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REVIEW

# A feminist history of Australian midwifery from colonisation until the 1980s

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**Summary** This paper uses a feminist interpretation and secondary sources to describe the history of Australian midwifery from colonisation until the 1980s. There have been too few midwife scholars who have had access to or used primary data collections to describe the role and place of midwives in the colonising community. I draw on a range of biography, medical literature and work by sociologists and economic historians to produce a limited picture of the history of professional midwifery. This helps to explain the position of midwives today and the problematic relationship we often have with medicine.


**Contents**



## Background

This is not an impartial history if such a thing exists! This is my interpretation of secondary sources originally studied in the 1980s when I was undertaking master's thesis studying midwifery. I attempted to bring this up to date for the recent oration I gave at our ACM conference in Canberra. Here I re-work a chapter originally presented in a thesis titled *One Right Way*; *the Midwife's Dilemma*[1]; that looks at midwifery from colonisation to the 1980s. This history, constructed from limited historical literature available at that time, contextualised contemporary Australian midwifery for me and made sense of my research into the role, education and regulation of midwives. It has not been published previously though an extract was included in a College journal without attribution in the early 1990s. Other valuable histories that work with primary sources have now been written (see for example

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Summers work).[2,24] Fahy's recent publication[3] complements what I add to a far too thin description of our rich traditions and history.

## Introduction: a feminist interpretation of our midwifery history

The absence of a recorded 'women's history' and the influence of this on current understanding is now recognised.[4,5] When examining history, one must acknowledge two factors which confound attempts at objective analysis. Firstly, the evidence supplied has been interpreted once already by the person recording it. Secondly, we re-interpret the evidence and fit it into our own knowledge, experience and time. This leads to debate between feminist, traditional or professionally oriented historians. Further 'who' records things and 'why' influences 'what' (if any) evidence is collected and preserved and 'what was not recorded' and 'why not' is better identified in some histories than in others. For example Gillison[17] writes of the onerous personal family responsibilities of Victorian country midwives in the late 1880s. She makes it clear that they had neither time nor motivation to record details of their practice. Another conflict occurs when interpretation of the evidence is attempted today. Our professional bias often leads us to assume that things have improved because of increased professionalism. This is exemplified by writing that assumes increased standing of 'his' or 'her' group of professionals is inevitably for the best (see, for examples of this[6,7]).

The feminist historian similarly unearths new facts or points to their non-existence as convincing support for their case (see, for example[8]). Shorter,[9] in his critique of a feminist interpretation of women's history, makes the same mistake of which he accuses others—that is, he is equally limited by his perceptions of the importance of advances in medicine. He claims that... 'after 1930 (or thereabouts) women became released from the terrible historic burden of their own ill health, making it possible for them to think of their femininity as a basically positive, life-giving force' [9, preface].

These brief statements within the first paragraphs of the book ignore two fundamental facts—firstly that women had achieved success in literature, science, art and many other fields previously.[4,5] This was despite social sanctions (not physical constraints attached to being female) that made this difficult, or relegated their successes into anonymity. Secondly, that improved sanitation, hygiene, nutrition and housing were responsible for improvements in health, not medical advances.[10] Feminist historians similarly must lay themselves open to similar charges of bias with emotion influencing their arguments at times.[8] The domination of women over childbirth, a lucrative area of human activity did not persist. This would have been contrary to a generalised movement towards economic, educational and social stratification of males and females previously unknown.[11] It is the manner the domination of midwives was removed that is interesting and important for us to consider today.

Midwives also need to counter their socialisation into a world of health care dominated by male, professional assumptions. For example, I found one interpretation of Australian maternity care in an influential medical journal by Shaw. There is no doubt this type of authoritative if nonsensical writing influenced medicine and indirectly Australian midwives and nurses.

