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“SHE DID WHAT SHE COULD”…

A HISTORY OF THE REGULATION OF MIDWIFERY PRACTICE IN QUEENSLAND 1859-1912

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The ascendancy of the medical profession in childbirth
The emergence of obstetrics as a medical discipline
The language of obstetrics

ABSTRACT

The role of midwife has been an integral part of the culture of childbirth in Queensland throughout its history, but it is a role that has been modified and reshaped over time. This thesis explores the factors that underpinned a crucial aspect of that modification and reshaping. Specifically, the thesis examines the factors that contributed to the statutory regulation of midwives that began in 1912 and argues that it was that event that etched the development of midwifery practice for the remainder of the twentieth century.

In 1859, when Queensland seceded from New South Wales, childbirth was very much a private event that took place predominantly in the home attended by a woman who acted as midwife. In the fifty-three years that followed, childbirth became a medical event that was the subject of scrutiny by the medical profession and the state. The thesis argues that, the year 1912 marks the point at which the practice of midwifery by midwives in Queensland began a transition from lay practice in the home to qualified status in the hospital.

In 1912, through the combined efforts of the medical profession, senior nurses and the state, midwives in Queensland were brought under the jurisdiction of the Nurses' Registration Board as "midwifery nurses". The Nurses' Registration Board was established as part of the Health Act Amendment Act of 1911. The inclusion of midwives within a regulatory authority for nurses represented the beginning of the end of midwifery

practice as a discrete occupational role and marked its redefinition as a nursing specialty. It was a redefinition that suited the three major stakeholders.

The medical profession perceived lay midwives to be a disjointed and uncoordinated body of women whose practice contributed to needless loss of life in childbirth. Further, lay midwives inhibited the generalist medical practitioners' access to family practice. Trained nurses looked upon midwifery as an extension of nursing and one which offered them an area in which they might specialise in order to enhance their occupational status and career prospects. The state was keen to improve birth rates and to reduce infant mortality. It was prepared to accept that the regulation of midwives under the auspices of nursing was a reasonable and proper strategy and one that might assist it to meet its objectives. It was these separate, but complementary, agendas that prompted the medical profession and the state to debate the culture of childbirth, to examine the role of midwives within it, and to support the amalgamation of nursing and midwifery practice.

This thesis argues that the medical profession was the most active and persistent protagonist in the moves to limit the scope of midwives and to claim midwifery practice as a medical specialty. Through a campaign to defame midwives and to reduce their credibility as birth attendants, the medical profession enlisted the help of senior nurses and the state in order to redefine midwifery practice as a nursing role and to cultivate the notion of the midwife as a subordinate to the medical practitioner.

While this thesis contests the intervention of the medical profession in the reproductive lives of women and the occupational territory of midwives, it concedes that there was a need to initiate change. Drawing on evidence submitted at Inquests into deaths associated with childbirth, the thesis illuminates a childbirth culture that was characterised by anguish and suffering and it depicts the lay midwife as a further peril to an already hazardous event that helps to explain medical intervention in childbirth and, in part, to excuse it.

The strategies developed by the medical profession and the state to bring about the occupational transition of midwives from lay to qualified were based upon a conceptual unity between the work of midwives and nurses. That conceptualisation was reinforced by a practical training schedule that deployed midwives within the institution of the lying-in hospital in order to receive the formal instruction that underpinned their entitlement to inclusion on the Register of Midwifery Nurses held by the Nurses' Registration Board.

The structure that was put in place in Queensland in 1912 to control and monitor the practice of midwives was consistent with the policies of other Australian states at that time. It was an arrangement that gained acceptance and strength over time so that by the end of the twentieth century, throughout Australia, the practice of midwifery by midwives was, generally, consequent upon prior qualification as a Registered Nurse. In Queensland, in the opening years of the twenty-first century, the role of midwife remains tied to that of the nurse but the

balance of power has shifted from the medical profession to the nursing profession. At this time, with the exception of a small number of midwives who have acquired their qualification in midwifery from an overseas country that recognises midwifery practice as a discipline independent of nursing, the vast majority of midwives practising in Queensland do so on the basis of their registration as a nurse.

Methodology

This thesis explores the factors that influenced the decision to regulate midwifery practice in Queensland in 1912 and the means by which that regulation was achieved. The historical approach underpins this research. The historical approach is an inductive process that is an appropriate method to employ for several reasons. First, it assists in identifying the origins of midwifery as a social role performed by women. Second, it presents a systematic way of analysing the evidence concerning the development of the midwifery role and the status of the midwife in society.

Third, it highlights the political, social and economic influences which have impacted on midwifery in the past and which have had a bearing on subsequent midwifery practice in Queensland. Fourth, the historical approach exposes important chronological elements pertaining to the research question. Finally, it assists the exposure of themes in the sources that demonstrate the behaviour of key individuals and governing authorities and their connection to the transition of midwifery from lay to qualified. Consequently, through analysing the

sources and collating the emerging evidence, a cogent account of interpretations of midwifery history in Queensland may be constructed.

Data collection and analysis

The data collection began with secondary source material in the formative stages of the research and this provided direction for the primary sources that were later accessed. The primary source material that is employed includes testimonies submitted at Inquests into maternal and neonatal deaths; parliamentary records; legislation, government gazettes, and medical journals. The data has been analysed through an inductive process and its presentation has combined exploration and narration to produce an accurate and plausible account. The story that unfolds is complex and confusing. Its primary focus lies in ascertaining why and how midwifery practice was regulated in Queensland. The thesis therefore explores the factors that influenced the decision to regulate midwifery practice in Queensland in 1912 and the means by which that regulation was achieved.

Limitations of the study

The limitations of the study relate to the documentary evidence and to the cultural group that form the basis of the study. It is acknowledged that historical accounts rely upon the integrity of the historian to select and interpret the data in a fair and plausible manner. In the case of this thesis, one of its limitations is that midwives did not speak for themselves but were, instead, spoken for by medical practitioners and parliamentarians. As a consequence, the coronial and magisterial

testimonies that are employed constitute a limitation in that while they reveal the ways in which lay midwifery occurred, they relate only to those childbirth events that resulted in death. Thus, they may be said to represent the minority of cases involving the lay midwife rather than to offer a broader and perhaps more balanced picture.

A second limitation is that the accounts are recorded by an official such as a member of the police or of the Coroner's Office and are sanctioned by the witness with a signature or, more often, a cross. It is therefore possible that the recorder has guided these accounts and that they are not the spontaneous evidence of the witness. Those witnesses and the culture they represent are drawn predominantly from non-Indigenous working class. Thus, a third limitation is that the principal ethnic group featured in this thesis has been women of European decent who were born in Queensland or other parts of Australia. This focus has originated from the data itself and has not been contrived. However, it does impose a restriction to the scope of the study.

CONTENTS

LIST OF APPENDICES

ABBREVIATIONS

Australasian Medical Gazette	AMG
Official Record of the Debates of the Legislative Council and of the Legislative Assembly	ORDLCA
Official Record of the Debates of the Legislative Assembly	ORDLA
Queensland Parliamentary Debates	QPD
Queensland State Archives	QSA
Queensland Women's Historical Association	QWHA
Royal Commission on the Decline of the Birth-Rate and on the Mortality of Infants in New South Wales, Report	RCDBR
Statistics for the Colony of Queensland	SCQ
Statistics for the State of Queensland	SSQ
The Brisbane Courier	BC
The Moreton Bay Courier	MBC

DECLARATION

The work contained in this thesis has not, at any time in the past, been submitted for a degree or diploma at any other higher education institution. To the best of my knowledge and belief the thesis contains no material previously written or published except where due reference is made.

Signed: _____

Dated: _____

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INTRODUCTION

> To enable man (sic) to understand the society of the past, and to increase his mastery over the society of the present, is the dual function of history.[1]

This thesis deals with childbirth in Queensland during the period 1859 to 1912. In particular, it explores the reasons that underpinned the transition of the role of midwife from lay to qualified. For the purpose of this study, lay practice is defined as habitual action or custom that is not supported by formal qualification and does not conform to learning or conduct that is synonymous with a profession.[2] The question posed at the outset of the research was, "Why and how did midwifery practice in Queensland arrive at its present point?" That point describes a childbirth culture in 2003 in which midwives work almost exclusively in the institutional environment of the hospital and are governed by nursing regulation in the form of the Nurses' Act 1992 and the Nursing By-Law 1993.[3]

The statutory body that regulates midwifery practice is the Queensland Nursing Council from which the midwife receives an *endorsement* to practice midwifery based upon prior registration as a nurse. For midwives who have obtained their midwifery qualification in Queensland, there is no provision for midwifery practice other than that

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1 E. H. Carr, *What is History? 2nd edition*, R. W. Davies (ed), (Middlesex: Penguin, 1987), p.55.
2 J.M. Hughes, P.A. Mitchell, W.S. Ramson, (eds) *The Australian Concise Oxford Dictionary, 2nd edition*, (Melbourne: Oxford University Press, 1992) pp. 639, 889, 905,
3 *Nursing Act 1992*, *Nursing By-Law 1993*.

derived from a general nursing qualification.[4] The exception to the requirement that midwives must first obtain registration as a general nurse exists in circumstances where a person has received qualification as a midwife outside Australia through what is often termed “direct entry” into a formal course of instruction that leads only to certification as a midwife.[5] This exception is possible under Section 77 (1) of the Nursing Act whereby the Queensland Nursing Council has the authority to grant permission for a person to practice as a midwife without first obtaining a qualification as a nurse. The powers of Council and the terms under which it make its determination are quite broad as the wording of this clause indicates:

> An individual may be authorised by the Council to practise midwifery if the person has successfully completed a midwifery course accredited by the Council or a comparable course outside Queensland that is based on similar competencies.[6]

In such an event, the midwife is classified as a non-nurse and is authorised to practice solely as a midwife. According to a Council representative, there are currently approximately eighteen people working as midwives under this authorisation, the majority of whom are from New Zealand and the United Kingdom. [7] The total number of registered nurses who currently hold an endorsement to practice midwifery is eleven

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4 Queensland Nursing Council, *Policy for the Accreditation of Nurse Education Courses*, (April 1998), pp.2-5.
5 Telephone conversation with Ms. Phyllis Davey, Nurse Adviser (Registrations), Queensland Nursing Council, 7th January 2003.
6 *Nursing Act 1992*.
7 Telephone conversation with Ms. Phyllis Davey, 7th January 2003.

thousand four hundred and fifty-five.[8] The Queensland Nursing Council was unable to provide figures relating to the numbers of practising endorsed midwives. However, a study conducted by the government initiated Health Workforce Planning and Analysis Unit in 1998 found that, at that time, approximately thirty-two percent of registered nurses authorised to practise midwifery were working as midwives, representing in the region of three thousand six hundred midwives.[9] This figure is consistent with thirty-two percent of the current midwifery workforce of eleven thousand four hundred and fifty-five.

Although the work of most midwives in Queensland is dependent upon initial qualification as a general nurse, the midwife performs an essential role in the provision of maternity care. The most recent birthing statistics issued by Queensland Health indicate that, during the latter years of the twentieth century and in the year 2000, the midwife or the midwife student constituted the principal accoucheur in "normal" childbirth that being, births defined as "spontaneous vertex" to indicate the retrospectively unproblematic nature of the event.[10] During this period, Queensland's average annual birth rate was almost fifty thousand, with the majority of these births taking place in a hospital institution.[11]

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8 Ibid.

9 Queensland Health, *Midwifery Workforce Planning for Queensland to 2011*, (Health Workforce Planning and Analysis Unit, Project Report Draft Copy, May 1998), p.26.

10 Queensland Health Information Centre, *Perinatal Data Collection 1995/1996* (preliminary). See also, *Perinatal Data Collection 1997/1998*.

11 Queensland Health Information Centre, "Total Number of Births in Queensland by Principal Accoucheur and Method of Delivery, 1995/1996", *Perinatal Data Collection* 1995/1996 (preliminary), (1997). See also Queensland Health Information Centre. "Total Number of Births in Queensland by Method of Delivery and Principal Accoucheur, 1997 & 1998", *Perinatal Data Collection*, (1999). And, Queensland

Midwives and student midwives took responsibility for an average of seventy one percent of such births compared with twenty-four percent conducted by obstetricians or medical officers. At the same time, midwives constitute the primary caregivers in the maternity service workforce.[12] Although midwives perform a crucial role in the processes of childbirth in Queensland, they are devoid of a professional standing of their own. Midwives work within the parameters of nursing legislation and derive their right to practice from registration as a nurse. This policy is comparable with other Australian states and territories in that there is no legislation specifically for midwives.[13] In some states, midwives are required to register as nurses in order to work as midwives, even though they do not possess a nursing degree, but have instead, obtained their midwifery qualification from a country where direct entry rules apply.[14] However, this may change as recently devised Bachelor of Midwifery programs begin to impact upon state regulations.[15]

The situation of non-nurses registering as nurses in order to practice as midwives has come about as a result of differences in the way in which midwives are viewed in countries other than Australia where the

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Health Information Centre, "Number of Births by Method of Delivery and Principal Accoucheur, Queensland, 1998 to 2000, *Perinatal Data Collection*, (Client Services Unit, Queensland Health, data extracted 23 July 2003).

12 Queensland Health, *Birthing Services Program; Service Provision Model*, (November 1995), pp. 3-5.

13 *Nurses Act, 1999,* (South Australia); *Nursing Act, Dec. 2001*, (Northern Territory); *The Nurses Act, 1992*, (Western Australia); *Nurses Act, 1991*, (New South Wales); *Nurses Act, 1993*, (Victoria); *Nurses Act, 1988*, (Australian Capital Territory).

14 S. Tracy, L. Barclay, P. Brodie, "Contemporary Issues in the Workforce and Education of Australian Midwives", *Australian Health Review*, (Vol. 23, No. 4, 2000), p.85.

15 Ibid., p.85.

midwife exists as a separate entity and midwifery practice conforms closely to the ideals of a profession.[16] In such countries midwifery expertise is perceived of as a skill that is not reliant upon nursing in the same way that midwives are accorded their own professional framework. Bennett and Brown profess that the concept of a midwife as an *independent practitioner* is not readily recognised, accepted, or acknowledged.[17] They explain this anomaly in the following way:

> The concept of the midwife as an independent practitioner in her own right is one that is precious to those within the profession but not always fully understood. The midwife may diagnose pregnancy and various conditions related to it, give certain drugs without prescription, especially during labour and the postnatal period and retain responsibility for the total care of a childbearing woman as long as events remain within the range of normality.[18]

An important aspect of the appearance of midwives as distinct practitioners rather than as midwives who practice as an adjunct to nursing, is a vision of midwifery practice that does not issue from, or interlink with, nursing.[19] Instead, midwifery practice is seen as a discrete body of knowledge that is as dissimilar from nursing knowledge as it is from medical knowledge. So different are these branches of learning that the renowned midwife advocate, Caroline Flint, was moved to comment that to enforce nurse training upon a midwife was as ludicrous as to

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16 A. Symonds, S. Hunt, *The Midwife and Society: Perspectives, Policies and Practice*, (Hampshire: Macmillan, 1996), pp.182-213. See also, H. Marland, A.M. Rafferty, *Midwives, Society and Childbirth: Debates and Controversies in the Modern Period*, (London: Routledge, 1997), And, T. Murphy-Black, (ed) *Issues in Midwifery*, (London: Churchill Livingstone, 1995), pp.119-220.
17 V.R. Bennett, & L.K. Brown, L.K. (eds) *Myles Textbook for Midwives 12th edition,* (Edinburgh: Churchill Livingstone, 1993), p.4.
18 Ibid., p.4.
19 C. Flint, *Communicating Midwifery: Twenty Years of Experience*, (Cheshire: Books for Midwives Press, 1995), pp.7-8.

require midwives to train first as florists, or dentists to undergo medical training, or solicitors to join the police force in order to study law.[20]

From Flint's perspective, midwifery is a profession that draws on its own body of knowledge; is woman-focused and facilitative of women's needs.[21] The term "profession", as it is employed in this thesis, defines an occupation whose mechanism of control is independent of outside influence.[22] Witz draws on the work of Freidson to argue that:

> …a profession is an occupation which has successfully struggled for the right to control its own work, and so has been granted legitimate organised autonomy, usually by a dominant elite or by the state.[23]

Adopting this viewpoint, an occupation that seeks professional status is required to demonstrate a functional resilience that is sanctioned by the state and to be independent of outside interference.

In New Zealand, midwives gained independent status in 1990 when legislation was changed to enable them to offer a full range of maternity services to women.[24] This change reversed an amendment in 1971 that required medical practitioners to supervise all births and represented a culmination of moves on the part of the medical profession and nurses to tighten their control over midwives.[25] Similarly, midwives in the Netherlands are renowned for providing independent care maternity

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20 Ibid., p.7.
21 Ibid., pp.229-231.
22 A. Witz, *Professions and Patriarchy*, (London: Routledge, 1992), pp.39-69.
23 Ibid., p.41.
24 V. E. M. Fleming, "Midwifery in New Zealand: Responding to Changing Times", *Health Care for Women International*, (17, 1996), pp.343-359.
25 Ibid., p.344.

care either at home or in the hospital.[26] It is claimed that this care has its roots in the conservative culture of its people, a pluralist political system and an educational arena for midwives that was focused upon midwifery rather than medicine or nursing.[27] Whatever the basis of the Dutch system, it has been of interest to health planners outside of the Netherlands, with both Britain and Canada drawing upon its organisation to implement policies within their own maternity services.[28]

In the province of Ontario, Canada, where midwives had been outlawed since 1865 when the Medical Act excluded all but medical practitioners from practising midwifery, a resurgence in demand for midwives in the 1980s resulted in the re-emergence of licensed midwifery as an independent profession.[29] In Britain, the concept of midwives as independent practitioners is a tradition that has withstood onslaught from medicine and nursing.[30] An important aspect of the services offered by midwives in Britain is midwife-led care both in and outside the hospital environment.[31] This type of facility was reaffirmed in the 1990s in response to government reports that identified a need to bring maternity services in line with consumer expectations.[32] An essential part of

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26 R. G. DeVries, "The Social and Cultural Context of Birth: Lesson for Health Care Reform from Dutch Maternity Care", *The Journal of Perinatal Education*, (Vol. 5, No. 2, 1996), pp.25-30.
27 Ibid., pp.29-30.
28 Ibid., p.26.
29 H. Tyson, A. Nixon, A. Vandersloot, K. Hughes, "The Re-emergence of Professionalization of Midwifery in Ontario, Canada". In T. Murphy-Black (ed) *Issues in Midwifery*, (Edinburgh: Churchill Livingstone, 1995), pp.163-175.
30 C. Flint, Communicating Midwifery: Twenty Years of Experience, pp.1-6.
31 L. Page (ed) *Effective Group Practice in Midwifery: Working with Women*, (Oxford: Blackwell Science, 1995), pp. 12-31.
32 Department of Health (U.K.) *Changing Childbirth I & II*, (London: HMSO, 1993).

consumer expectations was that the midwife would act as a principal service provider and that midwifery care would promote a continuity lacking in medical models. Indeed, twentieth century maternity care in Britain that had come to be closely linked with medical ideals was censured in a Government report with the criticism that:

> …it is no longer acceptable that the pattern of maternity care provision should be driven by presumptions about the applicability of a medical model of care based on unproven assertions.[33]

The report, in moving away from the medical model, enabled midwives to reaffirm the autonomy they once held and by so doing, assisted them to provide the type of service women wanted while at the same time meeting the principles of safe practice.[34]

In Australia, in the last decade of the twentieth century, it became apparent that maternity services were not meeting client needs and the extent of that deficit emerged as a political issue. Government reports conducted in New South Wales in 1989 and Victoria and Western Australia in 1990 confirmed that a divide existed between what women wanted and what they were getting from the state.[35] Subsequent research sought to identify ways to offer women a safe and cost effective service. The role of the midwife became a focus of attention as ways were sought

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33House of Commons (U.K.) *Maternity Services Vol 1: Report Together with Appendices and The Proceedings of the Committee*, (London: HMSO, 1992), p.xciv.
34 L. Page, *Effective Group Practice in Midwifery: Working with Women*, pp.131-139.
35 New South Wales Department of Health, *Report on Ministerial Task Force on Obstetric Services in New South Wales*, (Sydney: NSW Department of Health, 1989): Health Department of Victoria, *Having a Baby in Victoria: Final Report of the Ministerial Review of Birthing Services in Victoria*, (Victoria: Government Publication, 1990): Health Department of Western Australia, *Report of the Ministerial Task Force to Review Obstetric, Neonatal and Gynaecological Services in West Australia*, (Perth: Government Printer, 1990).

to offset the dissatisfaction that some client groups had expressed towards maternity care provision.

