"WHAT ARE THE ORIGINS OF THE REGULATION, TRAINING AND PRACTICE OF MIDWIFERY IN AUSTRALIA?"

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HISTORICAL ANALYSIS

When examining history, one must acknowledge two vital factors which confound attempts at objective analysis. Firstly, the evidence supplied has been perceived and interpreted once already by the person recording it. Secondly, as "... Levi-Strauss insists that when history takes the form of a recollection of past events, it is part of the thinker's present not of (the) past" (Leach, p.16, 1973).

We re-interpret the evidence and fit it into our own knowledge, experience and time. Thus the evident conflict which occurs between feminist and more traditionally or professionally oriented historians.

This conflict occurs at two levels. The limitations of recorded history have been identified by feminist historians recently but is less well recognised by "the health professional historian. The first enquiry the reader of history needs to make is "how", "when", "why" and "by whom" the data were collected and preserved. Further "what was not recorded" and "why not" are better emphasised in some histories than in others. (See for example, Versluysen, 1981, for general amplification of the topic in relation to the development of obstetrics). Gillison (not a feminist historian but rather a biographer), for example, writes of the onerous personal family responsibilities of Victorian country midwives of late last century. She makes it clear that they had neither time nor motivation to record details of their midwifery activities even if it ever entered their heads that it might be valuable to do so. Gillison (1974), Forster (1967), Pensabene (1980), Willis (1983) and others make it clear that economic concerns and the motivation of doctors to exclude midwives worked to ensure medical practitioners of the period would not report favourably, if at all, on these women's activities. The second level of enquiry by the reader occurs when interpretation of the evidence that is available is attempted today. The historian who writes from a professional bias sees that "things have improved because of increased professionalisation". The greater involvement of "his" or "her" group of professionals is inevitably for the best. (See, for example Cowell and Wainwright (1981) on Midwifery and Shaw (1947) on Obstetrics). The feminist historian unearths new facts or points to their non-existence as convincing support for their case. (See, for example, Ehrenreigh and English (1979)). Shorter (1983), in his attempt to answer a feminist interpretation of women's history, makes the same mistake of which he accuses others — that is, he is equally bound and limited by his own perceptions that the advances in medicine paved the way for the success of modern feminism and women's ability to co-operate and compete as equals with men.

"The argument of this book will be that, before 1900 or so, femininity was basically a negative concept for most women. It was something which they thought made them inferior to men, a burden with which God had saddled them since Eve was expelled from the garden, and which they carried in quiet resignation. Then, all the changes occurred that we shall be reading about, and 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" (Shorter, preface, 1983).

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 over the centuries (Spender, 1983). This was despite their so-called perception of inferiority to men and social sanctions (not physical restraints) that made this difficult or succeeded in relegating their achievements into anonymity.

Secondly, improved sanitation, hygiene, nutrition and housing were responsible for improvements in health, not medical scientific advances (see for example, Willis (1983). Medical advances made it possible to help the few, the exceptions suffering disease or abnormality, they did not appreciably help the majority at all. These two statements, made in the preface of the book, influence the course of the author's whole enquiry. The arguments, therefore, while well researched and documented, substantiate his thesis.

Of course feminist historians must lay themselves open to similar charges of bias and feminist histories must be examined as stringently for its results.

There is no doubt that emotion influences the quality of feminist argument at times (see, for example, Ehrenreich and English, 1973). But Shorter also has made little attempt to counter the socialisation of professional assumptions by, for example, proposing an antithesis. He starts by accept-

ing the assumptions of the thesis of "common knowledge" clearly promoted as used by medicine for its own ends (Willis, 1983). Mary O'Brien, in "The Politics of Reproduction" (1983), believes that it is now possible to understand and clarify the historical forces that worked against women's interests.

> We cannot analyse reproduction from the standpoint of any existing theory. The theories themselves are products of male-stream thought and are among the objects to be explained, but embedded somewhere in the theory and practice of male supremacy are the seeds of its growth and inevitable decay". (O'Brien, p23, 1983).

Women's sexuality in the middle ages was overt and powerful. Society was open and bawdy by today's standards (Skolnick, 1973). Sexuality was seen to possess a potential for evil (Ehrenreich and English, 1973).

Midwives, because of their intimate involvement with reproduction, were linked to power and the potential for evil by the superstition which originated and perpetuated such beliefs (Ehrenreich and English, 1973). The Church licensed midwives and attempted to control their behaviour to counteract these malevolent forces (Donnison, 1977). Midwives were frequent victims of witch hunts initiated or at least supported by the Church (Ehrenreich and English, 1973). Their "magic" (a combination of experience, herbs and intuition), when linked to female sexuality, combined to make them a powerful and feared force (Donnison, 1977). Male medicine conversely was gaining prestige associated with "Science" and "Rational Thought" which contrasted favourably with female "Superstition" (Donnison, 1977).

One interpretation of childbirth history is found in a forty year old Medical Journal — a time, it should be noted, when medicine's final spurt to dominate the economic control of normal delivery was completed in Australia.

> "Obstetrics, during this period sank to its lowest level. It was left almost entirely in the hands of women, most of them untrained, and those who had received any instruction had done so at the hands of other badly trained women. There was no increase of knowledge, and many barbarous customs were handed down from generation to generation.
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> 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. Few, if any, women took part in this wonderful revival of learning (the Renaissance) and as men were excluded from the bedchamber, no advance was made... In Great Britain... William Smellie fought and routed the midwives and laid the foundations for a school of British Obstetrics" (Shaw, 1947, p 284-5).

This relatively recent article emphasises the midwife's links with "evil" and "superstition" whereas the obstetrician (who developed from the vagabond surgeon or apothecary, rather than a university educated physician) likewise has an emotive but idealised image (Donnison, 1977).

To state that women had only an even chance of surviving labour is nonsense. Considerable demographic evidence is available demonstrating that families of the middle ages were of balanced structure with both the husband and the wife living with, on average, two to three children (Laslett, 1979). Laslett's research shows at least half the previously married adults who lived alone were women.

It is impossible to reconcile this fact with Shaw's unsubstantiated generalisation. If it were true, an extraordinary sexually unbalanced population would result.

Shaw's quotation, only forty-five years old, is more important for its perpetuation of an unrealistic image of myth of both male obstetrician and female midwife. The Sairey Gamp stereotype created by Dickens has been

> "... widely used by opponents of independent midwifery to describe midwives in general (at times), but particularly untrained ones. Its usage must be seen as an attempt to discredit midwives as a whole and as an element in the strategy of male medical takeover" (Willis, p 101, 1983).

Smellie, Shaw's "father of modern obstetrics" and exponent of safe forceps delivery, claimed it was only necessary to use these in ten out of ten thousand deliveries (Versluysen, 1981). This figure is even more remarkable when it is considered that he practised in the time before safe caesarean delivery. Furthermore, Smellie, himself a lowly apothecary, performed thousands of normal deliveries in working class women. He paid these women a small fee for the purpose of allowing his male students to be present and learn; tuition fees were his major source of income (Verluysen, 1981).

So we must take with us into any examination or interpretation of history, a knowledge of our own bias and an awareness that the data we have to examine have already experienced interpretation.