> We know little of mediaeval obstetrics, but we may gauge the extent of its degradation by what happened in the sixteenth century. In normal labour, it is stated, a woman had an even chance, if she did not succumb to puerperal fever or eclampsia. In difficult labour she was usually butchered to death if attended by a 'Sairey Gamp' of the time, or one of the vagabond surgeons'... Obstetrics, bound by the customs of many centuries, was enslaved in women's hands.[7]

To state that a woman had only an even change of surviving labour is incorrect. Demographic evidence demonstrates that families of the Middle Ages were of balanced structure with both the husband and wife living.[12] It is impossible to reconcile this fact with Shaw's[7] and Shorter's[9] unsubstantiated generalisations.

As male doctors entered the field of birth and records were kept, a 'sex-differential' did become obvious between male medical and female midwife accoucheurs. Contrary to Shorter's and Shaw's theses[7,9] fee-paying affluent clients of male practitioners had worse out comes than poorer women in less favourable economic circumstances delivered by midwives. This situation is similar today.[13] Researchers demonstrated in America (for example, Devitt,[14] and Kobrin,[15] and Great Britain (see for example Donnison[16]) that, in general, midwives performed better than doctors. While comparative historical research is limited in Australia, evidence is available showing female midwifery in normal circumstances was safe and of high standard.[8,17,19,20] Evidence shows that midwives achieved superior results with their poorer clients than doctors with their more affluent ones.[10]

As seen in Shaw's writing, fact becomes incidental to mythology and denied or ignored when it cannot be used to create or substantiate a dominant position. In this paper, I set out to correct some of these perceptions drawing on the few published sources available to me when I examined this some decades ago. I have identified milestones and political, religious and economic pressures as I believe these contributed to the decline of midwifery as a viable and respected profession for women. I conclude that the rise of nursing as a profession and the increasing respect and authority accorded medicine contributed to the decline of the midwife as a respected independent practitioner—the norm until after the Depression last century. My goal is to acquaint Australian midwives with the proud origins of their profession and to propose explanations for the demise that has required major regeneration in recent decades.

## Australian midwifery history

Thornton describes a number of stages of Australian midwifery. The first is the Convict Era or the time of the 'Accidental Midwife'. By 1824 there were isolated small settlements around our coastline, served by these practitioners.[21] The second stage is the Pioneer Era or the 'Aunt Rubina' period. 'Aunt Rubinas' were experienced married relatives who arrived before the baby was born and stayed

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some weeks. The fact of giving birth oneself was considered sufficient qualification to assist another during birth.

Mrs. McTavish, who advertised her services in the Hobart Town Gazette of 1824, was certainly one of the first trained midwives to practice in this country.[22] Her training was undertaken in Scotland, where training was available earlier and more widely than in England.[16] She was obviously a respected and successful member of Hobart's embryonic community as she received an official grant of land and a street was named after her.[22]

The majority of the women of the colony could not afford the services of either a midwife or a physician, even if one were available. Their plight was confounded by the fact they were not legally or morally 'respectable' and often correctly described as whores because of the limited options available to them for survival[23,24]). Dixson[23] describes how numbers of destitute free women re-entered service as wet-nurses, boarding out their own babies and paying for their keep out of their wages. The chances of these children surviving were poor, deprived of their own mother's milk and subjected to the care found in the notorious Baby Farms of the time.[18] Australia's first lying-in hospitals were the Female Factories or Asylums used to house and employ convicts.[22]

The second half of the 1800s saw a 'growth spurt' in the colonisation of Australia, initiated by the gold rushes and intensified by political strife, poverty and religious intolerance in Europe. The dispossessed Irish tenant farmer was quite typical of our new settlers. The cohesiveness and numbers of Irish settlers made an important contribution to our folkways, sense of identity, and our attitudes to women.[23] My own great grandmother, trained as a midwife in Manchester in the United Kingdom, arrived in Ballarat at this time and worked as a midwife until after the First World War.

The first hospitals in Australia were important for their care of the destitute convict or single government employee, as the preferred place to be ill or confined was home. Free settlers were only admitted if a clergyman certified their inability to pay for private medical care.[25] From 1850 onwards, however, hospitals became important as training centres for doctors, nurses and 'ladies monthly nurses', the fore-runner of the Australian midwife.