In 1998, the National Health and Medical Research Council published a *Review of Services Offered by Midwives*.[36] This review acknowledged the need to support the provision of midwifery models of care, defined as those in which, "…the midwife is the primary care provider for women with uncomplicated pregnancies…".[37] In accepting the wisdom of adopting this approach, the review confirmed that midwifery models of care are associated with fewer birthing interventions, lower costs and greater levels of satisfaction for women.[38]

In 1999, the Department of Human Services of South Australia, formulated guidelines for the creation of a midwife practitioner role in South Australia that is distinct from its nurse practitioner counterpart.[39] Taking direction from the Australian College of Midwives Incorporated, the Department instituted a means whereby midwives could gain the professional recognition and clinical endorsement that would enable them to pursue an independent midwifery role.[40] This means that midwives may now offer services as maternity care providers as determined by an especially convened Nursing and Midwifery Advisory Committee.[41] The

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36 National Health and Medical Research Council, *Review of Services Offered by Midwives*, (Canberra: Commonwealth of Australia, 1998).
37 Ibid., p.21.
38 Ibid., pp.1-8.
39 Department of Human Services, *Guidelines for the Granting of Clinical Privileges and Admitting Privileges for Nurses and Midwives in Public Hospitals in South Australia*, (South Australia: Department of Human Services, July 1999).
40 Ibid., p.3.
41 Ibid.

distinction that the South Australian government makes between nurses and midwives challenges the traditional view of nursing and midwifery as having largely shared roles that has existed in Australia throughout it history.

An important aspect of this initiative is the opportunity to gain registration through a course of instruction that eliminates the need for students to study nursing first and midwifery second.[42] In this system, which has been termed "direct entry", the student is able to concentrate on midwifery and its related topics and issues. Such a system positions the midwife role as quite independent of nursing. The argument has been put that nursing is not only inappropriate to the midwife role, but is harmful to it because it moves the focus from supporting the woman through her normal life event to caring for the sick women in the illness of her childbirth.[43] A contrasting and somewhat resilient view maintains that education in general nursing is an essential prerequisite to qualification as a midwife because it is through nursing knowledge that the family unit as a whole may be best served.[44]

In 2001, a paper published by Brodie and Barclay argues the case for a three year Bachelor of Midwifery program in all Australian states and territories.[45] The authors maintain that, the regulation of

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42 J. Alexander, "Midwifery Graduates in the United Kingdom". In T. Murphy-Black (ed) *Issues in Midwifery*, pp.83-98.
43 C. Flint, *Communicating Midwifery: Twenty Years of Experience*, pp.1-8.
44 R. Watson Lubic, "General Nursing Education: Prerequisite to Midwifery", *Nursing and Health Care*, (13: 6 June 1992), pp.314-315.
45 P. Brodie, L. Barclay, "Contemporary issues in Australian midwifery regulation", *Australian Health Review*, (Vol.24, No.4, 2001), pp.103-118.

midwives as it exists in Australia at present is inconsistent and lacks clear distinction between midwives and nurses. This distinction, they contend, is necessary if the public is to be provided with greater choice in maternity care and the role of the midwife is, as a consequence, to be maximised.[46] At present, midwifery education in Australia falls short of international guidelines and competency standards.[47] Its regulation is left to the individual states and territories to determine and there is no shared basis for practice.[48] Calling for a schedule of national standards and a clear differentiation between the professional scope of midwives and nurses, Brodie and Barclay urge that the title "midwife" be defined and the public made aware of the services offered by midwives.[49]

In 2003, there are further indications that Australia is growing more tolerant of a midwife role that is not reliant upon nursing. There are currently seven universities that offer a Bachelor of Midwifery degree that does not rely upon previous qualification as a nurse.[50] These universities are located in Victoria, Tasmania and South Australia. While tertiary facilities in Queensland do not yet offer such programs,[51] it is reasonable to suppose that this situation will be rectified in time. In May 2003, the Queensland Nursing Council announced that it was to undertake a review of the regulation of

46 Ibid., pp.103-105.
47 Ibid., p.106
48 Ibid., pp.109-114.
49 Ibid., pp.114-115.
50 Http://users.bigpond.net.au/birthwise/education.html, (29th January 2003).
51 Http://users.bigpond.net.au/birthwise/education.html, (29th January 2003).

midwifery.[52] Although by January 2004 this had not taken place, it is likely that delay occurred in order to enable the Nursing Council to evaluate the findings of the Midwifery Workforce Planning Project and to assess the effects of the New South Wales Midwives Act 2003.[53]

The reappraisal of the work of midwives and the scope of their practice are particularly relevant to this thesis. The primary and secondary sources upon which this thesis is based indicate that the midwife has always been a central service provider in maternity care in Queensland and other Australian states. However, while the role of midwife continues to be an identifiable and clinically credible role in many countries overseas,[54] in Australia it is an occupation that, for some time, has been blurred and almost indistinguishable from that of the nurse. This thesis argues that the statutory regulation of midwives that occurred in Queensland in 1912 represents a crucial stage in the development of the midwife role in that state. This thesis looks at **why** and **how** that situation came about. It captures a particular point in time when the lay midwife, the trained nurse and the medical practitioner became counterparts in a state campaign that was designed to enhance the population of Queensland, and of Australia generally, through the regulation of reproduction.

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52 Queensland Nursing Council, *Forum*, (Vol. 11, Issue 2, December 2003). P.5.
53 Ibid.
54 P. Brodie, L. Barclay, "Contemporary issues in Australian midwifery regulation", pp.103-104.

The thesis examines primary source evidence submitted at Inquests into maternal and infant deaths to explore the factors that led to the state regulation of lay midwives from the point of view of the medical profession, nursing, and the state. The thesis explores the medical profession's frustration with the inconsistencies of lay midwifery practice which it considered the cause of unavoidable maternal, foetal and infant death and isolates the issues that motivated the state to enter the arenas of childbirth and the regulation of midwives. Finally, the thesis demonstrates that the concept of the "trained nurse", employed within the institution of the hospital and under the direction of the medical practitioner, was not merely coexistent to the statutory regulation of midwives, but essential to the transition process.

The elimination of the lay midwife: a medical agenda

This thesis is based on certain constructs that frame the subsequent account. The first construct deals with the question of *why* the work of midwives became the target for control and what role the medical profession assumed in this process. It is argued that the medical profession was the initial and chief protagonist for the registration of midwives[55] and that it exploited the informal and unorganised nature of midwifery practice by women to further its cause. That cause was to establish midwifery practice as a branch of medicine and to assist the alignment of midwives with nurses in order to position midwives as

55 Anon. "A Meeting of the Medical Profession: Midwifery Nurses' Bill", *The Australasian Medical Gazette,* (hereafter *AMG*) (Nov. 21, 1898), pp.480-485.

childbirth attendants under the supervision and control of the medical profession.

In its campaign to restructure midwifery practice, the medical profession was committed to three specific goals: the elimination of independent practice by midwives; the amalgamation of midwifery and nursing through the establishment of hospital training schemes supervised by medical practitioners; and the control of midwifery and nursing through state legislation.[56] By these means, the medical profession believed it would be able to provide the obstetric services that *it* felt were in the best interests of mother and child.[57]

Medical practitioners were disturbed by the prevalence of midwives as birth attendants. It seemed that women either preferred to have midwives attend them or women had no choice but to accept assistance from midwives. Whatever the reasons that underpinned their work as birth attendants, midwives dominated the childbirth arena.[58] That domination was a source of concern to medical practitioners and during the closing years of the nineteenth century, protracted debate took place in medical circles focussing on the ways and means by which the work of midwives might be curtailed.[59] The choices open to the medical

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56 Ibid., pp.269-271.
57 *Official Record of the Debates of the Legislative Council and of the Legislative Assembly* (hereafter ORDLCA), during the Third Session of the Eighteenth Parliament Comprising the Period from the Eleventh day of July, A.D. 1911 to Ninth day of January A.D. 1912. Vol. CVIII (Brisbane: George Arthur Vaughan, Government Printer, 1912), pp.708–735.
58 Legislative Assembly New South Wales, *Royal Commission on the Decline of the Birth-Rate and on the Mortality of Infants in New South Wales, Report*, *Vols. I & II*, (hereafter RCDBR) (Sydney: William Applegate Gullick, Government Printer, 1904).
59 W. B. Nisbet, “The Education of Midwives”, AMG, (June, 1891), pp.269-271.

profession, as it saw them, were to support the concept of an independent practitioner midwife or to contain midwifery practice within the sphere of nursing. The decision was to pursue the latter option. The impetus for change came from the medical fraternity without consultation with midwives.

Medical practitioners argued that the work of midwives should be contained through regulation and subjected to continual monitoring. A Bill proposed to the parliament of New South Wales recommended the establishment of a registering authority for nurses and a period of training in a hospital institution.[60] It took some years of debate before the terms of the Bill could be agreed and it was not until 1898 that the Bill reached the stage of being presented to the Legislative Council of New South Wales.[61] The provisions of this Bill are wholly consistent with the terms under which the Health Act Amendment Act of 1911 regulated midwives in Queensland.[62]

The influence of the state on childbirth culture and on the work of midwives

The second construct also addresses the question of *why* midwifery came to be regulated. This construct is based upon the influence of the state in bringing about reform to the work of midwives. The moves on the part of the medical profession to regulate midwives came at a time when Australian states were becoming increasingly

60 Anon. "A Meeting of the Medical Profession: Midwifery Nurses' Bill", AMG, pp.480-485.
61 Ibid., pp.480-485.
62 *The Health Act Amendment Act of 1911*, (2 Geo. V. No. 26).

concerned with declining birth rates and high infant mortality rates throughout the country. In 1903, a Royal Commission was instigated in New South Wales to investigate the high infant mortality rates and to assess the decline in birth rates.[63] The Royal Commission findings, published in 1904, isolated certain factors it claimed to be significant to the decline in birth rates. These factors were, contraception, abortion, deaths associated with childbirth, illegitimacy and bottle-feeding of infants.[64] The untrained birth attendant, defined by the Commission as, "midwives, monthly nurses or accoucheuses", was implicated in the first four of the five causes.[65]

While the Commission sought the views of a relatively broad section of the community and in particular those with knowledge of infant welfare, it relied heavily upon evidence from the medical profession and, indeed, many of the members of the Commission held qualifications in medicine.[66] Along with the medical profession, the proceedings sought expert witness from, among others, chemists, state inspectors, police and clergy. One married woman and two monthly nurses gave evidence.[67] The dominant role played by medical practitioners, together with the significant presence of medical practitioners as members of the Commission, is likely to have influenced the eventual outcome. The views expressed by the Royal Commission were mirrored in debates that

63 RCDBR, Vols. I & II.
64 Ibid., Vol. I. pp.14-30.
65 Ibid., Vol. I. p.32, (paragraph 114).
66 Ibid., Vol. II.
67 Ibid., Vol. II. pp.9-21.

took place in meetings of the Legislative Assembly in Queensland that preceded the passing of the Health Act Amendment Bill in 1911.[68]

The Commission heard that, from 1891 to 1900, there had been a marked decline in birth rates in Australia, New Zealand and Britain.[69] Further, during the years 1894 to 1901, a decline in birth rates was also recorded in New York, Buenos Ayres and in twenty major European cities. With the birth rate defined as "the number of births per 1,000 of the population", the rate of decline varied between 0.3 percent in Copenhagen, 16.6 percent in Sydney, 19.7 percent in Melbourne and 21.4 percent in Hamburg.[70] The case was put that, in Australia, untrained midwives and nurses were second only to fortune-tellers as chief perpetrators in spreading knowledge of abortion procuring procedures.[71]

While it was conceded that women often sought out the services of others to help them limit their families and were, on occasions, prepared to attempt abortions on themselves, midwives' familiarity with feminine matters and their ready acceptance by women put them under suspicion of wrongdoing. It was argued that women were likely to approach midwives for advice and practical help in limiting their families and that midwives were more likely than medical practitioners to respond to their requests. The particular concern was that the use of contraceptive

68 ORDLC.
69 RCDBR, Vol. I, p.6.
70 Ibid., Vol. I, p.6.
71 RCDBR, Vol. II. p.75, (2573-2598).

devices or the inducement of abortions, which the Commission saw as meddling with nature, not only limited families by direct means but also put the woman at risk of developing pelvic disease that might eventuate in subsequent infertility.[72]

The Commission defined deaths associated with childbirth as, "deaths of women within one month of their confinement, due to illness which has arisen in connection with their pregnancy, confinement, or subsequent puerperal state".[73] The midwife was implicated in a number of ways. First, the custom of giving birth in the home assisted by a midwife, or in a private lying-in facility owned by a midwife, placed midwives and childbirth in an environment that could not be readily scrutinised.[74] The concealment that the domestic environment offered, whether in the home of the mother or the midwife, prompted the claim that midwives contributed to maternal and infant deaths either wilfully or through ignorance. It was the lack of surveillance that unnerved the state and caused midwives to be linked to stillbirth and infanticide.[75]

Second, the midwife was implicated in deaths attributed to stillbirth. Stillbirth was a relatively common cause of death in childbirth. The Commission heard that of one thousand viable births that took place in the Women's Hospital in Sydney, fifty were stillborn.[76] The argument was put that unqualified or unskilled midwives were contributing to the

72 Ibid., Vol. II. pp.78-83; 88-89.
73 RCDBR, Vol. I, p.31, (109).
74 RCDBR, Vol. II, pp.28, 87, 9, 106, 108.
75 Ibid., pp.78-85.
76 Ibid., Vol. II, p.84, (2779).

incidences of stillbirths either through mismanagement during labour or for want of accurate diagnosis and treatment at birth.[77] It was contended that infants born at home and asphyxiated at birth were more likely to die than those born in a similar condition in a lying-in hospital where staff were trained and facilities were better.[78] Indeed, the assertion was made that "Defective care of the newborn by ignorant or careless midwives" was a major contributor to infant deaths.[79] A particular aspect of this type of claim lay in differentiating between a stillborn infant and one who was asphyxiated and who might be restored by appropriate treatment.

Third, midwives were tenuously linked to illegitimacy. In the same way that midwives were implicated in incidences of stillbirths, abortion and infanticide, it was perceived that pregnancy birth attendants might manipulate outcomes. The concern here was that women who were pregnant and without the social and financial support that marriage afforded might either be tempted to procure an abortion during pregnancy or to resort to infanticide after birth.[80] It was claimed that the untrained midwife was both inherently inclined and well positioned to malpractice because she was without the benefit of hospital training and the formal certificate that pronounced her competent by medical standards.[81]

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77 Ibid., Vol. II, p.84, (2780-2781).
78 Ibid., Vol. II, p.84, (2780).
79 RCDBR, Vol. I, p.39, (142).
80 RCDBR, Vol. II, pp.78-85. See also, ORDLCA, Third Session of the Fifteenth Parliament Comprising the Period from the Twenty-Fifth of July, A.D. 1905 to the Twentieth of December A.D. 1905, Vol. XCVI, p.1657.
81 RCDBR, Vol. II, p.82-83, (2762-2767).

