Susan Everleigh	1898	uk	uk	1919-1974	M
Bertha Feltham	1888	ANG	43	1931-c1950	W
Annie Fizzard	1886	ANG	about 30	1916-1976	M
Freida Guinchard	1911	uk	25	1936-1965	M
Margaret Hibbs	1898	RC	18	1929-1969	M
Agnes Horwood	1880	UC	uk	uk-c1935	M
Marita House	1900	ANG	about 35	1935-1957	W 1935
Lillian Hynes	1904	uk	24	1928-1970s	W
Annie Le Moine	1903	RC	about 30	1923-1973	M
Margaret Linehan	1888	RC	uk	1920s-1960s	uk

CHART I: OCCUPATIONAL DATA SUMMARY CONTINUED

NAME	DATE OF BIRTH	RELIGION	AGE AT FIRST DELIVERY	YEARS ACTIVE	MARITAL STATUS
Clara McGrath	1893	RC	35	1928-1958	M
Florence Noble	1895	ANG	26	1921-1936	uk
Rhoda Maude Piercey	1909	ANG	45	1954-1960	M
Alexandra Poole	1907	ANG	uk	1924-1960s	uk
Catherine Reegan	c1885	RC	about 40	1925-1955	M
Maria Ryland	1884	uk	40	1924-c1954	M
Mary Sweetapple	1913	ANG	about 40	1951-1960s	W 1946
Olga Smith	1898	ANG	28	1926-1943	M
Clara Tarrant	1905	RC	uk	1933-1953	M
Dorcas Taylor	1899	ANG	uk	1930s-c1950	
Florence Thompson	1908	ANG	na	1943-1960s	W 1942
Beatrice Torrerville	c1902	uk	about 40	1942-1966	S
Lillian Wandling	1897	UC	26	1923-c1945	W 1913

CHART I: OCCUPATIONAL DATA SUMMARY CONTINUED

NAME	DATE OF BIRTH	RELIGION	AGE AT FIRST DELIVERY	YEARS ACTIVE	MARITAL STATUS
Mary Elizabeth Wells	1893	ANG	42	1935- 1965	M
Beatrice Wheaton	1927	uk	uk	1954- 1960s	M

CHART II: OCCUPATIONAL DATA SUMMARY (TWO)

NAME	FEE	NUMBER OF BIRTHS ATTENDED	COMMUNITIES SERVED	TRAINING AND SELECTION
Annie Andre	\$10	+200	Too Good Arm- Herring Neck NDB	self-sel PHC
Sophia Anstey	no fee or .50	300	Summerford NDB	client sel
Myrtle Atkinson	\$3- \$10	1	Embree NDB	uk
Elizabeth Austin	K before training, then \$10	302	Middle Arm, Bay Vert	client sel PHC
Fanny Avery	\$3- \$4	127	Southport TB and area	sel and app by midwife
Olive Bishop	paid by Govt.	uk	Hermitage Bay	Partial nurses' training/client sel
Irene Bradley	\$5- \$15	151	Eastport BB and area	Dr. sel
Dora Butt	\$5	+300	Springdale	app wi midwife and RN
Charlotte Carberry	\$10	+40	Burgoyne's Cove TB	app wi aunt
Lily Clarke	\$10- \$20	uk	Stanhope NDB	app wi aunt
Eliza Jane Dawe	uk	61	Seal Cove CB	assisted Dr.

Codes Used: + more than; c circa; Dr. doctor; RN registered nurse; app wi apprenticed with; K- payment in kind; sel-selected; PHC- Public Health Course

Abbreviations: BB Bonavista Bay; CB Conception Bay; FB Fortune Bay; HB Hermitage Bay; NDB Notre Dame Bay; PB Placentia Bay TB Trinity Bay; SS Southern Shore.

CHART II: OCCUPATIONAL DATA SUMMARY (TWO) CONTINUED

NAME	FEE	NUMBER OF BIRTHS ATTENDED	COMMUNITIES SERVED	TRAINING AND SELECTION
Elizabeth Day	\$15 no Dr. \$10 with	37 no Dr. 7 with	Quidi Vidi/ St. John's	app wi aunt age 17/PHC ci936
Alice Devereaux	\$5	25	Trepassey SS	app wi mother 3 Week PHC(?)
Lousia Dove	\$5-\$10- \$20	uk	New World I. NDB	client sel
Mary Margaret Drover	\$3	uk	Upper Island Cove CB	app wi mother- in-law\ PH exam 1937
Lenora Ellsworth	no fee \$2 or K	994	Carmenville to Ladle Cove	uk
Jane Ann Emberly	\$5-\$10	323	Bay de Verde CB	client sel
Susan Everleigh	whatever offered	1,534	Hampden\much of White Bay	Hospital worker in kitchen
Bertha Feltham	\$3-\$10	about 300	Gambo and Shoal Bay	app wi midwife PHC late 1940s
Annie Fizzard	no fee, then \$2- \$7	about 359	Grand le Pierre FB	self-taught
Freida Guinchard	\$10- \$20	+1,500	Daniel's Hr. then Deer Lake	six month PHC in Daniel's Hr.
Margaret Hibbs	paid by Co.	about 300	Lance Cove area Bell Island	app wi mother
Agnes Horwood	\$6-\$8	uk	South Side St. John's	app wi mother
Marita House	\$10- \$15	about 100	Catalina TB	trained wi Dr.s

CHART II: OCCUPATIONAL DATA SUMMARY (TWO) CONTINUED

NAME	FEE	NUMBER OF BIRTHS ATTENDED	COMMUNITIES SERVED	TRAINING AND SELECTION
Lillian Hynes	no fee, then \$2- \$10	about 350	Ship Cove, Port-au-Port	Client sel
Annie Le Moine	\$2 or K	600	Port au Port Peninsula	self-taught
Margaret Linehan	\$3 to \$10	uk	Colinet Island, Admiral's Beach	app with aunt, PHC
Clara McGrath	no fee to \$10	+240	Patrick's Cove PB	self-sel Dr. trained and PHC
Florence Noble	\$10	about 100	Curling and area Bay of Islands	3 months RN
Rhoda Maude Piercey	\$8 to \$10	about 25	Winterton, TB	4 months RNA client sel
Alexandra Poole	uk	56	Fox Hr. Labrador and area	app wi midwife
Catherine Reegan	\$4 per	uk	Petty Hr, SS	Midwives's Club (?) 1923
Maria Ryland	\$1	400 to 500	L'anse au Loup Labrador and area	app wi aunt
Mary Sweetapple	\$2- \$5	+200	Hodges' Cove TB, then Glovertown	PHC 1953
Olga Smith	no fee	+1000	Gooseberry Cove, TB and area	Chicago School of Nursing correspondence, PHC
Clara Tarrant	\$5	463	St. Lawrence PB	app wi mother 6 month course with nun
Dorcas Taylor	\$10 to	1056	Topsail to Duff's, CB	app wi related midwives and doctor

CHART II: OCCUPATIONAL DATA SUMMARY (TWO) CONTINUED

NAME	FEE	NUMBER OF BIRTHS ATTENDED	COMMUNITIES SERVED	TRAINING AND SELECTION
Florence Thompson	\$10	na	Grand Falls, Windsor	PHC 1943
Beatrice Torraville	\$5	uk	Gander Bay area	PHC 1942
Lillian Wandling	\$7 to \$10	700	St. John's and area	Midwives' Club 1923
Mary Elizabeth Wells	\$2 to \$5 to \$10	about 200	Muddy Hole HB	app wi midwives
Beatrice Wheaton	\$9 (one per day)	uk	Frederickton NDB	app wi midwife