In the 1800s a patient could consult a variety of practitioners—homeopath, optometrist, chemist, midwife or doctor. Pensabene[26] demonstrates that all had similar status with the midwife and optometrist, in particular, offering a better service than the doctor. The doctor's inadequate training meant that they possessed little theoretical or practical advantage over midwives.[26] The principles of antiseptics and wound suppuration were not described by Lister until 1862 and not generally accepted for many years. Midwifery was poorly taught in the Victorian medical curriculum[10] and considered the 'Cinderella of Medicine' for another 100 years.[7] Midwives attended the majority of births in Australia at this time.[26]

Gillison[17] writes vividly about rural colonial medicine and midwifery during the 1880s. The midwife was an institution in the colony. They were valuable friends, rich in common sense, experience, kindness and with skilful hands. They had families of their own which allowed them to share the problems, concerns and joys of the families they serviced. Their results described by her medically trained grandfather and settlers of the district were excellent, and the doctor was well satisfied to leave all normal midwifery to their care.

Williamson[19] writes of midwifery some years later through the turn of the century, describing women of high integrity and dedication, also much loved by their community. Increasingly they became formally trained and operated at a professional rather than social level. They often ran small 'nursing homes', where women stayed for confinement and for some time thereafter.[20]

Nightingale-type nurses first arrived in Melbourne at the Alfred Hospital in 1871, and by 1881 were training Victorian nurses in this tradition.[25] The Melbourne Hospital followed suit in 1889.[25] In keeping with Miss Nightingale's philosophy,[31] nurse trainees had to fit certain criteria: '...be between twenty and thirty, to look ...respectable... and to have the necessary references from clergy, doctors, etc., they also had to be healthy and strong'.[27] The word 'Sister' used for Nightingale graduates did not indicate religious affiliation. As Kingston writes, however,

> 'The only difference between those women who became nurses through a religious order and those who trained in a public hospital was that the latter were paid a token salary and were free to marry...'.[27]

The first training of midwives in Australia occurred in 1862 at the Women's Hospital in Melbourne.[21] The Diploma of Midwifery established in 1893 could only be taken after general nurse training.[10] By 1899 only midwives who were also general trained nurses would be employed in the hospital's midwifery department.

> 'Both doctors and nurses agreed on this it is important to note: nurses because it extended their occupational territory to include the tasks associated with childbirth, doctors because the incorporation of midwifery into nursing ensured its subordination'.[10]

As medicine entered its 'Golden Age' in 1870[26] and established theories of disease, it was able to offer more effective treatments. The effects of improvements in hygiene and public health including such factors as drainage and sewerage schemes created a synergism which was seen by society as a victory by medicine rather than engineering. Surgery now with anaesthetics and antiseptics was more likely to be successful, and drugs (vaccines and antitoxins) were being introduced.[26] The doctor's status was beginning to rise, paralleling a decline in mortality. This was largely coincidental as mortality fell just as dramatically in those where treatment was not available.[18] The doctor's status and skill were no longer under attack in the popular press as it had been some 50 years earlier and he became an 'heroic' and 'stately figure'.[26]

Willis adds another important reason for the rise in status of the medical practitioner and their dominance over other health workers which began about this time. He sees both class and gender as mechanisms which supported the differentiation between medical doctors and their competitors. State patronage of medicine completed the achievement of medical dominance over other practitioners and allowed this to be sustained.[10]

Medical practitioners prior to 1890 were almost certainly British, coming to Australia for various reasons, as government officials, prospectors, land seekers or seeking an improved

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climate for their own health problems.[28] By 1890, Australia's own graduates entered the medical market with rivalry occurring between the two groups. By 1911, the numbers of local graduates outnumbered their imported colleagues, and by 1933 eighty percent (80%) were Australian born.[26]

The general practitioner's status in the Australian community rose higher and more quickly than his contemporary in England or America. Gandevia[28] sees this originating in the high standard of care they provided, however, this argument seems more satisfactorily addressed by Willis, who uses the notion of class and gender to explain the developing 'authority' accorded doctors.[10] The overall standard of education in the community was poor so the general practitioner became a wealthy and educated leader. Once Australia started to train her own doctors, medicine became a suitable profession for the children of wealthy pastoralists and merchants and an aspiration and path to advancement for the children of accountants, teachers and chemists.[26]