Fourth, it was strongly suggested by members of the Commission, and certain contributors to it, that midwives were ignorant of the means by which sepsis was spread and that midwives' ignorance of asepsis was a major contributing factor in the spread of puerperal infection.[82] It was argued that while many *nurses* held certificates pertaining to asepsis, the majority of *midwives* did not, with the result that midwives perpetuated puerperal infection that all too commonly led to maternal death. The answer to the problems confronting the state in relation to the work of lay midwives and the custom of birthing in the home, was to bring the prospective midwife into the hospital institution where she could be trained by members of the medical profession to a standard that was acceptable to them.[83]

The trained nurse; the hospital institution and the midwifery nurse

The third construct has to do with *how* midwives were brought under the control of the state and the medical profession. It is argued that the concept of certification and its links with the role of the nurse and the institution of the hospital were imperative to the curtailment of midwifery practice. Those members of the medical profession who supported the registration of midwives believed that, in coalescing the roles of midwife and nurse, a more compliant practitioner would be created to replace the lay midwife.[84] The "midwifery nurse" would fulfil the role of the midwife

82 Ibid., Vol. II, p.73, (2531-2549).
83 RCDBR, Vol. 1, p.31, (109-110).
84 Anon. " Meeting of the Medical Profession: Midwifery Nurses' Bill", AMG, pp.482-483.

but, as was the case with nurses, would be subservient to the medical profession.[85]

The construct of the trained nurse, a woman of good character, morally sound and obedient to the orders of her superiors, derived from nursing reforms initiated in Britain by Nightingale in the mid-nineteenth century and which spread rapidly throughout the countries of the Empire.[86] Nightingale promoted a strict training scheme for nurses based upon models developed in France and Germany where nursing was already well established and highly regarded.[87] Although religious orders had demonstrated a strong presence in skilled nursing for some time, Nightingale possessed the social standing to disseminate her own particular ideals and the social contacts to ensure her goals were realised. These goals took the form of a training schedule that prepared a minority with the means, ultimately, to train the majority. This schedule concentrated initially on producing matrons who would be able to set up and oversee hospital schools for trainee nurses.[88]

By the opening years of the twentieth century, nurses who had been trained under the schedule initiated by Nightingale were themselves

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85 Ibid., p.481.
86 M. E. Baly, "Florence Nightingale and the Establishment of the First School at St. Thomas's: Myth V Reality". In V. L. Bullough, B. Bullough, M. P. Stanton, *Florence Nightingale and her Era: A Collection of New Scholarship,* (New York: Garland, 1990), pp. 3-4.
87 B. Abel-Smith, *A History of the Nursing Profession*, (London: Heinemann,1960), pp.17-23.
88 Ibid., pp.24-25.

agitating for further change. These nurses saw state registration, as an imperative that was essential to the professionalisation process that they felt nursing should undergo.[89] In Britain, it took from 1888 until 1919 for the advocates of registration to claim victory.[90] An important precedent for them was the passing of the Midwives' Act in 1902.[91] An Act that was supported by the medical profession and which was designed to regulate the practice of midwives in order to address the high numbers of maternal and infant deaths that were attributed to carelessness and ignorance on the part of the untrained midwife.[92]

The concept of the 'professional nurse' gathered impetus in Australia and in 1899 the Australasian Trained Nurses Association was established in Sydney to act as gatekeeper to the employment of women who sought to practice without prior formal instruction in a hospital institution. Medical practitioners were active participants in the business of the Association.[93] In 1904 the vetting of nurses extended to Queensland when a group of medical practitioners and nurses worked together to establish a branch of the Australasian Trained Nurses Association in Brisbane. Accordingly, when the Nurses' Registration Board commenced its duties on the first day of January 1912, medical practitioners

89 A. Witz, *Professions and Patriarchy*, pp.128-167.
90 Ibid., 128.
91 B. Abel-Smith, *A History of the Nursing Profession*, p.77.
92 Ibid.
93 Strachan, G. *Labour of Love: The History of the Nurses' Association in Queensland 1860-1850*, Allan & Unwin, St. Leonard's New South Wales ,1996, pp. 44-91.

dominated the membership of a Board they shared with members of the Australasian Trained Nurses Association.[94]

The merging of the role of midwife with that of nurse and the requirement that trainee midwives should enter a hospital institution in order to gain licence to practice enabled controls on midwives that were hitherto impossible to secure and, in time, changed the way in which the role of the midwife was enacted in society. A hospital-based course of instruction relied upon the compliance and acquiescence of its senior midwifery or nursing staff and the willingness of the medical profession to direct and supervise the training of its pupil midwives and to examine their knowledge.[95] More than this, it necessitated the presence of parturient women to act as patients. Once women and midwives became oriented to the concept of the hospital as a viable birth venue, it was only a matter of time before it was perceived to be the *optimum* birth venue. Indeed, the prospect of creating a central maternity hospital in which the medical practitioner might oversee both the training of midwives and the processes of childbirth appeared in the 1904 Royal Commission Report.[96] That possibility was realised in Queensland in 1922 under the provisions of the Maternity Act. From that point, the building of public maternity

94 *The Health Act Amendment Act* (2 GEO. V. No. 26, 1911), Section 85 [154C], pp. 5174 – 5179.
95 *Queensland Government Gazette,* (hereafter QGG), (Vol. XCIV, Friday, 1st November, 1912, No. 118), pp.1116-1128.
96 RCDBR, Vol. II, p.108.

hospitals escalated so that by 1945 two thirds of all births in Queensland took place within a hospital institution.[97]

The incorporation of midwives within a regulatory authority for nurses brought about a re-definition of the role of the midwife that has had a lasting impact on midwifery practice in Queensland. In combining the roles of midwife and nurse, the concept was forged that midwifery practice and nursing practice were inextricably linked and that the only distinction between the one and the other was the *branch of nursing* in which midwives elected to specialise. The creation of a *midwifery nurse* in place of the *midwife* worked to marginalise the midwifery role, strengthen the position of nursing in relation to midwifery and cement the role of the medical practitioner in the birthplace.

This thesis, then, identifies the medical profession, senior nurses and the state as instrumental to the regulation of midwives in Queensland and it argues that the strategic alignment of the roles of midwife and nurse contributed to the eventual decline of midwives as independent practitioners. However, this thesis does not defend the position of the lay midwife. Nor does it maintain that the regulation of midwives was unnecessary or that the claims against them were unfounded. Rather, it acknowledges that from the evidence upon which the study is based there was clearly a need to bring about reform to childbirth practices and to the

97 W. Selby, "Motherhood in Labor's Queensland 1915–1957", *Unpublished PhD Thesis*, (Griffith University, Queensland. 1992), pp.154-155.

work of women acting as midwives. It shows that *some* midwives *were* directly responsible for deaths in childbirth. These midwives may well have been only a minority group, but they provided the incentive to mount a campaign to halt population decline and the ammunition to destroy the role of midwife, as it then existed.

This thesis does not suggest that the move made by the medical profession to limit the work of midwives was merely a ploy designed to enable medical practitioners to subjugate midwifery practice, although that might appear to have been an outcome. Neither does it contend that the state introduced legislation against midwives as part of a larger plan to control childbirth and situate it in the public institution of the hospital, although that too, was an outcome. It concedes, too, that while the medical profession may have encouraged the alignment of nurse and midwife to ensure the obedience and compliance of a previously unruly body that had traditionally dominated the childbirth arena, it may equally be argued that lay midwives were a menace to the women and children in their care and that the medical profession was ideally placed to remedy the damage caused by untrained midwives.

The thesis demonstrates that the attainment of the joint medical and political objective of the regulation of midwives by statutory means was based, not merely on power relations between medical practitioners and midwives, nor solely on gender inequality, social disequilibrium, or the overuse of state power. Those factors existed as preconditions and were major influences to the transition, but they were

not the driving force. The thesis contends that the foremost motive of medical practitioners and politicians was to bring a stop to the waste of life that was occurring in childbirth. While it may be feasible now to suggest that the means used to regulate midwives in 1912 acted to disadvantage their subsequent professional development, at the time, it was the best and most judicious solution to a dire social problem.

Thus the statutory regulation of midwives that began in Queensland in 1912 may be seen as the culmination of a campaign designed specifically for that purpose or it may be explained as an unpredictable aftermath of a series of disconnected events. This thesis tends towards the latter viewpoint and contends that, while the medical profession was generally desirous of bringing about changes to the practice of lay midwives, it did not act as a unified body directed towards the particular objective of state regulation. However, medical involvement in the affairs of midwives came at a time when the political and social climate was conducive to change.

The difficulties that beset childbearing women and newborn infants in the years leading to the state registration of midwives are no longer a part of the childbirth culture in Queensland, and the conditions that commonly killed women and babies, although still existing as deviants to "normal" childbirth, seldom pose the threat to life they once did.[98] In their

98 Queensland Health, *Perinatal Statistics: Queensland 1996*, (Brisbane: Queensland Health).

place are different problems and other concerns. In 2003, childbirth has moved almost exclusively from the domesticity of the home to the institution of the hospital. In the hospital, medical procedures aimed at facilitating and shortening the childbirth process are commonplace, with the result that childbirth by means of forceps, vacuum extraction, or caesarean sections account for a little over thirty-two percent of the total births, and it is a trend that is increasing.[99]

In recent years, concerns have been voiced in Queensland and elsewhere in relation to what has become known as the medicalisation of childbirth, a term often used to deride the interventions that have become routine to the culture of childbirth in the societies of developed countries.[100] Women as mothers and as midwives are questioning the historical processes that placed them in their present situation.[101] That position, they argue, is one of disempowerment and lack of control. Some women regret their lack of autonomy over their childbirth experiences and some midwives rue the events that subjugated them to the more powerful medical group.[102] As part of the process, some have voiced

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99 Queensland Health Information Centre, "Total Number of Births in Queensland by Method of Delivery & Principal Accoucheur, Queensland, 1995/1996 & 1997/1998",
100 C. Flint, *Communicating Midwifery: Twenty Years of Experience*, See also, A. Summers, '"For I Have Ever So Much More Faith in her Ability as a Nurse': The Eclipse of the Community Midwife in South Australia 1836- 1942", *Unpublished PhD Thesis*, (Flinders University, South Australia, 1996).
101 K. M. Reiger, *Our Bodies, Our Babies: The Forgotten Women's Movement*, (Melbourne: University Press, 2001).
102 L. M. Barclay, C. A. Andre, P. A. Glover, "Women's Business: The Challenge of Childbirth", *Midwifery*, (1989, 5), pp.122-133. See also, S. Brown, J. Lumley, "Satisfaction with Care in Labor and Birth: A Survey of 790 Australian Women", *BIRTH*, (21, 1 March 1994), pp.4–13. And, J. MacVicar, L. Owen-Johnstone, M. Hopkins, "Simulated Home Delivery in Hospital: A Randomised Controlled Trial", *British Journal of Obstetrics and Gynaecology*, (April 1993, Vol. 100), pp.316–323.

condemnation of the shift in power from the midwife to the medical profession, which is seen to have attained a monopoly over the reproductive processes to the detriment of women's birthing experiences.[103]

This study highlights the culture of childbirth that existed among women of European descent in Queensland's past. It was a culture in which lay midwives did what they could to lend assistance to women during a momentous life event. Sometimes that was not enough and women and infants died needlessly. Whether or not medical technology was really able to make a difference to birth outcomes, the medical profession was sure of its position as a superior and professional group. The state was equally confident that by taking advice from social and medical experts it would be able to reverse the downward trends in population. Caught up somewhere in the middle were parturient and postpartum women and their infants who were reliant upon others at a crucial time in their lives. This study captures some women's experiences of those times and draws from them an analysis of the factors that underpinned the inception of midwives' regulation in Queensland.

This thesis constitutes original research into the culture of childbirth and the work of midwives in Queensland during the period 1859 to 1912. The study starts in the year 1859, not only because it marks the

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103 M. Tew, Safer Childbirth: A Critical History of Maternity Care 2nd edition (Chapman & Hall, 1995). See also, M. Wagner, *Pursuing the Birth Machine: The Search for Appropriate Birth Technology*, (New South Wales: ACE Graphics, 1994).

inauguration of Queensland as a colony, but also to facilitate the collection of Inquest data upon which much of the thesis is based. Queensland has been selected as the focus of the study to fill a gap in knowledge that currently exists. With the exception of a substantive project by Selby that explores childbirth in Queensland during the period 1915 to 1957,[104] little attention has been paid to the role of the midwife. A central tenet of Selby's argument is that the Maternity Act of 1922 marked the point at which the Labor Government of Queensland committed itself to the hospitalisation of women for childbirth.[105] An important aftermath of the hospitalisation process was its impact on the work of midwives. Once the venue for childbirth moved from the home where it had largely taken place in the years prior to 1922, to the hospital, which accelerated in significance as a birth venue after 1922, the territorial boundaries of midwives' practice changed. This thesis argues that the transition of the role of midwife from lay to qualified facilitated the hospitalisation of women during childbirth and was crucial to the later development of the midwife role in Queensland.

Limitation of the Study

The study is limited in a number of ways. One of the most significant limitations relates to the lack of primary source data generated by the midwives themselves. While primary source material has been

104 W. Selby, "Motherhood in Labor's Queensland 1915-1957"
105 Ibid., pp. 143-174.

gathered from people whose recollections of midwives and midwifery practice have been obtained second or third hand, such as those contained with compilations printed by historical societies, no first hand accounts have been found.[106]

A second limitation to the study is its reliance upon coronial and magisterial testimonies to provide the basis of a construction of the role of the midwife, the involvement of the medical practitioner and the culture of childbirth itself. Public records, reflecting as they do the affairs of government and state, are characteristic of the administrative processes of the time. However, formal testimony such as that presented to and gathered by a court may be biased on a number of counts. For example, during the period under review a proportion of the testimonies were rendered by men and women who were illiterate and who were therefore reliant upon the police or a court official to transcribe their evidence. Another factor that relates to court processes is that they were, to a large extent, foreign to members of the working class who were called upon to step outside their usual environment and to bring to memory events that might be painful to recall and which might ultimately result in criminal proceedings being brought against them.

A third limitation exists in focussing on the childbirth culture of non-indigenous women rather than extending the study to include Aboriginal

106 E. Shepherd, *The Midwives of Rosewood and Other Birth Stories*, (Glenroy: The Pioneer Women's Hut, 1989). See also, A. Little, *Days Gone By*, (Mareeba, North Queensland: Pinevale Publications, 1992, and Eacham Historical Society, *Voices: Past & Present: Stories of Women of the Atherton Tableland*, (Malanda, Queensland. 1999.

and Torres Strait Islander peoples and immigrant populations from Europe and Asia. These omissions are deliberate and derive from the contention that the historical and cultural differences amongst and between these groups are too great to allow adequate and meaningful analysis of the data. It is proposed that historical research specific to the childbirth practices of these and other groups within the Australian community would benefit women's history.

Finally, the work of religious orders has not been included for discussion in this thesis. This omission does not in any way underrate the significant contribution that the Sisters of Mercy, in particular, have made to the education and practice of nurses and midwives in Queensland. However, after the Sisters of Mercy arrived in Brisbane from Dublin in 1861, their primary work was in visiting the sick, both in their own homes and as patients at the Brisbane Hospital.[107] Although the Order opened the Mater Misericordiae Hospital in South Brisbane in 1911, it was not until the 1960s that it had any major involvement in the work of midwives when the Mater Mothers' Hospital was opened in 1960.[108]

The historical method

History as a philosophy is characterised by discrepancies over the ways in which history is conceptualised as a discipline and the

107 R. Longhurst, *In The Footsteps Of The Mercies: A History Of The Mater Misericordiae Public Hospitals, Brisbane*, (South Brisbane: Mater Misericordiae Public Hospitals, 1992), p.21.
108 Ibid., pp.21, 90-91.

consequent methods employed in conducting historical research. The basis of methodological discussion lies in determining the most appropriate way to arrive at knowledge. The search for knowledge assumes that truth is the source of knowledge and that underpinning truth are beliefs upon which truth is constructed.[109] The concept of a historical truth was once believed to be beyond the control of the historian, a universal truth that could neither be manipulated nor denied. From this perspective, the historian conducts a scientific investigation of the sources to discover the objective truth contained within the documents.[110] This concept of truth has lost credence as greater emphasis has been placed on the choice of sources and the interpretation placed upon them.

Carr concluded that *truth* is a word derived from *fact* and *value* that conveys an impression that rests somewhere between the two. To Carr, neither *truth* nor *fact* could be detached from the historian, so that while a common adage may be that, "facts speak for themselves", in terms of history Carr maintained that, "facts speak only when the historian calls on them".[111] The selection of what is and what is not to be included as *fact* therefore rests with the historian in the same way that a news editor determines which events are worthy of inclusion in the media.[112]

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109 J. Olen, *Persons and Their World: An Introduction to Philosophy*, (New York: McGraw-Hill, 1983), pp.278-279.
110 L. von Ranke, *The Theory and Practice of History*, edited by G. G. I. Iggers & K. von Miltke, (USA: Boobs-Merrill, 1973) p.7.
111 E. H. Carr, *What is History?* p.11.
112 Ibid., p.12.

The sources

The difficulty in identifying clear-cut boundaries between what constitutes data and what does not, especially when no such history has been written previously, may be assisted by a prescriptive method. Such a method is practised when the historian selects the data on the basis of both the research question and the direction received from primary sources.[113] Where the question is unclear it is more appropriate to read extensively in the topic area, starting with secondary sources and moving to primary sources as the focus of the topic becomes clearer. At other times, the research question provides sufficient direction to enable access to relevant source documents at the outset. In keeping with many historical studies, the method used to collect and collate the sources that underpin this thesis drew upon each of these approaches. In the early stages, the compilation of data deemed capable of providing insight into the work of midwives and the culture of childbirth relied heavily on secondary sources. The secondary sources include histories of women, nurses, midwives and institutions.

Although secondary sources were foundational to the study in its early stage, primary sources have formed the basis of explanation and analysis. Ultimately, the sources, both primary and secondary, have modified and guided the objectives of the study, a process that is integral to the historical approach. Tosh argues that without willingness on the part of the historian to allow the sources to illuminate the unexpected or

113 Ibid., pp.131-133.

the unforeseen, the study risks being confined to an account based upon a preconceived notion held by the historian and imposed by him or her on the subsequent analysis.[114]

The literature that underpins this thesis has been selected for its credibility as representative of the work of midwives and of the influences on their practice. Midwives as a group do not feature as a political body of any sort in the literature. There are sources that offer the perspective of the nurse. There are sources that put forward the case for the medical practitioner. There is limited information related to the way in which midwives performed their role and little to link that role with the way in which women themselves viewed the services they received from midwives. In the absence of accounts written by midwives themselves, and with minimal material from childbearing women, state legislation provided a starting point. Parliamentary debates that underpinned the legislation, Government Gazettes that expanded upon and made explicit the legislation, and local newspapers that reported on daily happenings, all proved to be useful sources.

Medical journals were invaluable for the insight they provided into medical and midwifery care of childbearing women and for their representation of the perceptions of lay midwives in medical circles. These primary sources provided the foundation upon which the study developed, but they did not offer first-hand accounts of birth-room practice. They did, however, highlight negative aspects of the midwife role

114 Ibid., p.55.

and the accusations that were levelled against midwives by some medical practitioners.

The coronial and magisterial evidence filled the gap, offering both the chance to acquire in-depth knowledge of childbirth practices and the opportunity to confirm or refute the claims against midwives. As one historian has observed, such records do not merely represent evidence of what happened, they are part of what happened.[115] While this is not to say that such records necessarily portray "the truth", they do provide a documentary source from which a plausible and durable account might be constructed. A criticism against public records is that they are biased toward administrative ideals and should be balanced against sources contemporary to them such as Hansard and the press.[116] This thesis has tried to do that by using a range of primary sources that are employed as cross references to validate the evidence and to test it against the analysis.

Selection and Interpretation of the data

Data Collection

This thesis relies for its insight into childbirth practices and, in particular the role unqualified midwives played in childbirth, on the testimonies submitted at Inquests into maternal and neonatal deaths. The collection of these documents, which are held at Queensland State

115 N. Cox, "Public Records" In A. Seldon, (ed) *Contemporary History: Practice and Method*, (Oxford: Basil Blackwell, 1988), p.73.
116 J. Tosh, *The Pursuit of History: Aims, Methods, and New Directions in the Study of Modern History*, *2nd edition*, (London: Longman Group, 1991), pp. 63-67.

Archives, was a lengthy and involved process. Attention was concentrated on any deaths that might be associated with childbirth. The research therefore adopted a bi-focal approach in that it was concerned with the deaths of women *and* neonates. The archival data is indexed on cards that have been typewritten and which contain the name of the deceased, the date, place and cause of death and the location of the full Inquest record. Each card index was scanned to determine its eligibility for inclusion, the inclusion parameters being deaths associated with childbirth or those that occurred in the early neonatal period.

The neonatal period is defined in its present-day usage as being deaths occurring within the first twenty-eight days of life, with the early neonatal period taken to be the first seven days of life.[117] However, the archival records do not use this definition and therefore all deaths of infants that might, based on the information provided in the indices, reasonably have occurred within the first twenty-eight days of life were included in the initial data collection. This first stage of data collection recorded ninety-one maternal deaths and five hundred and seventy two infant deaths.[118]

Those who criticise historical method as non-scientific point to documentary evidence such as this as an example of the subjectivity they believe constitutes an inherent flaw in accounts of the past, claiming that

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117 V.R. Bennett, & L.K. Brown, L.K. (eds) *Myles Textbook for Midwives 12th edition,* (Edinburgh: Churchill Livingstone, 1993), p.691.
118 Queensland State Archives Justice Department, (hereafter QSA), *Index to Inquests 1859-1886, 1887-1897, 1897-1914.*

both the selection and interpretation of data rests with the historian.[119] Windschuttle refutes the claim, arguing that the historian employs documentary evidence that is available in order to *construct* an account from evidence that is *discovered*. He maintains that the historian compiles evidence from the working records of human institutions and that this data has been gathered by those organisations in order to manage their affairs. Those records therefore offer a comprehensive and accurate foundation for the subsequent account.[120] Windschuttle argues the point thus:

> Archival research has to be both painstaking and imaginative – the past does not yield up its secrets willingly – and is never neatly packaged and readily accessible… It is important to emphasise that those who insist that all historic evidence is inherently subjective are wrong. Archive documents have a reality and objectivity of their own. The names, numbers and expressions on the pages do not change, no matter who is looking at them, and irrespective of the purposes, ideologies and interpretations that might be brought to bear upon them. Historians are not free to interpret evidence according to their theories or prejudices. The evidence itself will restrict the purposes for which it can be used.[121]

In this study, categorisation of the archival data proved difficult at first because the data accounts for *all* deaths and does not identify deaths in childbirth as a discrete grouping. It was therefore necessary to evaluate each entry for its relevance to the study and this required advanced familiarity with the topic.

An initial appraisal of the data revealed first, that there were a disproportionate number of infant deaths compared with maternal deaths. Second, taking into account the probability that not all infant deaths were

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119 K. Windschuttle, *The Killing of History*, (San Francisco: Encounter Books, 1996), pp. 243-244.
120 Ibid., pp.244-245.
121 Ibid., 245.

neonatal deaths, there were relatively high numbers of deaths in infancy that had been attributed to causes other than those considered to be natural or the aftermath of a particular medical condition.[122] The neonatal data was arranged into fifteen categories according to the official cause of death and retained in the alphabetical order in which it appears in the archival indices. It was noted that the greatest number of deaths, eighty-six, were attributed to medical causes. These, along with twenty-seven deaths that were due to natural causes and thirteen that had been attributed to teething were eliminated from the study.[123]

Of the four hundred and forty-six that remained, sixty-three were due to gastro-enteritis, fifty-four to convulsions, thirty-nine to drowning, thirteen each to starvation or murder, and twenty-three were reputed to have been the cause of overlaying by their mothers. In forty-nine deaths no cause was found. All of these, and fifty-one that did not fit into any other category received no further attention. However, the data had revealed two things. First, a significant number of infants had died in Queensland during this fifty-three year period. Second, it was possible that the true reasons for those deaths might easily have been camouflaged or misrepresented. As the research progressed and the population concerns of Australian governments emerged from other sources, the archival data acted to support the validity of their disquiet.

The one hundred and forty-two deaths that remained comprised infants who had died as a result of stillbirth, prematurity, or suffocation

122 Appendix Seven.
123 Appendix Seven.

and asphyxia, and included those whose deaths had been recorded as occurring “at birth”. As the research progressed, the category of suffocation and asphyxia proved too difficult to link to childbirth and the thirty-eight deaths ascribed to one or other of these causes were removed from the study. For example, the twenty-third entry in Appendix Six records that an unknown infant died as the result of suffocation while the fifty-first entry indicates that John Cockerill was two months of age when he was suffocated by “accident in the night”, and the fifty-seventh entry describes the death of an infant caused by a blow from a falling veranda post.[124]

Similarly, of the one hundred and four deaths that remained, the fifty-seven that were related to prematurity were eventually eliminated on the basis that prematurity did not constitute a close enough correlation with deaths in childbirth. It seemed that the two categories most likely to expose the work of midwives were those that dealt with birth and stillbirth. Forty-seven in total, these two categories represent one of the two major sources of archival data upon which the thesis is based. The second source is that of maternal deaths.

The ninety-one maternal deaths that became the subject of official inquiry in the period 1859 to 1912 represent a minority both in terms of births and deaths. Queensland government statistics indicate that there were 545,101 births during that period.[125] This study acknowledges that, due to the recording procedures in place at that

124 Appendix Six.
125 SCO, for the year 1920, Part VIII, Vital Statistics), Table No. XVII.

time, and Chapter Five deals with this in greater detail, the actual numbers of deaths in childbirth cannot be accurately ascertained. However, the average number of deaths of women in or associated with childbirth appears to have been between thirty-five and fifty-five each year.[126] This gives a minimum figure of 1,855 deaths and a maximum figure of 2,915 deaths. The ninety-one maternal deaths that were examined at Inquest therefore represent at most 4.9% of all deaths associated with childbirth and at least 3.2%. The cases brought before the court were determined under the terms of the Registration of Births Deaths and Marriages Act of 1855, as those warranting official attention.[127]

In the early stages of the research it was intended to examine each of the ninety-one cases of maternal deaths and the forty-seven instances of neonatal deaths, but it became apparent that this was not a practicable strategy. The majority of Inquests for this period are on microfilm and some are absent from the collection. There were often lengthy periods spent in attempting to track down a particular Inquest only to find that it had "disappeared" from the collection or that, once accessed, it contained no details of the work of midwives or of the circumstances of the birth.

The archival documents represented a further challenge in that the accounts were handwritten and many of them were almost

126 Queensland Legislative Assembly, Votes and Proceedings, 1871-1872, p. 427. See also, SCQ for the year 1884, 25th Annual Report. See also, SCQ for the year 1890 And, SCQ for the year 1920 , Part VIII, Vital Statistics Table No. XVII.
127 *The Registration of Births Deaths and Marriages Act of 1855* (Vic.19, No.34).

indecipherable. It often required many hours of examination by magnifying glass to determine exactly what had taken place and a further period to analyse the account against other evidence that was emerging from parliamentary debates and medical journals. Appendix Two carries an example of an official record of the Inquest into the death of the newborn infant of Jane Glass that occurred in Fortitude Valley, Brisbane in 1870.[128] What this data began to show was that the unqualified midwife was a menace that needed to be contained. An important branch of the archival research therefore became focused on cases that might support or refute the criticisms being levelled at unqualified midwives by the medical profession and the state.

A total of twenty-eight cases that appeared before the coroner or magistrate have been included in this thesis. Each has been selected for the detail it provides in revealing and explaining the work of the lay midwife and the impromptu and informal nature of midwifery practice at that time. The location of the cases includes urban and rural areas and these are identified on the map of Queensland published in 1900 that appears as Appendix One.

The first six accounts that appear in Chapter Two highlight the role of relatives and neighbours acting as midwives as well as that of the experienced lay midwife. The ten testimonies contained in Chapter Four depict the most common causes attributed to maternal deaths and they act to indicate the midwifery response to the conditions treated by

[128] Appendix Two.

medical practitioners in Chapter Three. A further twelve accounts are discussed in Chapter Five and are employed to amplify the issue of negligence in the light of the population concerns faced by state governments.

The data collection identified only two midwives holding formal qualifications to practice. The first was Wilhemina Zingelmann who, in 1885 was working as a midwife in the Logan district of southeast Queensland.[129] Wilhemina was midwife to Hilda Sommer who died at home on 13th February from "Exhaustion after childbirth". In concluding her evidence Wilhemina stated that:

> I am a duly qualified midwife and produce a medical certificate issued in Berlin to that effect.[130]

The second midwife was Louisa Laidlow of Nambour who, in 1911 at the Inquest of Muriel May Fraser, identified herself as a "Certificated Ladies Nurse".[131]

Interpretation of the data

While it may be acknowledged that there are different ways of interpreting historical data and that the perspective adopted will affect the subsequent account, it is important not to lose sight of the significance that the written word carries. In writing this account of past midwifery practice, history is taken to be a progression in which past events are

129 QSA.,JUS/N115 85/79
130 Ibid.
131 QSA., JUS/N482 540/1911

connected to the present and to the future.[132] Carr has described this method as:

> …a continuous process of interaction between the historian and his (sic) facts, an unending dialogue between the present and the past.[133]

The process depends, as with all historical accounts, not only on the selection of the sources and an assessment of their validity, but also on the way the data are interpreted and presented. The facts themselves, like truths, are pliable and controversial commodities.

The *facts* that form the basis of this thesis have been selected from a range of primary sources for their potential to offer *one way* of understanding the role of lay midwifery practice in the culture of childbirth in Queensland. The account does not, therefore, claim to be based on universal truths or to offer a definitive interpretation. It is an account of the past that has been created by evaluating and re-evaluating the sources and by revisiting their interpretation as the process of writing has developed. This method places the historian precariously between fact and interpretation and requires a flexible approach to the sources. Carr has cautioned, "Study the historian before you begin to study the facts."[134] By this, he means to indicate that the management of historical events and the accumulation of facts are as much a product of the historian as of

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132 J. Tosh, *The Pursuit Of History: Aims Methods & New Directions In the Study Of Modern History, 2nd edition*, pp.63-67.
133 E. H. Carr, *What is History?* p.30.
134 Ibid., p 23.

the subject under investigation. As Carr points out:

> [Facts] are like fish swimming about in a vast and sometimes inaccessible ocean; and what the historian catches will depend, partly on chance, but mainly on what part of the ocean he (sic) chooses to fish in and what tackle he chooses to use - these two factors being, of course, determined by the kind of fish he (sic) wants to catch. [135]

In this way, the writers of history gather the data they believe to be the most supportive of their perspectives. This does not mean that the subsequent account will be flawed. In terms of source validity and reliability, the onus is on the writer to evaluate the sources and to justify their selection. This evaluation involves authentication of the source, assessment of the content, and testing of its reliability by searching out the intentions and prejudices of the writer.[136] In this way, the reader too, is expected to contribute to the process by identifying the ideological stance adopted and judging the viability of the content.

The presentation of the data

This thesis combines narration with analysis to produce an account that amplifies the social atmosphere in which the role of the midwife was located to recreate the past through links with the present. The subsequent account does not adhere to a strict chronology that is characteristic of the narrative. Instead, it concentrates on explaining the actions and interactions of the principal groups involved, taking into account the complexities associated with causality.[137] The process of elucidating connections between events in the context in which they

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135 Ibid..
136 J. Tosh, *The Pursuit Of History: Aims Methods & New Directions In The Study Of Modern History, 2nd edition*, pp.61-63.
137 E. H. Carr, *What is History?* pp.31-55.

occurred acknowledges the multifaceted nature of causation and the importance of social influences and forces that existed at the time. As Carr points out, while past events may have been actioned or enacted by individuals, those actions were affected both by the relationships between people in society and by the impact of society itself. The result is often quite different from the initial intention.[138]

In attempting to answer the question of why midwifery in Queensland arrived at its present point and *how* that point was reached, it is acknowledged that causation and consequence stem from the interpretation put upon them by the historian and, as such, are not accepted beyond doubt. The best the historical writer can hope achieve is a plausible account that is based on the sources and which explains the relative importance of the sources to each other and to the resultant interpretation. Carr suggests that in determining causation, it is important to identify long and short-term factors and to order the causes into a hierarchy based upon their relationship to one another.[139] That is what this thesis seeks to do.

Issues of validity and bias

The interpretations of the sources and the historiography I have employed have their roots in my social background and my beliefs, past and present. That background includes many years of work as a midwife and it was my experience of midwifery practice in Queensland that prompted me to begin the investigation. The notions I held at that time

138 Ibid., pp 87-108.
139 Ibid.

and the assumptions I made in the early part of the research have been modified and in some instances replaced. Windschuttle acknowledges this process as a normal part of historical method and he says of it:

> Although theories or values might inspire the origins of an historic project, in the end it is the evidence itself that determines what case it is possible to make.[140]

As the examination of primary sources continued, I was conscious of constantly re-evaluating the implications of those sources against my own beliefs and of modifying those beliefs accordingly. Carr has argued that, while total objectivity in historical writing is an impossible goal, once a writer is aware of the way in which individual attitudes may affect analysis the potential for bias is reduced, so that:

> …the historian who is most conscious of his own situation is also more capable of transcending it, and more capable of appreciating the essential nature of the differences between his own society and outlook and those of other periods and other countries…[141]

Tosh has put forward suggestions for achieving greater conformity amongst writers of history including the formulation of working hypotheses and the use of accurate contextualisation.[142] At the same time, he has conceded that:

> The nature of historical enquiry is such that, however rigorously professional the approach, there will always be plurality of interpretation.[143]

In writing this thesis, every attempt has been made to balance and objectify the evidence that has been presented. As Carr has cautioned, while the historian has the responsibility for offering an unbiased account,

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140 K. Windschuttle, *The Killing of History*, p. 246.
141 E. H. Carr, *What is History?* p.44.
142 J. Tosh, *The Pursuit of History: Aims, Methods, and New Directions in the Study of Modern History, 2nd edition*, pp.150-151.
143 Ibid., p.151.

the reader should be made aware of the background of the writer in order to be better placed to weigh existent preconceptions against the interpretation being offered. [144]

Organisation of the Thesis

Chapter One reviews the literature of childbirth and draws from it certain themes that frame the subsequent account. This chapter identifies the Report of the Royal Commission on the Decline of the Birth-Rate and on the Mortality of Infants in New South Wales, initiated by the New South Wales Legislative Assembly in 1903, as indicative of the issues that challenged the medical profession and the Queensland parliament in their deliberations regarding the regulation of midwives in Queensland.

Chapter Two explores the preconditions in which the midwifery role in Queensland developed. The chapter begins with an exploration of the role of midwife in its traditional, historical sense, before moving on to discuss the emergent role of midwife in the European settlements established in Australia. This chapter traces the foundations of the midwife role in New South Wales in 1788 as the precursor to the subsequent development of midwifery practice in Queensland. The characteristics of that practice are grounded in primary sources that demonstrate the informal and domestic nature of the lay midwife role during the study period.

Chapter Three traces the involvement of medical practitioners in childbirth and argues that the increasing presence of the medical

144 E. H. Carr, *What is History?* p.30.

profession brought about changes in the way that childbirth was conceptualised and practised. The chapter examines some of the common complications that impinged upon childbirth in the nineteenth century and suggests the types of remedies that medical practitioners might employ to treat them. The chapter acts also as a response to the comment frequently made by medical practitioners during coronial and magisterial Inquests that, had they been called in earlier, the life of the woman or infant might have saved life. Based on anecdotal accounts that were written by medical practitioners and submitted to medical journals during the closing years of the nineteenth century, this chapter evaluates the capacity of medical practitioners to make a difference to childbirth outcomes.

The medical profession came increasingly to perceive of childbirth as a medical event and its members were often critical of the practice of lay midwives. That criticism took the form of certain claims in relation to midwives that were voiced repeatedly by medical practitioners both in medical literature and in the form of evidence to the New South Wales Royal Commission. In the light of such claims, Chapter Four draws on testimonies submitted at Inquests into maternal and infant deaths to examine and evaluate the work of lay midwives in the latter half of the nineteenth century and the first decade of the twentieth century. The evidence portrays childbirth in Queensland through the eyes of midwives, mothers and husbands. These accounts

demonstrate the many variations of the midwifery role and highlight problems inherent within it.

Chapter Five employs archival testimonies to investigate cases where the mother or the infant, or both, died as a result of neglect. The claim of negligence arose in a number of cases that appeared before the coroner or magistrate. It was a claim that was directed sometimes at the woman herself and on other occasions at a person such as the husband or the midwife who was deemed to have failed to provide the woman with appropriate care during childbirth. On other occasions, neglect occurred in association with illegitimacy where the unmarried women was unsupported socially and unassisted practically.

Chapter Six argues that in order to limit the work of lay midwives, the medical profession sought to create a “midwifery nurse”, to be trained in the hospital institution along the model of the “trained nurse”. Moves to professionalise the role of the nurse, that had begun in the mid-nineteenth century, formed the bases on which the work of lay midwives was brought under statutory control. This chapter traces the processes that saw the elevation of nursing from lay practice to a respectable social role, one that was the product of the disciplined hospital environment and one that evolved under the watchful eye of the medical profession. When it came to regulating the work of midwives, the hospital assumed the function, not possible in domiciliary practice, of scrutinising and curtailing the midwifery role.

Chapter Seven reviews the options that presented themselves to medical practitioners and politicians in the pursuit of the regulation of the work of midwives. This chapter considers the medical and political debates that surrounded the issue of the regulation of midwives and explores the processes by which midwives were brought under state and medical control. The debates highlight the divisions in medical circles and related concerns over the licensing of midwives by the medical profession. The chapter considers in detail the rules that were applied to midwives with effect from March 1912 and appraises the means by which the scope of midwifery practice was brought within the confines of the hospital institution and, ultimately, the medical practitioner. The concluding chapter consolidates the arguments for and against the regulation of midwives in 1912 and evaluates the impact that midwifery registration may have had on the subsequent role of the midwife in Queensland.

This thesis has employed the male gender when referring to medical practitioners. The first female medical practitioner in Queensland, Lilian Cooper, was registered in June 1891.[145] The second woman, Eleanor Greenham, gained registration in May 1901.[146] By 1912, a total of eighteen women were registered compared with three hundred and

145 L. Cazalar, "Lilian Violet Cooper 1861-1947 Queensland's First Female Medical Practitioner". In *Women in History: Places of Purpose*, (Brisbane: The Australian Institute for Women's Research and Policy, Griffith University, 1994), pp.82-91.
146 L. Williams, "A Pioneer not a Traditionalist: The life and work of Dr. Eleanor Greenham". In *Women in History: Places of Purpose*, pp.24-29.

thirty three men practitioners.[147] Seven of these women became registered practitioners between 1910 and 1911. Of the remainder, one registered each year between 1902 and 1909 with the exception of 1907 when no woman practitioner registered and 1903 and 1905 when two received registration.

147 QGG, (Thursday, 4 January, 1912, No.4, Vol. XCVIII), pp.7-14.

CHAPTER ONE

A FRAMEWORK FOR ANALYSIS

The key to an understanding any period of history
lies in the discovery of its major shaping forces.[1]

This chapter constructs a framework within which the research question is analysed. The chapter reviews theoretical themes that emerge from the literature to argue that the changes taking place in western society and in western thought during the nineteenth century culminated in a redefining of childbirth culture and the role of the midwife. The chapter isolates social and political factors that influenced the redefinition of childbirth and postulates that, in the process of its reappraisal, childbirth came ultimately to be construed as a problematic medical condition that both necessitated and justified the greater involvement of the medical profession within it. The context in which this occurred saw childbirth become a public event for which first, philanthropically motivated members of the middle class and later the state, assumed increasing responsibility. The purpose of this chapter, then, is to establish those factors that combined to enable and sustain the changes to childbirth culture and to the role of the midwife as they manifested in Australia and specifically in Queensland.

The chapter postulates that when the First Fleet landed in Sydney Cove in January 1788,[2] childbirth practices in Britain and Europe, the geographical areas that were to exert the greatest influence on Australia's

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1 Immanuel C.Y. Hsü, *The Rise of Modern China, 3rd edition*, (Hong Kong: Oxford University Press, 1983), p.7.

social, political and economic development throughout the nineteenth century had already begun to change. Intrinsic to that change was the interest that medical practitioners were taking in midwifery practice and their increasing involvement in childbirth. The foremost contribution that medicine made to childbirth at this time was to redefine it as a sinister event and to understand it according to a calendar of ailments that required medical intervention.