Nurses struggling to obtain rights to suitable education had to combat resistance from medical practitioners who feared further inroads into their declining incomes.[25] The Nightingale philosophy of subservience ensured that nurses would not compete but rather improve the service a doctor could offer. Midwives also became seen as a threat, but in a different fashion from nurses struggling for recognition. Local midwives had status and respect; some also had an assured income from their practice. Willis claims that medicine dealt with the threat posed by midwives by promoting their links with nursing until 'incorporation' occurred. The midwife became the obstetrical nurse and, as such, subject to 'medical dominance' and nursing controls.[10]

As the medical practitioner's status in the community improved, he won legislative controls over the Medical Act in the early 1900s that permitted greater autonomy of his own practice.[26] Medicine spearheaded the attack against alternative practitioners of all types. Midwives were neither powerful nor organised as a group to resist. Married women, constrained by the demands of their own families, lack of funds and education, did not really constitute any opposition to medicine's take over. There was no Australian Rosalind Paget or Zepherina Veitch (Midwifery activists in the United Kingdom who fought to retain and strengthen midwifery).[6,16] We lacked strong midwifery leaders to fight for the right of independent midwifery status and practice. With this, the assumption developed that, despite a 100 years of contrary and very different experiences, midwives should be nurses. It is interesting to speculate what would have happened to Australian midwifery if European midwives, with a strong tradition totally separated from nursing, had set up the first midwifery training programmes.

Nursing's battle for survival in the early 1900s was hard fought. Establishment of training schools for nurses was opposed by some, on the grounds that better trained nurses would trespass into the province of medical practitioners.[29] Making the nurse subservient to the physician was one way of countering medical opposition to a well-trained competent nurse and fitted into the current Victorian view of the superiority of men in personal and professional relationships. Miss Nightingale's founding philosophy became the established tradition of an 'ever-willing obedient nurse'.[29] Nursing developed a characteristic unquestioning acceptance of authority that spread to include hospital administrators, senior nurses and midwives.[30]

Despite Australia's early midwifery programmes graduating 'Ladies Monthly Nurses' not midwives,[21] the lot of the women giving birth was greatly improved with their assistance.[21] By 1904, a 12-month course in midwifery was mandatory for trainees without previous nursing experience; trained nurses could complete their training in 6 months.[19] In 1913, 37% of deliveries in Melbourne were attended solely by a midwife.[26] Thornton[21] describes that midwifery graduates of the early 1900s greatest interests lay in district work with many going into private practice or working with doctors. Some scholarships were made available to cover the costs of training to ensure graduates were available to work in outback areas.[21]

In 1907, there were four midwifery training hospitals authorised by the New South Wales Council of the Australian Trained Nurses' Association.[19] Trained midwives were described as 'Hospital Midwife'. Thornton[21] describes how it took many years before such persons outnumbered their 'experienced' colleagues. Prestige was associated with the title 'Hospital Midwife', less accorded by their 'lay' colleagues, as had happened in England.[16]

Although there was a marked increase in the number of doctor-managed births between 1900 and 1940, there was no significant reduction in maternal mortality. According to some authorities, the medical profession still lacked adequate education in obstetrics, and were precipitate in their use of risky surgical procedures.[20] Confirmation of Lewis' conclusions is found in Reports from the Director General of Public Health between 1920 and 1930.[19] Despite this midwives continued to be blamed for excessive maternal mortality until it was no longer possible to do so because doctors were confining the majority of women.[19] 'In fact, however, the more affluent middle class woman attended by doctors ran a greater risk of infection than did the poorer woman attended by the midwife'.[10]

After World War I, a trend towards hospital delivery became noticeable—more beds were provided to meet dangerous levels of overcrowding.[21] Interestingly, neither Thornton nor others attempt to explain the reasons for such a shift. A quote from the Annual Report of the Women's Hospital in 1923 cited by Thornton, however, suggests an explanation:

> 'Owing to the lack of employment this year many of the homes visited are lacking even the barest necessities and in many cases it has been found necessary to help the mothers over their critical time by assisting them with food and clothing'.[21]

Birth in hospital ensured that food and shelter were provided, and probably a set of clothes for the infant. The destitute still relied on the Lying-in Hospitals, the descendants of the early Asylums that served the convicts and poor new settlers. The wealthy employed a private midwife and a physician and remained at home. The middle class increasingly disappeared as the depression took hold. The numbers of poor increased rapidly and, it is reasonable to assume, the midwives' clientele diminished. The affluent continued to have their babies at home up till World War II and employed midwives. My mother-in-law, the daughter of a prominent Melbourne doctor, employed her own midwife who lived with

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her for 2 weeks around the birth of both her children in the late 1930s and early 1940s.

During the depression, numbers of small cottage hospitals run by nurses and midwives were forced to close[21] because of the inability of patients to pay their fees. Those that survived finally succumbed to staff shortages that occurred during the war. The midwives who remained behind (as most were nurses also, many were accepted for war service) became accustomed to a regular wage. They also became increasingly reliant on the facilities provided by large hospitals and lost some of their skills of district midwifery.[21] Cottage hospitals lacked facilities considered essential as medicine entered the age of technology and the hospital's supremacy as the place of even normal birth was assumed.

Thornton, writing in 1972, saw the end of an era clearly claiming all babies were born in hospital.[21] Midwives as independent practitioners were almost non-existent though there was a resurgence of 'lay' midwives helping women who wanted home birth and who could not find professionals willing to assist. In 1982, 10 years later, a report claimed 5000 babies were born at home over the last 5 or 6 years, and most were attended by midwives. This appeared to presage a movement that ultimately led to the government sanctioned home birth that exists today, albeit reluctantly (information given at the 1981 Home Birth Conference, Canberra).

As the independent status of the midwife disappeared, and she was subsumed into nursing, her role became more obstetric nurse than midwife. This was conscious and orchestrated by medicine and nursing.[10] It ensured that home birth also disappeared as a viable option to hospital birth. Birth for the majority of Australians now takes place in an institution; however, this has only been common since World War II.[21] These institutions rely on highly specialised staff, complex technical equipment and expensive differentiation of labour which substantiates and perpetuates 'medical dominance'.[10] As a consequence, birth has become costly for the individual and society. This also is culturally and historically unique in Australia and one wonders if today the wheel has turned with four States and Territories offering government funded home birth. A major shift is underway; one could argue this is a return to where we were before!

In summary, Australian midwives performed well and were respected members of their communities, despite 'spin doctoring' to the contrary.[7,17,19] Further, their results in urban or rural practice were at least as satisfactory, if not better than their medical colleagues.[20] The increasing employment of doctors in birth last century improved neither the maternal nor infant mortality rates.[10,19] Australian policy, regulation and practice of midwifery reflect the respect and authority accorded medicine[1] and our health systems remain dominated by medicine. Nurses have traditionally evolved out of and supported this system.

## Conclusion

Important assumptions influence today's assessment of past situations. One is the assumption, explicit in most medical history and rarely questioned, that medicine is progressing along a continuum from darkness into light, with ever increasing specialisation. I have argued that the analysis is neither straightforward nor correct. However, much of what we think today is coloured by this view. Secondly, midwives themselves rarely chronicled their own activities and we have to rely on others' interpretation of their performance. Frequently, these writings contain scarcely veiled, or blatant, attempts at discrediting midwives for the writers' own ends.[7,16] As so well stated by Oakley '...the lessons history may generate, depend on who it is who wants to learn what, about which particular issue'.[32]

There has been a marked change in the responsibility for the conduct of normal labour and birth in Australia since colonisation. There is substantiated evidence suggesting this parallels changes in society and the place of medicine in Australian society. Changes in the health and well being of women and families improved the safety of birth, rather more than the contribution of professionals, in particular medicine. Economics also gives us clues to reasons for the decline in midwife led birth as medicine created a territory and income for itself in this field.

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