The acceptance of male practitioners as childbirth experts came about as a result of a number of coexisting factors that worked, for the most part unwittingly, to propel childbirth towards its redefinition as a medical specialty. Those factors include the emergence of a new class system in which, in the industrialised capitalist world that promoted and sustained it, male dominated professional classes and a new working class materialised. The context in which medical practitioners and midwives practised was fundamentally changed and medical knowledge, invested with social and scientific authority, attained pre-eminence. Important also to capitalist ideals was the perpetual need to populate and thus to provide the state with the basic economic unit upon which capitalist production was based; human labour. The chapter develops these and other themes to structure the subsequent account.

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2 F.A. Crowley, *A Documentary History of Australia Volume I: Colonial Australia 1788–1840*, (Victoria: Nelson, 1980), p.1.

The traditional midwife role

In Britain and Europe, the midwife role developed over centuries and was based upon the conceptualisation of childbirth as being a normal part of life and one that was essentially the business of women.[3] In Britain and Europe, midwifery was a skilled occupation often undertaken by literate women who attained their competence through lengthy apprenticeships. The literature attributes to these women certain general characteristics that distinguished them and identified them as members of a specialised group.[4]

First, the majority were mature women who had begun to practice midwifery once their own children had grown up. In Haarlem, Holland, where midwives had been subject to formal examination since 1694, the minimum age at which the examination could be taken was thirty years.[5] In Italy, new midwives were usually drawn from the family so that the skills that had been learned and developed might be passed on to a daughter, a niece, a sister, or perhaps a daughter-in-law, from within the mesh of an extended family network.[6]

However, exceptions existed, such as Eleanor Willoughy who began practising as a midwife in England in 1654 at the age of fifteen and who continued in this capacity until she married; the childless midwife Justine Siegemund of Prussia who practised in the late seventeenth century; and the midwife teacher Madam du Coudray who

3 A. Rich, *Of Woman Born: Motherhood as Experience and Institution,* (London: VIAGRO, 1976) pp.128–297.
4 H. Marland, (ed) *The Art of Midwifery: Early Modern Midwives in Europe*, (London: Routledge, 1993), p.4.
5 Ibid., p.197.
6 N. M., Filippini, "The Church, the State and Childbirth: The Midwife in Italy during the Eighteenth Century. In H. Marland, (ed) *The Art of Midwifery: Early Modern Midwives in Europe*, p.154.

taught midwifery throughout France in the 1760s was unmarried and never bore children.[7] Gélis, discussing the image of the ideal midwife in eighteenth century France, maintains that availability was also a factor in selecting a midwife.[8] He argues that both parturient women and local women entrusted with the task of employing a midwife, valued a woman who was able to commit herself to her work without the distraction of family or other responsibilities.

Second, many midwives received an apprenticeship system of training that might be either formal or informal. For example, in 1743 a midwife from Manchester, England, spent three years in an apprenticeship for which she paid eight guineas in tuition fees.[9] In seventeenth century London, unofficial apprenticeship systems were in place in which a senior midwife acted as teacher and role model.[10] Harley maintains that during this period in British and European history, midwifery was regarded as a skill rather than a trade.[11] There were instances where midwives from England travelled to the Hôtel Dieu in Paris to receive instruction in anatomy and during the eighteenth century some London midwives sought access to instruction that was available in certain London hospitals.[12]

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7 C. McClive, "The Hidden Truths of the Belly: The Uncertainties of Pregnancy in Early Modern Europe", *The Society for the Social History of Medicine*, (Vol.15, No. 2, 2002), pp.209-213.
8 J. Gélis, *History of Childbirth: Fertility, Pregnancy and Birth in Early Modern Europe*, Translated by Rosemary Morris, (Cambridge: Polity Press, 1991), pp.104-105.
9 D. Harley, "Provincial Midwives in England: Lancashire and Cheshire", 1660-1760. In H. Marland, (ed) *The Art of Midwifery: Early Modern Midwives in Europe*, p.28.
10 D. Evenden, "Mothers and their Midwives in Seventeenth-Century London". In H. Marland, (ed) *The Art of Midwifery: Early Modern Midwives in Europe*, p.9.
11 D. Harley, "Provincial Midwives in England: Lancashire and Cheshire", 1660-1760. In H. Marland, (ed) *The Art of Midwifery: Early Modern Midwives in Europe*, p.28.
12 Ibid., p.28.

Third, midwives were often the wives of tradesmen or farmers and therefore from a middle strata in society whereby their fees made a helpful contribution to the family revenue. Variations in this characteristic extended to either end of the social spectrum with some midwives being wealthy and educated while others were poor and illiterate.[13] Evenden found that many London midwives were affluent, of high social standing and neither poor nor ill informed.[14] Her examination of sixteenth and seventeenth century archival sources found that a feature of the work of midwives in Britain was their dependence on personal referral from women who had been satisfied with the care they had received during childbirth. This satisfaction was the basis upon which complex and long-term friendship developed between midwives and their clients.[15] Similarly, the testimonials produced by midwives in support of their claims to practice derived from women they had attended in childbirth.

It is apparent from Evenden's research that midwives in England dealt with women from all social classes and, on many occasions, the women who testified to the midwives competence were "wives of gentlemen" including apothecaries, clergymen, surgeons, and aristocrats.[16] It seems that midwives were able to breach social divisions to accrue a diverse clientele and, in some cases, considerable wealth. In 1662, twenty-four midwives presented the sworn testimony of one hundred and forty-two clients in support of their applications, over sixty

13 H. Marland, (ed) *The Art of Midwifery: Early Modern Midwives in Europe,* p.4.
14 D. Evenden, "Mothers and their Midwives in Seventeenth-Century London". In H. Marland, (ed) *The Art of Midwifery: Early Modern Midwives in Europe*, p.4.
15 Ibid., p.10.
16 Ibid., pp.16-19.

percent of which represented "repeat business".[17] The account book of one midwife indicates that, during the period 1694 to 1723, she attended a total of six hundred and seventy-six women.[18]

Thomas, in his exploration of the life of the midwife Bridget Hodgson of York, supports the contention that the occupation of midwifery offered women both good social status and a reputable means of earning a living.[19] The social role of the midwife extended to acting as senior godparent to infants they helped birth and participating in selecting a name for the child. Thomas traced four goddaughters to Bridget, all of whom were named after her and which, he maintains, acted as "…a series of living monuments to herself".[20] As Thomas points out, the appointment of a woman as midwife signified a trust in her capacity to assist the family to perpetuate itself. When that selection came from a wealthy family it confirmed the midwife's social role and elevated her status above that of her peers.[21]

Throughout the continent of Europe it became common practice for midwives to receive training and to be licensed by state or local government, with the result that they were accorded ready recognition as skilled practitioners and were acclaimed for their expertise.[22] Perkins, in her study of the French midwife, Louise Bourgeois, argues that, in France during the sixteenth and seventeenth centuries "the" midwife did not exist, but rather it was a title that described a variety of

17 Ibid., p.10.
18 Ibid., p.11.
19 S. S. Thomas, "Midwifery and Society in Restoration York", *Social History of Medicine*, (Vol. 16, No. 1, 2003), pp.1-16.
20 Ibid., p.9.
21 Ibid.
22 I. Loudon, *Death in Childbirth: An international study of maternal care and maternal mortality 1800 – 1950*, (Oxford: Clarendon Press, 1992), p. 424.

women and diverse occupational territories.[23] Perkins explains that while in some communities a number of women might adopt the role of midwives on an irregular basis, in others one woman might emerge as an expert and trusted practitioner and it would be she who would act as midwife. There were also instances where midwives had been formally trained and might be contracted to practice on an annual basis, while in other circumstances, the midwife might be an independent and transient practitioner endorsed by the Church and the municipality in which she worked.[24]

McClive, in her discussion of the different perceptions of the prenatal period that women and physicians held in early modern Europe, highlights the importance of midwives as expert witnesses.[25] Drawing on contemporaneous accounts, McClive cites an incident that occurred in Paris in 1665 when a pregnant woman was publicly hanged.[26] The woman had pleaded mitigation on the grounds that she was pregnant, an appeal that, under the custom of Roman law, would have been heeded had pregnancy been confirmed.[27] However, despite having been examined by two midwives, "'no sign of pregnancy'" was found.[28] When the body was later dissected and a four-month foetus was discovered the public outcry that followed extended to horror among the medical and legal professions that was still evident a century later. The midwives

23 W. Perkins, *Midwifery and Medicine in Early Modern France: Louise Bourgeois*, (Devon: University of Exeter Press, 1996), pp.1-2.
24 Ibid.
25 C. McClive, "The Hidden Truths of the Belly: The Uncertainties of Pregnancy in Early Modern Europe", *The Society for the Social History of Medicine*, (Vol.15, No. 2, 2002), pp.209-213.
26 Ibid., pp.209-210.
27 Ibid., p.212.
28 Ibid., p..213.

concerned were discharged of their duties and prohibited from working in the capacity of midwife again.[29] During this period, either a certified midwife or an officially trained surgeon might testify as an expert witness.[30]

Midwives also made a significant contribution to the body of midwifery knowledge in the seventeenth and eighteenth centuries. *Observations*, written in 1621 by the renowned French midwife Louise Bourgeois held equivalence with contemporary medical literature.[31] Fifty years later in 1671, The *Midwives Book* was published by English midwife Jane Sharp, and has been criticised by Donnison as relying too much on prevalent superstitions, although nonetheless useful for its practical approach.[32] Lay, in her appraisal of the knowledge and practice of early midwives disagrees, pointing to the thorough anatomical descriptions provided by Jane Sharp and applauding her non-interventionist approach to childbirth.[33] Lloyd also sees much value in this text. In a paper that discusses man-midwives in the eighteenth century, Lloyd includes the work of Jane Sharp with those of Percival Willugby's *Observations in Midwifery,* and Peter Chamberlen's, *Dr. Chamberlain's Midwifes Practice,* all of which she considers to be "outstanding".[34]

In 1737, another English midwife, Sarah Stone, produced *A Complete Practice of Midwifery* that included discussion of neonatal

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29 Ibid.
30 Ibid., p..217.
31 J. Donnison, *Midwives and Medical Men: A History of the Struggle for the Control of Childbirth,* (Hertfordshire: Heinemann Publications, 1988), p.28.
32 Ibid., pp.27-28
33 M. M. Lay, *The Rhetoric of Midwifery: Gender, Knowledge, and Power*, (New Jersey: Rutgers University Press, 2000), pp.45-48.
34 J. M. Lloyd, "The 'Languid Child' and the Eighteenth-Century Man-Midwife", *Bulletin of the History of Medicine*, (75, 2001), pp.648-649.

resuscitation measures and the management of babies damaged physically by the process of birth.[35] A little under a quarter of a century later, in 1760, Elizabeth Nihell produced a treatise condemning birth instruments on the grounds that they were often unwarranted and the cause of birth injuries that might otherwise not have been sustained.[36] Arguing that the hand was more discerning in diagnosis and treatment of complicated labour than the forceps, Nihell demonstrated sound skill that was the result of attendance as midwife at nine hundred births.[37] Both Nihell and Sharp acknowledged the differences in medical and midwifery approaches and, although disapproving of medicine's reliance on instruments, showed a tolerance of the medical attitude towards childbirth. Nevertheless, medical men were far more prolific writers and their texts assisted the dissemination and sharing of topical information amongst a group of practitioners who were gaining increasing acceptance for their expertise.[38]

The practice of midwifery by women continued to dominate childbirth throughout the eighteenth and nineteenth centuries. Loudon, in an international study of maternal mortality during the period 1800 to 1950, found that by the 1880s, midwives were a significant presence in the culture of childbirth in England and Wales.[39] At this time there were approximately 890,000 births of which something in the region of one per

35 Ibid., pp.652-655.
36 M. M. Lay, *The Rhetoric of Midwifery: Gender, Knowledge, and Power*, pp.43-50-51. See also, J. Donnison, *Midwives and Medical Men: A History of the Struggle for the Control of Childbirth*, pp.34-52.
37 M. M. Lay, *The Rhetoric of Midwifery: Gender, Knowledge, and Power* , p.52.
38 J. M. Lloyd, "The 'Languid Child' and the Eighteenth-Century Man-Midwife",pp.641-679.
39 I. Loudon, *Death in Childbirth: An international study of maternal care and maternal mortality 1800 – 1950*, p.177.

cent occurred in Poor Law hospitals and less than half a percent in voluntary hospitals. The remaining 878,000 births took place in the home and were divided between medical practitioners and midwives with 450,000 being attributed to doctors and 420,000 to midwives.[40]

Medical participation in childbirth: man-midwives

The involvement of men midwives in childbirth and their eventual ascendancy over all aspects of a sphere that had historically been the affair of women first emerged in the thirteenth century.[41] Towler and Bramall argue that it was the moves on the part of barber surgeons to establish occupational boundaries for themselves that heralded the diminution of the role of women midwives and their eventual capitulation as principal childbirth practitioners. Barber surgeons were lay people who had become skilled in the use of instruments that they used to treat certain illnesses and to manage obstructed childbirth.[42] At first, women were able to obtain apprenticeships and gain membership of barber surgeon guilds, but in time women were excluded from the guilds and this effectively acted to retain their work as an amateur occupation.

The barber surgeon guilds worked both to professionalise the occupation of the barber surgeon and to curtail the practice of other healers in their domain. This restriction of practice occurred through agreements with regional controllers to ensure that barber surgeons, who were members of the guild, received exclusive rights to practice in

40 Ibid.
41 J. Towler, J. Bramall, *Midwives in History and Society*, (Surry Hills, NSW:Croom Helm, 1986), pp.10-19.
42 Ibid., pp.13–15.

that area.[43] The establishment of universities and guilds to teach and control healing practices, combined with moves by the Church to curtail the involvement of women as healers, eventually began to erode the position of women as midwives.[44] The minimisation of the midwife role that ensued was associated with a corresponding increase in the acceptance of men, not merely as practitioners in childbirth, but as specialists in the birthing process.

Tatlock, discussing a sixteenth century illustration that appeared in Germany in a handbook of midwifery, offers an insightful interpretation of the role played by male attendants in childbirth.[45] The illustration portrays the act of birthing. Two women midwives are in attendance and they receive the child from beneath the woman's skirt. To the right and in the background are two men. They sit, facing away from the birthing scene and look toward the stars. The crux of Tatlock's observation is that women's contribution to childbirth is undervalued in comparison with that of men. Women's tendency to undertake the mundane but essential aspects of childbirth is pitched against men's preoccupation with the more abstract elements of this new life's existence.

The argument has been put that women midwives once held positions of considerable power and that the man midwife employed unscrupulous means to usurp them.[46] The contention is made that the

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43 Ibid., p.14.
44 Ibid., p.13.
45 L. Tatlock, "Speculum Feminarum: Gendered Perspective on Obstetrics and Gynecology in Early Modern Germany", *SIGNS,* (Summer 1992), pp.725-760.
46 A. Rich, *Of Woman Born: Motherhood as Experience and Institution.* See Also, J. Towler, J. Bramall, *Midwives in History and Society*. And, J. Donnison, *Midwives and Medical Men: A History of the Struggle for the Control of Childbirth.*

role of the male accoucheur was based upon techniques developed by women midwives and that the man midwife repeatedly used knowledge gained from female midwives to promote his own best interests.[47] Further, male midwives wrote books whose theoretical structure derived from premises developed by midwives. They employed drugs and potions that had been discovered and utilised by midwives for centuries. It was therefore on the basis of stolen wisdom that the male accoucheur replaced the midwife as the principal birth attendant and promoted himself to a position of authority over her.

However, the contention that physicians became expert by default and that their knowledge originated from midwives in the first instance,[48] is not supported by evidence. Indeed, there is nothing to suggest that midwives in any society ever held positions of real power. Whatever status their work as midwives afforded them it was always inferior to men and to physicians.[49] Although midwives were generally the principal birth attendants, the continuance of their practice depended upon the goodwill and magnanimity of the physician.[50] Even in the early civilisations of Egypt, Greece and Rome, physicians exercised the right to determine the parameters of midwives' participation in childbirth and to insist that midwives worked under the proviso that the physician would be consulted in circumstances of complex childbirth or when unforeseen complications developed during labour.[51]

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47 A. Rich, *Of Woman Born: Motherhood as Experience and Institution,* pp.130-139.
48 Ibid., pp.128–297.
49 J. Towler, J. Bramall, *Midwives in History and Society* pp.10-19.
50 Ibid.,pp.12-16.
51 Ibid.,pp.7-15. See also, A. Rich, *Of Woman Born: Motherhood as Experience and Institution* pp.131-133.

Lloyd, in her evaluation of the contribution made by the eighteenth century man midwife, portrays men who, for the most part, were imbued with Christian virtues and high moral standards.[52] Humbled by the burden of divine responsibility he perceived had been placed upon him, the man midwife concentrated first on preserving the life of the parturient woman and later on restoring the health of the languid neonate.[53] Lloyd's assertion that the English man midwife William Hey, "…saw the death of a baby more as a failure of the medical techniques he could offer than as the will of God…" [54] if true of others, might suggest an important principle on which man midwifery was based. This altruistic viewpoint acts to refute those who accuse the man midwife of *taking from* the traditional midwife in order to further his own selfish objectives or professional ideals. Instead, the man midwife and his successors are positioned as disciples of humankind whose prime motivation was *to give* and *to serve*.

Lloyd maintains that midwifery texts published by male and female midwives in the seventeenth century identify two priorities as being foremost in the minds of *all* midwives. The first was the delivery of a living child and the second the treatment of physical trauma caused by the birth itself.[55] She concludes that while skilled midwives were able to make a contribution to the welfare of the newborn at birth, it was the man midwife who had endowed himself not only with the ability to "deliver" the child but also to "preserve its life".[56] Whatever the basis of his knowledge and by

52 J. M. Lloyd, "The 'Languid Child' and the Eighteenth-Century Man-Midwife", (75, 2001), pp.641-679.
53 Ibid., pp.643-645.
54 Ibid., p.647.
55 Ibid., p.648.
56 Ibid., p.679.

whatever means he acquired his skill, the man midwife was making an important contribution to childbirth.

Among the theories that have been offered to explain the acceptance of men as midwives and their consequent influence on the culture of childbirth, gender and class and the concomitant concepts of inequality and dominance inform compelling interpretations that are underpinned by the broader issues associated with patriarchy and capitalism.[57] At the same time, any attempt to analyse the changes that were taking place in the culture of childbirth and the role of the midwife in western societies cannot fail to take into account the dynamic nature of social interaction and social thought.

Capitalism

Wilson attributes the altered ideology of childbirth that facilitated the acceptance of men in the birth room, to the transition from agrarian to industrial society and the associated changes in social organisation.[58] Wilson argues that, in Britain, the greater presence of men in childbirth was neither the result of fashion nor the availability of obstetric forceps, but was the aftermath of the breakdown of neighbourhood networks that were a feature of village life. Whereas, in pre-industrial societies, two midwives and a group of local women acting as birth attendants cared for the woman during her labour, as an aftermath of industrialization, women were more likely to have to rely upon strangers.

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57 E. Willis, *Medical Dominance: The Division of Labour in Australian Health Care*, (St. Leonards New South Wales: Allen & Unwin, 1989), pp.92-124.
58 A. Wilson, *The Making of Man-Midwifery: Childbirth in England, 1660-1770,* (Massachusetts: Harvard University Press, 1995), p.4.

In the vast urban areas that were emerging, women worked outside the home and many were regulated by factory hours. In such circumstances, attendance by an unknown midwife at home or in the hospital became acceptable and facilitated the extension of midwifery practice to men.[59] Once the closeness of family and village life had been compromised, traditional values and rituals became neglected and were replaced with other values and rituals more suitable to the new lifestyles.[60] Arguing that it was childbirth traditions that empowered women, Wilson believes that the transference of power from a women's collective to the medical field of men reduced the authority of the midwife role. Wilson explains this transition in the following terms:

> …the traditional role of the midwife was embedded in the collective culture of women. It was the ceremony of childbirth that conferred authority on the midwife; the mother's personal choice extended only to the selection of which midwife, of those locally available, would deliver her. What gave the ritual itself its immense power was the collective female authority, which transcended the whims and wishes of the individual mother…[61]

The ensuing fragmentation of the once strong and united female culture was, according to Wilson, the turning point in the history of the woman midwife.

The erosion of the female collective brought with it a diversity that had hitherto been absent. That diversity was expressed in the formation of a middle class and a complex female culture. The women of this newly formed class were literate and had the wealth and leisure hours to indulge themselves and their ideas. The overall effect, Wilson argues, was a class of women who could afford to experiment with the innovations of the industrial age. These women began to see childbirth

59 Ibid., pp..205-206.
60 Ibid., p.4.
61 Ibid., p.185.

in a different light and to reject its association with inevitable pain and occasionally death. As a consequence of this altered perception, these women increasingly sought the services of the modern men midwives in preference to the traditional, old fashioned, women midwives.[62]

The emergent middle-class

The notion of class as a defining factor in the medical take over of childbirth and the concept of two types of childbirth services that are dependent on social status and financial means are taken up by Litoff.[63] Litoff identifies a pattern of medical intervention in childbirth and the consequent downfall of the American midwife early in the twentieth century that has become familiar to the literature on childbirth. The core components of medical professionalism; the preference exhibited by middle class women to consult with the obstetric specialist rather than the midwife; and the limitation of the scope of midwifery practice by means of legislation, are all present in the midwifery history of North America.[64]

Ehrenreich and English agree that the wealthy female middle class assisted the ascendency of the medical practitioner in their adherence to what the authors have termed, “the cult of female invalidism” that stemmed from boredom and was enhanced by an ability to pay for medical services.[65] Denouncing the notion of women as a class that stood alone, Ehrenreich and English argue that there was never one uniform class of women.[66] There were, they maintain, two divergent

62 Ibid.,pp.185-192.
63 J. B. Litoff, *The American Midwife Debate: A Sourcebook on its Modern Origins*, (New York: Greenwood Press, 1986).
64 Ibid.,pp.4-26.
65 B. Ehrenreich, D. English, *Complaints and Disorders: The Sexual Politics of Sickness*, (New York: The Feminist Press, 1973), pp.11-18.
66 Ibid., p.11.

groups that shared the same gender but little else. Class divided these groups rather than defining them and the basis of that division was wealth and social standing or the absence thereof.[67] Ehrenreich and English argue that engendered power disequilibrium was the root cause of women's oppression by medical science and that this came about on the basis of the sharing or withholding of knowledge.[68] The medical profession, through its specialist knowledge and expertise, forced women to seek out the benefit of medical opinion and in this way, robbed them of control of their own bodies.

Tew brings the argument back to the social aspirations of the nineteenth century and to the middle and upper class values whereby the successful man was expected to have a wife who was delicate and refined.[69] Tew believes that there was an expectation that these women needed a doctor to take charge of them and to help them through childbirth. Highlighting the paternal nature of the medical role and the collusion of medical practitioner and childbearing woman as factors that assisted changes to childbirth, Tew argues:

> It was as though doctors were saying 'Let us of the stronger sex overcome your difficulties for you', while the midwives were saying, 'Let us of the same sex support you while you overcome your own difficulties, which most of you are well able to do'. The leisured ladies preferred the doctors' option.[70]

These notions are in keeping with fatherly concern whereby the husband makes provision for his wife and the doctor takes charge of his patient. They are concepts that promote the controlling influence of the male

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67 Ibid., pp.11-14.
68 Ibid., pp.5 & 83-89.
69 M. Tew*, Safer Childbirth? A Critical History of Maternity Care, 2nd edition,* pp.40-54.
70 Ibid., p. 45.

medical practitioner over women as patients and extend to the broader sphere of the medical role in control over women as midwives.

Reiger makes a similar observation in her analysis of childbirth in Australia during the period 1880 to 1930 when she argues that the rise in the popularity of obstetrics cannot be reduced solely to conscious intention on the part of the medical profession. Instead, Reiger sees changes to childbirth practices as a two way process in which interaction between medical practitioners and women worked, without intention, to achieve this end. Reiger has observed that:

> Doctors' motivation combined compassion arising out of their practical experience with a general taken-for granted paternalism towards females.[71]

At the same time, women contributed to those changes by seeking out hospital care and anaesthesia. One reason that Reiger identifies as instrumental in bringing about change on the part of women is the connotation attached to the concept of being pregnant. In arguing that women were conditioned to see pregnancy as a "time of trouble" and to refer to it as "the difficulty", Reiger points out that social etiquette required behaviour modification that changed women's whole lifestyles at a time in history when women were quite ignorant of the processes of change that their bodies were going through.[72]

Reiger attributes the accord with which women met these changes to a lack of understanding of reproduction and the processes of childbearing. Additionally, once childbirth came to be looked upon as a medical condition, it moved out of the realm of women and into the

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71 K. M. Reiger, *The Disenchantment of the Home: Modernizing the Australian Family 1880-1940,* (Melbourne: Oxford University Press, 1985), p. 84.
72 Ibid., pp.84-87.

province of medicine. Women were faced with the choice of a midwife whose power in the birth room was limited by educational constraints and lack of access to treatments that might facilitate the birth, or a medical practitioner who had available to him all the facilities the midwife lacked. When faced with such a choice, the middle and upper class woman and her family were unlikely to opt for the midwife.[73]

Huff, from her examination of diaries of women residing in Britain and giving birth during the nineteenth century, came to a similar conclusion. The women whose diaries Huff explored were predominantly middle class and two of them were from the upper class.[74] These women regarded pregnancy, childbirth and the puerperium as a sickness.[75] While the origins of these ideas are not revealed in the diaries, they indicate that these women were more likely to obtain the services of a medical practitioner than a midwife. Women were disposed to think of childbirth as an affliction and to respond with gratitude to the paternalistic attitude of the medical man.

Leavitt, in her study of childbirth history in North America, found that changes in women's own attitudes towards childbirth during the nineteenth century were a major contributor to the involvement of medical practitioners in the birth room.[76] That involvement marked a drastic change to childbirth culture in which childbirth, as a "woman-centred home event" became a "hospital-centred medical event".[77] Leavitt

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73 Ibid., pp.102-103.
74 C. A. Huff, "Chronicles of Confinements: Reactions to Childbirth in British Women's Diaries" *Women's Studies International Forum,* (Vol. 10, No.1. 1987), p.63.
75 Ibid., p.69.
76 J. W. Leavitt, *Brought to Bed: Childbearing in America 1750 to 1950,* (New York: Oxford University Press, 1986).
77 Ibid., p.5.

explains that in the first fifty years of European settlement in North America, women employed midwives but, at the same time, surrounded themselves with friends and neighbours to succour them through the trials of childbirth.[78]

Leavitt argues that, prior to the nineteenth century, the role of the midwife in North America was traditional and non-interventionist in a culture in which childbirth was a social function whereby women shared all aspects of the birth experience and worked alongside the midwife to provide care that often extended into weeks after the birth.[79] It was a culture in which an "ideology of domesticity and nurturance" prevailed.[80] Leavitt maintains that the origins of the increasing presence of the physician in birth rooms in North America stemmed from women's fear of death or debility associated with childbirth and their concomitant willingness to trial childbirth analgesia.[81] She argues that women were definitive manipulators of change that they, as a group, considered to be advantageous to them.[82] It was this body of women that allowed the physician into the birth room and assisted the rise of obstetrics as a childbirth specialty. That speciality was associated with the concept that "modern" childbirth should take place in a hospital and should replace the "old fashioned" practice of giving birth to babies in the home with all its outmoded rituals and customs.[83]

78 Ibid., pp.13- 35.
79 Ibid., p.38.
80 Ibid., p.34.
81 Ibid., pp.116-170.
82 Ibid., pp.58-63.
83 Ibid., pp.171-179.

The accelerated involvement of male practitioners in childbirth that began in the eighteenth century, coincided with advances in science and technology that altered the way in which medicine was viewed from both inside and outside its own clinical and philosophical parameters.[84] As obstetric forceps and anaesthesia became available to counter the duration and pain of labour, childbirth came increasingly to be perceived of as an illness.[85] The reconceptualisation of childbirth as an ailment that required treatment from a medical expert was a precondition both to the takeover of midwifery by medical practitioners and to the encroachment of the state in women's reproductive lives.

Changes in medical practice and social thought

A precursor to the changes taking place in traditional childbirth practices was the growing conceptualisation of childbirth as a science. Although medical men had been a presence in the culture of childbirth for centuries, their involvement became pervasive in the seventeenth century when the medical discipline of obstetrics began to insinuate itself into the realm of normal childbirth.[86] The participation of the medical man was no longer quiet and subtle and his previously infrequent visits to the birth room increased. The developments in medical science, both ideological and empirical, lay the foundation for changes that were to permeate societies throughout the western world. As Abel-Smith points out, health and illness came increasingly to be perceived as a consequence of physiology and environment rather than

84 Ibid, p.4.
85 J. W. Leavitt, *Brought to Bed: Childbearing in America 1750 to 1950*.
86 A. Wilson*, The Making of Man-Midwifery: Childbirth in England, 1660-1770,* p.4.

as an act of God.[87] When science became legitimised every facet of life was viewed as a scientific phenomena rather than the consequence of divine intent.

Caton attributes the greater dependence on medicine and medical treatments to a revolution in the practice of medicine that began in France in the 1830s.[88] He argues that drastic change occurred in medical theory and practice that involved more complex techniques than had hitherto been employed. These innovations represented a break from the Galenic methods that had underpinned medical thought up until the late eighteenth century. So rapid was the change prompted by French medical schools that it was a period when the application of leaches and the practice of bleeding, procedures commonly promoted in the treatment of ailments as diverse as headaches and toxaemia of pregnancy, were practised alongside the administration of ether.[89] It was at this time that clinical conditions came under greater and more precise scrutiny and documentation and instruments were being developed to study and measure what was being observed.[90]

Martin has reached similar conclusions with regard to the influence of French medical schools on the ideology and practice of medicine in western societies.[91] Arguing that the French influence on childbirth began earlier than the 1830s, Martin maintains that it was in seventeenth and eighteenth century France that the body came to be

87 B. Abel-Smith, *A History of the Nursing Profession,* p.1.
88 D. Caton, *What a Blessing She Had Chloroform: The Medical and Social Response to the Pain of Childbirth from 1800 to the Present,* (New Haven: Yale University, 1999), pp.39-50.
89 Ibid., pp.46-50
90 Ibid., p.47.
91 E. Martin, *The Woman in the Body: A Cultural Analysis of Reproduction*, (Boston: Beacon Press, 1989).

viewed as a machine. The consequence of that conceptualisation was that the uterus was portrayed as a mechanical pump whose function was to expel the foetus.[92] The medical practitioner was the mechanic with the responsibility to ensure the good functioning of the unit and the best possible outcome.

The emergence of a 'medical model' of childbirth

When male practitioners began to take an interest in childbirth they brought with them a method of interpreting and understanding that was quite different from that of the midwife. O'Brien argues that the distinction that exists between "modern obstetrics" and "ancient midwifery" derives from the different views that men and women hold towards reproduction.[93] While the obstetrician sees reproduction as an objective science that is unilinear and mechanistic, women's appreciation of it is deeper and more diverse. The obstetrician's conceptualisation of childbirth as an imperfect mechanism that may require intervention is discordant with the view that reproduction is a natural process and essentially a normal life event.[94] These divergent views on childbirth are representative of secular ideologies that, Wagner argues, in the twentieth century came to reflect opposing models of health.[95]

Drawing an analogy between the reproductive woman and a machine, Wagner positions the obstetrician as a leader in the design and utilisation of the technology upon which the smooth running of this

92 Ibid., pp.54-57.
93 M. O'Brien, *The Politics of Reproduction,* (London: Routledge & Kegan Paul, 1981), pp.46-47.
94 R. M. Bryar, *Theory for Midwifery Practice,* (London: Macmillan, 1995) pp.104-125
95 M. Wagner, *Pursuing the Birth Machine,* p.6.

"birth machine" has become dependent.[96] But the machine itself is conceptualised differently by the two primary ideologies that exist in relation to health. Wagner believes that the medical profession sees the body as a potential problem and health as a state that is only achievable with help from outside of the body.[97] Implicit within this view of health is the notion that any deviation from a normal state needs correcting and that the onus is on the medical profession to achieve that objective. Wagner defines this conceptualisation as a medical model of health.[98]

When Wagner's viewpoint is applied to childbirth, the medical model describes birth in terms of a medical problem.[99] The problem is exacerbated by the unpredictable nature of childbirth and the inherent imperfections of a "birth machine" that may malfunction at any time. The only chance to counter this unpredictability and to offset the delicacy of the machine is to apply medical intervention at an early stage and to monitor and manage the birth process until its completion. Wagner succinctly summarises his notion of the medical model in the following passage:

> From this world view, safety – a healthy woman and baby – can only be guaranteed by such a system, in which the doctor objectively chooses the best course. The woman is viewed as subjective, and unable to comprehend the medical and scientific intricacies involved in the decision. It is best, of course, if the woman feels good and is satisfied with the care she receives during pregnancy and birth, but her feelings are regarded as less important than her safety and that of her baby.[100]

96Ibid., pp.9-25.
97 Ibid., p.28.
98 Ibid., p.28.
99 Ibid.,p.30.
100 Ibid.,p.31.

The observations made by Wagner provide an explanation of the motivations of the medicine profession in the practice of obstetrics, one that is generally absent in medical literature. The medical profession has tended not to discuss its own views on childbirth and has left it to others, usually those who are challenging that presence, to describe the medical role.

As Wagner argues, the medical model has dominated to the extent that its strategies alone are considered responsible for reductions in maternal and infant mortality. Wagner points out, however, that the conditions responsible for the largest proportion of deaths in childbirth in the nineteenth century were the spread of puerperal sepsis and toxaemia of pregnancy.[101] The remedies for these conditions lay in hand washing to prevent the spread of infection and in appropriate diet and rest for the treatment of toxaemia that was diagnosed in its early state. In the twentieth century, improvements in the form of better nutrition and housing, advances in public health and fewer pregnancies, have contributed to healthier women and therefore to lower childbirth mortalities.[102]

However, twentieth century improvements in childbirth outcomes for women and their neonates, at least in terms of mortality, that have come to be associated with medical advance have been questioned as have the social and psychological effects that the medicalisation of childbirth may have on women. The most radical views are expressed in terms of male supremacy in the form of medical power over women

101 Ibid.,pp.30-31.
102 Ibid.,p.40.

in general and midwives in particular.[103] This perspective sees dominance as an insidious process that is characterised by the increasing presence of the male medical practitioner in the realm of childbirth with the result that the ownership of reproduction has been transferred from women and women's circles to medical practitioners and the medical profession.[104]

An opposing viewpoint understands enhancement in the sphere of medical knowledge as a taken-for-granted improvement and one that does not necessitate deliberation upon the broader social and psychological impact.[105] It is a standpoint that is often apparent in language rather than argument and it is one that the medical profession generally sees no reason to defend. Medical involvement in childbirth is seen as a positive and timely step in the course of human and medical progress.[106] Furthermore, the training of midwives and the change of birth venue from the home to the hospital are looked upon as logical consequences of enhanced medical knowledge.[107] Thus, the control of childbirth that ensued is seen to have been a right and inevitable consequence that placed the medical profession in a position to manage childbirth in the manner that, it believed, would achieve the optimal outcome for mother and child.

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103 B. Ehrenreich, D. English, *Complaints and Disorders: The Sexual Politics of Sickness.*
104 M. O'Brien, *The Politics of Reproduction,* pp.1-64.
105 J. Pearn, (ed) *Pioneer Medicine in Australia,* (Brisbane: Amphion Press, 1988).
106 R. Patrick, *The Royal Women's Hospital, Brisbane - The First Fifty Years*, (Brisbane: Boolarong, 1988). See also, H. Gregory, *A Tradition of Care: A History of Nursing at the Royal Brisbane Hospital*, (Brisbane: Boolarong Publications, 1988). And, R. Longhurst, *In the Footsteps of the Mercies: A History of the Mater Misericordiae Public Hospitals.*
107 J. Revitt, (ed) *With Courage and Devotion: A History of Midwifery in New South Wales* (New South Wales: Anvil Press, 1984).

Regulating the medical profession

An important factor in the dominant position forged by medical practitioners relates to their credibility as experts in the various specialties they adopted as their own. During the mid-nineteenth century, medical practitioners in Britain and Australia responded to the perceived need to professionalise their sphere of practice in order to consolidate and strengthen their individual and collective positions. Three Medical Acts, that progressively enabled medical practitioners to enhance their occupational status and delineate their professional boundaries, guided the professionalisation process that followed. These Acts are discussed in greater depth in Chapter Three. The first of them, the Medical Act of 1858 represented an attempt to organise medical practitioners into a formal body of workers.[108] Under the terms of this Act, a Council was established to monitor medical education and compile a list of those registered to practice.[109]

Parkinson, in his history of the legal traditions upon which Australian law was based in the first two hundred years of European settlement, draws attention to the legal framework that existed at that time.[110] Parkinson emphasises that Australian law was the product of the seven centuries that had shaped British law so that when Governor Phillip's was required to establish courts in the new colony he did so according to the current British law system.[111] Even when representative governments emerged in Australia in the mid-nineteenth

108 *Medical Act [1858].*
109 *The Medical Act [1858*].
110 P. Parkinson, *Tradition and Change in Australian Law, 2nd edition*, (Sydney: LBC Information Services, 2001).
111 Ibid., p.3.

century, the legal institutions were expressed through Acts of Parliament derived directly from Westminster. Parkinson has summarised this legal framework in the following terms:

> …the tradition of law in Australia is received rather than indigenous, the product of evolution not of revolution, and monocultural rather than multicultural.[112]

The reduction in the power of Westminster to determine the statutory prerogatives of Australia did not diminish until the first decade of the twentieth century when the States Constitutional Act of 1907 discouraged the Australian states from deferring to the Westminster parliament before passing Bills.[113] Thus, when the Medical Acts came into effect in the second half of the nineteenth century, they replicated those that had been passed in Britain and other colonies of its Empire.

The role of the medical practitioner in Australia prior to the Medical Act of 1858 held a certain ambiguity in that while some doctors were perceived to be competent and highly regarded, others were described in less favourable terms. As Crowley points out in his discussion of early medical practitioners, it was not customary to subject these men to scrutiny and relatively little is therefore known about them.[114] Crowley cites an article in the *Hobart Town Magazine* published in 1834 that casts medical practitioners as inept and ignorant, its author calling for the establishment of a Medical Board to assess their qualifications and supervise their practice.[115] In July 1844, an article in *The Times* categorised medical practitioners as university-educated professionals

112 Ibid.
113 Ibid., pp.138-140.
114 F. A. Crowley, F.A *Documentary History of Australia Volume 1: Colonial Australia 1788-1840*, (Victoria: Nelson, 1980), pp.458-459.
115 Ibid.

who were less able to secure employment than tradespeople, whose expertise was in greater demand.[116]

During the period 1852 to 1853 in the goldfields of Melbourne and Sydney, doctors practised from tents that they set up alongside those of butchers and grocers. These men offered prospectors cures for the illnesses that were the result of exposure to harsh climatic conditions and from the consequences of poorly prepared food.[117] Crowley cites William Howitt who, in 1855, wrote of his experiences in the Victorian goldfields. He describes medical men who practiced without formal qualifications and who charged large fees for their work. Calling them, "arrant and impudent quacks", Howitt bemoaned the lack of effective monitoring and inspection that he believed would have limited the occupational activities of these men.[118]

The second Act, the Medical Act of 1867 was designed to consolidate the practice of medical practitioners, chemists and druggists.[119] This Act provided for the founding of a Medical Board in Queensland that would hold a register of those entitled by qualification to follow the occupation of medicine or pharmacy. Membership of the Board was open exclusively to medical practitioners, thus ensuring that occupational directives remained within the profession.[120] This Act also made provision for medical practitioners to act as experts on subjects associated or aligned with medicine.[121] The medical practitioner as expert

116 Crowley, F. *A Documentary History of Australia Volume 2: Colonial Australia 1841- 1874*, (Victoria: Nelson, 1980), pp. 60-61.
117 Ibid., pp.214-215 & 233-235.
118 Ibid., pp.244-245.
119 *Medical Act of 1867*.
120 Ibid., Sections 1-3.
121 Ibid., Sections 12-13.

witness is demonstrated in the coronial and magisterial documents that feature in this thesis.

The third Act is, arguably, of greatest significance to this thesis in that this, the Medical Act of 1886, required the medical practitioner to have experience in midwifery in order to gain his medical qualification.[122] The defining of medical expertise according the three basic areas of medicine, surgery and midwifery is of importance both to the progress of medical development and to the increasing reliance placed upon the hospital in the furtherance of medical knowledge and practice. Once a framework for medical practice had been identified, it enabled greater consolidation of medical knowledge within discrete clinical areas and, at the same time, assisted the emergence of other more specialist spheres within them. The medical profession thus provided itself with the opportunity to monopolise the study and treatment of illness and the clinical manifestations of it.

Weisz, in his evaluation of the emergence and regulation of medical specialities in France in the first half of the twentieth century, links the interest in creating discrete areas of medical specialty with moves to construct boundaries to regulate and monitor them. Weisz maintains that the mid-1880s was the point at which medical specialisation began to accelerate.[123] By 1905, thirty-five percent of all medical practitioners in Paris were specialists in a field of medical practice.[124] Weisz argues that, consequent upon the specialisation fervour that was evident in western

122 *Medical Act, 1886*. *49 & 50 Vict. c.48*.
123 G. Weisz, "Regulating Specialties in France during the First Half of the Twentieth Century" *Social History of Medicine*, (Vol. 15, No. 3, 2002), p.457.
124 Ibid, pp.457-461.

societies during the late nineteenth century was the perceived need to certify the credentials of specialists and to regulate their practice. This came, Weisz contends, at a time when the medical profession was promoting widespread regulation and licensing. By the first decade of the twentieth century the issue of specialist regulation had become caught up in moves to define the professional boundaries of medicine in order to preserve medical territory and to ensure that the specialties were provided with hospitals and medical schools in which they might be nurtured and perpetuated.[125]

Borst concurs that specialist medicine was an important factor in the development of medicine as a profession. Borst points to the greater dependence placed on medical schools and hospitals in furthering the promotion of specialties.[126] In discussing obstetric training in the United States in the first half of the twentieth century, Borst argues that medical educators were seeking out hospital patients as early as the 1870s and by the 1890s prominent medical professors were calling for a structured participation program for medical students in which they might be actively engaged in patient management.[127]

While the long term effects of medical professionalisation and the extension of medical practice into areas that had previously lay unclaimed by the medical profession were yet to be streamlined, when medical legislation was introduced in Australia it acted not only to raise the standards of medical practice, but also to unify medical practitioners into a

125 Ibid., p.461.
126 C. Borst, "Teaching Obstetrics at Home: Medical Schools and Home Delivery Services in the First Half of the Twentieth Century", *Bulletin of the History of Medicine*, (72. 2, 1998), pp.220-245.
127 Ibid., p.220.

collective body.[128] The professionalisation process to which the medical profession subjected itself in the second half of the nineteenth century is viewed by Willis as the first of three actions that facilitated its dominance over other health occupations.[129] The second and third levels, the exercise of authority over associate health occupations[130] and patronage by the state,[131] are features of this thesis.

Pro-natalism and the need to populate

An important factor that supported the ascendency of medical practitioners in the sphere of childbirth was a perceived necessity on the part of nation states to boost their populations through infant life. During the eighteenth century, a pro-natalist movement spread across Europe and in the nineteenth and twentieth centuries extended to Britain[132] and Australia.[133] At the basis of pro-natalism was the need to provide manpower to protect national and regional boundaries.[134] The plagues that had debilitated the populations of Europe from the fourteenth century were exacerbated in the seventeenth and eighteenth centuries by wars and their aftermath.[135] The imperative to populate was an objective that was strengthened by an imperialistic fervour that

128 E. Willis, *Medical Dominance: The Division of Labour in Australian Health Care*, p.104
129 Ibid., pp.8-19.
130 Ibid., p.17.
131 Ibid., pp.18-20.
132 J. Donnison, *Midwives and Medical Men: A History of the Struggle for the Control of Childbirth*, p.51.
133 ORDLCA) Vol. XCVI, p.1652.
134 J. Donnison, *Midwives and Medical Men: A History of the Struggle for the Control of Childbirth,* p.51.
135 S.J. Lee, *Aspects of European History 1494-1789, 2nd edition*, (London: Routledge, 1984), pp.85-91.

saw smaller and weaker societies engulfed by nations that were politically and economically stronger.[136]

Australia, as a colony of Britain, adopted British concerns and emulated British policies, including a drive towards increasing its population through reproduction.[137] By the early twentieth century, Australia's primary stimulus for promoting population growth derived from a perceived threat of invasion from the countries of Asia.[138] As Mackinnon points out in her discussion of government population policies in early twentieth century, birth rates were considered to be representative of national well being and government attention naturally turned to maternal and infant health in the first instance.[139] Mackinnon maintains that the primary purpose of subsequent policies was to meet government population objectives and she argues that:

> The growth of maternal and child health services needs to be viewed in this perspective as first and foremost (though not exclusively) a population policy and not an intervention for the intrinsic benefit of women and children. Professionals became involved and, gradually, the population objectives diminished and the interventions were viewed as public goods in their own right.[140]

Coincidentally, it was at this time that Australian states and members of the medical profession became stakeholders in childbirth in a partnership that reflected changing social attitudes and expectations that had begun to emerge a century before.

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136 B. Waller, (ed) *Themes in Modern European History 1830-1890*, (London: Unwin Hyman, 1990), pp.273-288.
137 ORDLCA, Vol. XCVI*,* 1905, p.1652.
138 S. Macintyre, *A Concise History of Australia*, (Cambridge: University Press,1999), pp.140-142.
139 A. Mackinnon, "'Bringing the Unclothed Migrant into the World': Population Policiies and Gender in Twentieth-Century Australia", *Journal of Population Research,* (Vol. 17, No. 2, 2000), pp.109-123.
140 Ibid., p.112.

The increasing presence of medicine and politics in a sphere that had previously been dominated by midwives was facilitated by the collective power these factions of prestigious men held in a strongly patriarchal society. It was a society that relied upon working class women to provide the population upon which the economic wealth of the country depended. But women's contribution to population growth was conditional; women were expected to give birth in wedlock and there was little provision for those who delivered an illegitimate child.[141] The family unit became of such importance, both as a perpetual source of labour and as a means of promoting the interests of a white Australia, that the state was moved to intervene in the processes of childbirth and in the regulation of midwives.[142] The escalated presence of the medical practitioner as an expert in childbirth and the greater interest shown by the state in the reproductive aspects of women's lives, were inevitable responses to social change and to a political environment that sought to preserve its British heritage.

The state and childbirth

While medicine may claim a long and continued association with childbirth, the state has been just as solid a participant. The concepts of the state and of state power are central to the analysis that underpins this thesis. Historically, the involvement of the state in the affairs of midwives had its origins in the Church, which, from the fifth century

141 P. Grimshaw, M. Lake, A. McGrath, M. Quartly, *Creating a Nation*, (Victoria: McPhee Gribble, 1994, pp.205-208.
142 RCDBR, Vols. I & II.

onward, held ever-increasing control over all social institutions.[143] By the twelfth century, Roman Catholicism was the formal religion recognised by most of the populations of Western Europe and it used its capacity as a political system to control the reproductive culture of women.[144] Church leaders were amongst some of the most affluent men in the country and held the mechanisms of state firmly in their grasp.[145]

As Goodrich points out, the Church was the only organised literate body and as such represented the division between the scholarly elite and the illiterate crowd.[146] Bishops and principal abbots, whose ownership of large areas of land assured them political power and legal supremacy, officiated at courts of law that the Church had established. In England, ecclesiastical courts dictated the religious and moral behaviour of the people and trained and supervised the scribes used in the chancellery and the royal courts. It was from this ecclesiastical class that the first chancellors, royal judges and legal drafters were drawn.[147]

The influence of the Church in shaping the role of the midwife continued until the sixteenth century when, under the inspiration of agitators such as Luther in Germany and Calvin in Switzerland and assisted by the innovation of the printing press, the power of the Catholic

143 P. Goodrich, "Literacy and the Languages of the Early Common Law", *Journal of Law and Society*, (No. 14. 1987), pp.426-427.
144 J. Donnison, *Midwives and Medical Men: A History of the Struggle for the Control of Childbirth,* pp.11-52.
145 P. Goodrich, "Literacy and the Languages of the Early Common Law", p.431.
146 Ibid., pp.426-427.
147 Ibid., p.431.

Church began to decline.[148] By the end of the sixteenth century, when the development of centralised states assisted the replacement of Church power with state power,[149] control of childbirth moved from the Church to the modern state. Until that time, the Church provided midwives with a framework for practice and a schedule of ordained rituals and ceremonies. In Munich in 1488, midwives regularly performed baptisms in circumstances in which they believed the newly born child was unlikely to survive.[150] By 1585, so many baptisms had been undertaken by midwives that it became necessary in Stuttgart and its provinces for midwives to be instructed in the act of baptism by their parish priest.[151] In Italy, when the power of religion as a social control began to wane in the sixteenth century and states assumed control of midwifery practice, their decisions and judgements were based on principles that had been founded by the Church.[152]

The Church was also active in initiating the licensing of midwives, an innovation initially begun by the Church and later adopted by states. In Britain, in 1512, midwives had to apply to the Church for a licence to practice and would receive one only after close investigation and upon the formal swearing of an oath to obey the Church's rules for the conduct of midwives.[153] In 1686, new licensing rules in Britain authorised midwives

148 S.J. Lee, *Aspects of European History 1494-1789, 2nd edition,* pp.1-17.
149 Ibid., pp.1-17.
150 M. E. Wiesner, "The Midwives of South Germany and the Public/Private Dichotomy". In H. Marland, (ed) *The Art of Midwifery: Early Modern Midwives in Europe,* (London: Routledge, 1993), p.85.
151 Ibid., p.85.
152 N. M. Filippini, "The Church, the State and Childbirth: The Midwife in Italy during the Eighteenth Century". In H. Marland, (ed) *The Art of Midwifery: Early Modern Midwives in Europe,* pp.161-162.
153 J. Donnison, *Midwives and Medical Men: A History of the Struggle to Control Childbirth,* pp.18-19.

to perform baptisms and arrange for the burial of infants in the absence of a priest.[154] Across Europe, from the fifteenth century, the trend developed for midwives to be licensed by the municipal council and examined for competency by physicians. In Germany, midwives completed a one-year apprenticeship before presenting themselves to the City Council to be examined for proficiency by a city physician.[155] From the late fifteenth or early sixteenth century, ”honourable women” judged midwives for their moral and ethical values while physicians tested their clinical acumen. Wiesner points out that these physicians are unlikely to have witnessed a live birth whereas midwives would have assisted in hundreds of birthings.[156]

In Denmark, legislation enacted in 1714 set a pattern for the midwife role that extended for the next two hundred years.[157] Under the terms of this special Act, midwives were required to be apprenticed and were examined for competency by a Board of Midwifery comprised of a select body of physicians and sworn in by the local authority.[158] In France in 1745, a midwife completed a three-year apprenticeship followed by examination supervised by a city surgeon.[159] In Spain, midwives fell within the jurisdiction and supervision of physicians, but they were not examined

154 Ibid., pp.236-237.
155 M. E. Wiesner, ”The Midwives of South Germany and the Public/Private Dichotomy”. In H. Marland, (ed) *The Art of Midwifery: Early Modern Midwives in Europe,* p.82.
156 Ibid., p.82.
157 A. Løkke, “The ‘antiseptic’ Transformation of Danish Midwives, 1860-1920”. In H. Marland, A. M. Rafferty, *Midwives, Society and Childbirth: Debates and Controversies in the Modern Period,* pp.104-105.
158 Ibid., p.104.
159 N. Gelbart, ”Midwife to a Nation: Mme du Coudray Serves France”. In H. Marland, (ed) *The Art of Midwifery: Early Modern Midwives in Europe,* p.133.

for competency.[160] A very different situation existed in the Netherlands where, by 1763, a large group of trained and licensed midwives had already been formed.[161] Marland argues that at a time when the role of midwives in Europe was said to have been in decline, this group of expert practitioners worked in hospital and home environments. Employed by the town or municipality, the midwives practiced under the direction of the local authority and the medical fraternity.[162]

The state in Australia

The origins of state and government in Australia derive from an authoritarian organisation whose primary focus lay in determining and promoting the best interests of the state and the public and private elites within it.[163] The basis of state power, according to Davis, Wanna and Warhurst, thus derived from cooperation between business and politics whereby the economic growth of the settlement took precedence over individual civil rights and equity. The result, as these authors point out, was a relatively high degree of state involvement in Australia whereby the state was responsible for grouping together and overseeing the productive forces upon which the new society was built.[164]

State involvement was based on the categorisation of Australia as a "settled" colony. This term defined an area of land acquired without the

160 T. Ortiz, "From Hegemony to Subordination: Midwives in Early Modern Spain". In H. Marland, (ed) *The Art of Midwifery: Early Modern Midwives in Europe,* pp.98-99.
161 H. Marland, "The 'burgerlijke' Midwife: the Stadsvroedvrouw of Eighteenth-Century Holland". In H. Marland, (ed) *The Art of Midwifery: Early Modern Midwives in Europe,* pp.192-213.
162 Ibid., pp.192-193.
163 G. Davis, J. Wanna, J. Warhurst, P. Weller, *Public Policy in Australia,* (New South Wales: Allan & Unwin, 1988), pp.27-28.
164 Ibid., p.15.

use of force and without relinquishment by treaty.[165] It was land obtained through claim and one not previously inhabited by British subjects or governed by British laws. According to this categorisation, British law was automatically applicable and supplemented by legislation specifically designed for Australia that initially derived from Britain and later from the Legislative Councils. The concept of "state" in Australia therefore came to be aligned with a rigid and controlling organisation that worked with principal private interest groups to control the economy.[166] The relationship between public and private elites on the one hand and colonial administrators on the other brought about a system of government that served the best interests of the dominant social groups while at the same time underwriting state sovereignty.[167] Through its instrumentalist position, the state represented a bureaucratic structure that combined with various powerful interest groups to achieve the joint objective of economic and social control.

In 1859, the division of New South Wales and Queensland marked the establishment of the sixth separate colony within Australia.[168] As Waugh has observed, although each Australian colony had its own constitution, those constitutions originated from Britain where the decisive power and authority lay.[169] The overriding power of Westminster to determine the course of political, social and economic development in Australia was manifest in the control that each state held to direct and

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165 J. Waugh, *The Rules: An Introduction to the Australian Constitutions,* (Melbourne: University Press, Victoria, 1996), p.4.
166 G. Davis, J. Wanna, J. Warhurst, P. Weller, *Public Policy in Australia,* p.28.
167 Ibid., p.28.
168 J. Waugh, *The Rules: An Introduction to the Australian Constitution,* p.22.
169 Ibid., pp.7-8.

oversee its development. The degree of state involvement constituted activist input in all aspects of national development. While industrialisation has been blamed for breaching the culture of the extended family and the female supportive networks they contained, the working class that emerged represented fiscal wealth on the one hand and social rather than family responsibility on the other.

Connell and Irving argue that, in Australia, the working class forged a subculture that was based upon community ties and cultural dependence.[170] The working class ethos that emerged was evident in both rural areas, where the economic emphasis was on primary production, and in the commercial centres that characterised Australia's urbanised areas, until well into the 1920s.[171] It was a culture that was easily identifiable and one that the state sought to contain through policies that integrated working class ideals and promoted them as essential to the common good.[172] That integration was manifest in a variety of ways, including state expansion into welfare, education and legal systems.[173] The result was hegemony rather than domination that enabled the creation of interclass relationships that sustained the notion of subordination while at the same time, embodying working-class interests.[174]

Queensland parliamentary debates in the first decade of the twentieth century indicate that the involvement of the state in the private

170 R.W. Connell, T.H. Irving, *Class Structure in Australian History: Poverty and Progress, 2nd edition*, (Melbourne: Longman Cheshire, 1992), p.127.
171 Ibid., pp.126-127.
172 Ibid., pp.137-152.
173 Ibid., pp.14-20.
174 Ibid., pp.18-19.

affairs of its population extended to reproduction.[175] The commitment of state governments to the protection of the potential labour force that childbirth promised was manifest in the infant life protection legislation that emerged during the first decade of the twentieth century.[176] When state intervention was combined with the power of a leading interest group such as medicine, the result could be nothing other than effective. Willis points out that a capitalist society relies upon the cooperation of financially powerful individuals or groups to sustain it and further its economic ideals. He locates the medical profession as an elite group within an intermediary class located between the working class and the upper class.[177]

Willis argues that the medical profession, in keeping with other liberal professions, was able to attain a position of power by providing an expert service unmatched by others and held in high regard by the state.[178] Willis contends that not only was the medical profession strongly aligned with the state by virtue of the class of its members, but that medicine's claim to being a profession further legitimised it as a formidable force within the health care arena and enabled it to dominate.[179] Medicine's relationship with the state has been mutually rewarding in that the one has interacted with the other to bring about joint objectives.

The power of the medical profession and the state was reinforced by a social structure that continually undervalued women. The

175 ORDLCA, *Vol. XCVI*, p.1652.
176 *Infant Life Protection Act*, (5 Edw. VII. No. 19).
177 E. Willis, *Medical Dominance: The Division of Labour in Australian Health Care,* pp.8-17.
178 R. Theobald, *Understanding Industrial Society,* (Hampshire U.K: The Macmillan Press, 1994), p.54.
179 E. Willis, *Medical Dominance: The Division of Labour in Australian Health Care* pp.8-15.

subordination of women was reinforced by a lack of acknowledgement of their existence outside the patriarchal family so that in the evidence submitted to coronial and magisterial inquiries, women introduced themselves as "wife of" in order to define themselves. In the same way, women were excluded from political activity in Queensland until the twentieth century. Although women in Queensland were entitled to vote in federal elections in 1902 and state elections in 1905,[180] there is no indication that they were a credible political force. In comparison, men who met certain criteria, that being, financially secure, over the age of twenty-one and either born in Australia or naturalised citizens approved by the British state, had been entitled to vote since 1859.[181]

The economic value of the family unit and infant life

A commonality shared by the state and the medical profession was the conceptualisation of the family unit as a source of economic wealth and social stability. Theobald has identified that in pre-capitalist societies the family unit and economic activity were interdependent.[182] In its simplest form, the family represented the basic unit of production.[183] However, as Showstack Sasson points out, in post-industrial societies the family unit became a source of labour power and as such attracted the interest of the state.[184] State intervention in domestic affairs was therefore the normal consequence of a process in which the family constituted one

180 J. Haines, *Suffrage to Sufferance: 100 years of Women in Politics*, (New South Wales: Allen & Unwin, 1992), p.51.
181 *Statistics of Queensland for December, 1859*, (QSA, Blue Book, 1859-1860), p.24.
182 R. Theobald, *Understanding Industrial Society: A Sociological Guide,* pp.70-94.
183 Ibid., p.70.
184 A. Showstack Sasson, "Introduction: The Personal and the Intellectual, Fragments and Order, International Trends and National Specificities". In A. Showstack Sasson (ed) *Women and the State: The Shifting Boundaries of Public and Private,* (London: Hutchinson, 1987), p.18.

part of a whole productive force. The constituents of that force were so entwined that none of them might be isolated from the other so that family, production, civil and state mechanisms were interwoven and interdependent. According to Turnaturi, the result has been that the state, in its attempts to counter the changes that industrialisation brought to the family unit, was prepared to at first instigate policies and then to modify them in order to maintain the family unit as a functioning source of labour and therefore capitalist wealth.[185] The family unit was also important to the medical profession whose members in the community regarded family practice as a continued and reliable means of remuneration for professional services to it.[186]

The joint significance that the family held as a source of immediate income on the one hand and a continual supply of ongoing labour on the other acted as imperatives to both medicine and the state in their quest to protect this valuable resource. Deacon concurs with this viewpoint, arguing that in Australia in the first three decades of the twentieth century, motherhood became an important state commodity.[187] Support comes also from Finch who maintains that, during the nineteenth and early twentieth centuries, the medical profession in Australia instigated campaigns against midwives that were later implemented by the state.[188]

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185 G. Turnaturi, "Between Public and Private: The Birth of the Professional Housewife and the Female Consumer". In A. Showstack Sasson (ed) *Women and the State: The Shifting Boundaries of Public and Private,* pp.255-261.
186 Anon. "A Meeting of the Medical Profession: Midwifery Nurses' Bill", *AMG* (Nov. 21), pp.482-483.
187 D. Deacon, "Taylorism in the Home: The Medical Profession, the Infant Welfare Movement and the Deskilling of Women", *ANZJS*, (Vol. 21, No. 2, July 1985), pp.161-173.
188 L. M. Finch, "Sexuality and the Working Class: An Australian Case Study", *Unpublished PhD Thesis*, (University of Queensland, 1992), pp.166–173.

Finch contends that the state used the propaganda of falling birth rates to justify a ruthless campaign to increase the white population of Australia by encouraging relentless childbirth and that it began by targeting working class women as the group most likely to consult with nurses and midwives rather than doctors.[189] The state, Finch argues, contrived to take over the responsibility for motherhood by moving it from the private sphere of the home into the public arena of the hospital.[190] This manipulation of motherhood brought about a decline in the role and status of midwives in New South Wales and changed, irrevocably, the childbirth culture in which they worked.[191] In Queensland, a substantive work by Selby draws similar conclusions.

Selby argues that, in the early twentieth century, medicine and the state forged a partnership that changed the culture of childbirth in Queensland.[192] Selby, who draws upon oral histories to depict the experiences of women who gave birth in Queensland during the period 1915 to 1957, argues that the state policies implemented in Queensland during this period were designed to move childbirth into the institution of the hospital and away from the territory of the home. This strategy, instigated under the provisions of the Maternity Act of 1922, had the effect of bringing about a decrease in the work of midwives in the home and a consequential increase in their presence in the hospital.[193]

The domination of childbirth and of the work of midwives, contrived by the medical profession and supported by the state, reflects

189 Ibid., pp.166–173.
190 Ibid., pp.167–203.
191 Ibid.
192 W. Selby, ”Motherhood in Labor’s Queensland, 1815-1957”.
193 Ibid., pp.143-174.

the findings of Summers in her investigation of the impact of the registration of midwives in South Australia.[194] Summers argues that those members of the medical profession who advocated the registration of midwives did so in order to reduce the scope of midwifery practice because its popularity with women was a source of competition to medicine. The medical profession used the impetus created by nurses in their quest to achieve professional status to push forward state legislation that would curtail the practice of midwives.[195]

Willis also argues that the subordination of midwives was an essential strategy to the attainment of control over labour power.[196] Willis maintains that a crucial factor in the subjugation of midwives was their gender, but it was not the only factor. Class played an important part in the controlling processes and the combination of gender and class enabled a dominance based on subordination.[197] That subordination was enhanced by what Willis calls the "genderisation of medicine" which defines a campaign whereby the midwife was defiled as a "Sairey Gamp" and her occupational activities were subsequently curtailed through restrictive statutory regulations.[198]

Medicine and the state in Australia in the early twentieth century

As the literature has indicated, the combination of expert medical advice and the authority of state power were prominent features of childbirth culture in Australia during the early twentieth century. The

194 A. Summers, '"For I Have Ever So Much More Faith in her Ability as a Nurse:' The Eclipse of the Community Midwife in South Australia 1836–1942".
195 Ibid., pp.198-221.
196 E. Willis, *Medical Dominance: The Division of Labour in Australian Health Care,* pp.92-93.
197 Ibid., pp. 122-123.
198 E. Willis, *Medical Dominance: The Division of Labour in Australian Health Care,* p.123.

collegiality shared by medical practitioners and politicians, and their intentions with regard to reproduction, is evident in the Report of the New South Wales Royal Commission.[199] Although the Inquiry was held in New South Wales, it took evidence from other states of Australia and from countries overseas, and its relevance extended to Queensland.[200] It is apparent from Queensland parliamentary debates that took place between 1900 and 1911 that the experiences of other states in Australia, and of New Zealand and Britain, exerted a strong influence on the deliberations that ensued.[201] In particular, the debates that underpinned the Queensland Infant Life Protection Act of 1905 and the Health Act Amendment Act of 1911 depict the same problems and solutions that had appeared in the New South Wales Royal Commission Report.[202]

The mandate of the Royal Commission acts as an expression of faith in the powers of the exclusively male agency to get to the roots of the problem. The Board was entrusted with the following task:

> …to make a diligent and full inquiry into the causes which have contributed to the decline in the birth-rate of New South Wales, and the effects of the restriction of child-bearing upon the well-being of the community.[203]

The Commission received one hundred and fifteen submissions including fourteen from representatives of pharmaceutical companies, nine from wholesale chemists, twenty seven from medical practitioners, nine from

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199 RCDBR, Vols. I & II.
200 RCDBR, "Evidence of Statisticians" & Vol. II, "Index to Witnesses", pp.9-21.
201 ORDLCA, *during the Third Session of the Thirteenth Parliament, 64 VictoriÆ, Comprising the Period from the Seventeenth of July A.D. 1900 to the Twenty-Eighth of December, A.D. 1900,* Vol, LXXXIV, pp.223-245. See also, ORDLCA, Vol. XCVI, 1905, pp.1652-1663.
202 ORDLCA, Vol. CVIII, 1912, pp.512-541, 724-737. See also, ORDLCA, *during the Third Session of the Fifteenth Parliament, 5 Edward VII,* Vol. XCV, 1905, pp.509-513, 881-882, 974-975.
203 RCDBR, Vol. I, iii.

statisticians, eight from ministers of religion of various denominations, eight from benevolent agencies, and five from police.[204] A "monthly nurse" and "a married lady, one of the general public" provided a woman's perspective. Four other women acted as witnesses and these were, an "ex lady officer of Salvation Army", a saleswoman and two matrons of children's homes.[205] A barrister-at-law, engaged as an Associate to the Commission, provided context to the evidence with an overview of international literature on topics such as, the work of midwives, the significance of declining birth rates to the populations of Britain and the United States and issues concerning social economy.[206]

As the title of the Commission suggests, the aim of the Inquiry was to determine the causes of population decline and infant mortality. A significant cause of population decline was the perceived reluctance on the part of women to give birth. Drawing on medical evidence the Commission noted that:

> There is a remarkable unanimity of opinion among the medical men, who are perhaps better able to judge than any other persons in a community, that deliberate interference with the function of procreation has during recent years become extremely common.[207]

This interference with procreation included the use of contraceptive devices and termination of pregnancy through abortion and extended to neglect in childbirth and wilful or accidental infanticide.[208] The Royal Commission concluded that a major contributing element to this list of causes was, "decay in religious sentiment or moral feeling".[209] To the

204 Ibid., pp.2-5.
205 RCDBR, Vol. II, pp.9-21.
206 Ibid., pp.18-19.
207 RCDBR, Vol. I, p.14 (71).
208 Ibid.,pp..30-36.
209 RCDBR, Vol. II, p.87 (2891).

state, large families held more than simply economic value; they provided the basis of moral and social stability and control.[210]

The family unit was looked upon as a reflection of the patriarchal organisation of the state. Large families were preferred because they were considered to be better able to inculcate the individual to accept responsibility within the unit, to work for the greater good of the unit and to defer to the hierarchical structure upon which the unit was organised.[211] Women of the middle and working classes were isolated as being the most likely to limit family size, the former by means of contraception and the latter by abortion, and it became important to the state to discover ways by which this trend might be halted or reversed.[212] The state looked to the medical profession and the Church for answers. The medical profession was quick to draw an association between contraception and abortion and a resultant sterility and even neuroticism and insanity in women, while the Church blamed limitation of family size on reckless disregard of duty and moral obligation that, one witness asserted, was tantamount to murder.[213]

Evidence submitted to the Royal Commission suggested that, while the disinclination to bear children originated with the "well-to-do classes", it was a trend that was rapidly spreading to the working classes.[214] Allen, in her appraisal of the social practices that impacted upon population decrease in New South Wales in the late nineteenth and early twentieth centuries, argues that declining birth rates were a direct

210 RCDBR, Vol. I, pp.26-30.
211 Ibid., p.28.
212 RCDBR, Vol. II, pp.88-93.
213 RCDBR, Vol. I, pp.18-30.
214 RCDBR, Vol. II, p.71.

consequence of the decision on the part of working class women to limit family size.[215] Allen sees this as a latent challenge on the part of women to relieve themselves of what she terms, "the biological reproduction and childcare imposed on them by patriarchal gender relations and the sexual division of labour within the family".[216]According to Connell and Irving, by the 1890s, the Australian working class collective posed a challenge to political objectives that rendered state intervention in working class lives inevitable. Connell and Irving contend that:

> State intervention rested on the argument that the working-class community was the seat of dangerous moral contagion, which arose, so the scientists said, from the poor physical conditions of working-class life.[217]

As a result, the state became involved in *providing for* the working class in the way that the state deemed appropriate. This provision included the health, welfare and education of the working classes. Not, as Connell and Irving argue, to liberate this class, but to control and manage it.[218] This is a persuasive argument that is borne out, to a large extent, by both primary and secondary sources, including the decisive 1904 Royal Commission Report that went to considerable lengths to determine ways in which childbirth amongst the working classes might be encouraged and facilitated.[219]

The Royal Commission heard that working class wages were so low that men were often unable to support themselves, much less a

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215 J. Allen, "Octavius Beale Reconsidered: Infanticide, Babyfarming and Abortion in NSW 1880-1939, In Sydney Labour History Group, *What Rough Beast" The State and Social Order in Australian History*, (Sydney: George Allen & Unwin, 1982), pp.111-129.
216 Ibid., p.112.
217 R.W. Connell, T.H. Irving, *Class Structure in Australian History: Poverty and Progress 2nd edition,* p.140.
218 Ibid., pp.1-41.
219 RCDBR, Vol.II, p.91 (2999).

family.[220] The average wage for a general labourer had fallen from £2 to only 15s. or £1 per week in urban areas and in rural areas men were receiving around 15s. a week on average.[221] Faced with such economic hardship, working class women were likely to employ any means available to them to limit family size, while those whose pregnancies terminated in childbirth were relying on untrained midwives to assist them.[222] A trained midwife charged in the region of £2. 2s. a week, an amount clearly prohibitive for many working class women, whereas to call upon a friend or a neighbour would cost nothing.[223] The solution that presented itself to the Royal Commission was to provide for working class women by establishing state-funded lying-in hospitals in much the same way that benevolent institutions had provided for the destitute,[224] thus giving support to the construction of midwives as negligent.

The Royal Commission argued that, if childbirth were to be rendered safer and the complications associated with it were to be eliminated or reduced, women would be less inclined to reduce family size. The work of untrained midwives and the domestic environment as the principal birth venue were identified as particular targets for reform as the following passage indicates:

> We find from the evidence we have taken that the deaths of women in childbirth – that is the deaths of women within one month of their confinement, or subsequent puerperal state – are unduly numerous. We note also the liability of women to suffer from ill-health, and even from sterility, in consequence of the risks to which they have been exposed in childbirth. On the other hand, it is well known that the obstetric art has attained a very high standard of excellence in modern times; and this is illustrated in Sydney by the work, during the last ten

220 RCDBR, Vol.II.
221 RCDBR, Vol.II, p.76.
222 Ibid., pp.71-77.
223 Ibid., p.84.
224 Ibid., pp.72-75, 82-84.

> years, of the Women's Hospital, which includes 3,891 deliveries of women without the occurrence of a single death from puerperal infection, and with an extremely low general mortality. It is obvious, therefore, that as much facility as possible should be afforded to parturient women to receive the best care in their confinement. Puerperal infections, which are unduly prevalent, can be prevented by a proper observance of what is known in obstetrics as surgical cleanliness, a knowledge of which cannot be expected of the untrained women who so largely fill the part of midwives throughout the community.[225]

The Royal Commission proposed that deaths in childbirth might be avoided by the simple move of providing lying-in facilities, funded and managed by the state, where women might give birth and their attendants might be trained. The Commission put the case that:

> We note also that existing hospital accommodation provided by the State and by such institutions as the Women's Hospital, St. Margaret's Maternity Home, and others, for the care of parturient women is almost entirely devoted to the care of the unmarried women. We are of opinion, therefore, that a strong claim is established for increased public hospital accommodation, both in the metropolis and in country districts, for parturient women, and especially for married women. We are also advised that the lives of certain women could be saved if they could be received into hospital some weeks before their confinement; and we think that provision should be made to received these women into hospitals, that is women whose health requires special attention to enable them to pass through the critical period of confinement with safety. Further benefit, we think, would also accrue from such an extension of the public maternity hospital system as we propose in enabling more women to be trained as obstetric nurses than is possible under existing conditions.[226]

The isolation of the home as a problematic factor in deaths in childbirth was a major influence in the development of subsequent policies in Queensland between 1905 and 1922. Specifically, three separate pieces of legislation that were initiated during this period attempted to achieve greater scrutiny of childbirth and infant rearing practises in the home than had hitherto been possible. The Infant Life Protection Act of 1905 that tightened the control over unlicensed people who were involved in the

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225 RCDBR, Vol. I, p.31 (109).
226 Ibid., p.31 (110).

childbirth or the care of infants;[227] the Health Act Amendment Act of 1911 that provided for the training of midwifery nurses and the registration of lying-in facilities,[228] and the Maternity Act of 1922 that provided maternity hospitals throughout the state for the "reception, care, and treatment of midwifery cases" and where "training schools for nurses in midwifery" were established throughout the state,[229] represent government responses to its population dilemma.

Conclusion

As this chapter has so demonstrated, the reproductive lives of women had, traditionally, been very much a part of a female culture in which conception and its aftermath were firmly entrenched in feminine circles. The learned male physician, while prepared to assist if needed, was generally content to leave the business of childbirth to women and their care to midwives. The medical practitioner defined a traditional role that was, for centuries, exclusively male and generally respected. Over time, the involvement of the medical professional in childbirth grew from an occasional presence as expert adviser to complete domination.

Similarly, for centuries the Church and the state determined the practice parameters of midwives, at times independently and at others, collectively. In contrast to the medical profession, whose focus was on the technical aspects of childbearing, the Church sought to preserve its doctrines through this important rite of passage and to vet and licence those who acted on its behalf. The modern state, after a lapse of some two hundred years, adopted the licensing policy initiated by the Church.

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227 *Infant Life Protection Act*, *1905*.
228 *Health Act Amendment Act of 1911*, Sections 69–76 & 85-87.
229 *The Maternity Act of 1922,* (13 Geo. V. No. 22), 5 (1).

But class and gender separated midwives and the majority of childbearing women, from medical practitioners and the state. It was this disparity that enabled changes to be initiated that were to have far reaching repercussions on both the practice of midwives and the culture of childbirth.

In Australia, population became an important asset that provided a labour force to strengthen and enhance its economy and to protect its sovereignty. Coincidentally, the medical profession had begun to take a greater interest in childbirth and to look upon reproduction as a valuable source of income that also acted as a catalyst to general practice. Scientific and technological advances that enabled larger numbers of people to be sustained by food production and capitalist ideals that promoted monetary gain were important precursors to alterations in social structure, social values and social consciousness. Although childbirth was a function exclusive to women, women were not a part of the decision making process. Women and midwives were a majority that were, for the most part, silent and passive recipients of medical and state policies. While Church and state regulation, industrialisation, the rise of the medical profession and the perpetuation of the subordination of women within capitalist society, are all important factors in explaining the evolution of midwifery practice, the historical context in which midwifery practice developed in Australia facilitated the submersion of midwifery by both medicine and nursing.

But the inclusion of midwifery and nursing and the dominance of the medical practice in the work of midwives and nurses cannot be

explained without taking into account certain factors that initiated, supported and propelled the regulation of midwifery and nursing practice. That regulation was based upon the concept of professionalisation and the intention on the part of nurses, medical practitioners and the state, to improve the status of nurses and midwives. The medical profession began by scrutinising its own practice and practitioners before moving on to consider ways in which the subordinate occupations of nursing and midwifery might be regulated in order to provide a more predictable, consistent and reliable level of practice than had previously existed.

The discordant nature of the midwife role in Australia that rendered it vulnerable to take-over by more powerful forces is still evident today. Whereas the midwife role in certain countries outside Australia exists as a discrete profession,[230] in Australia the role of the midwife has diminished in comparative terms and the medical profession continues to be a significant influence on midwifery practice.[231] The following chapter goes some way to explaining how this has come about. The chapter demonstrates that the midwife role in Queensland and elsewhere in Australia emerged as an inherently unorganised function taken on by a variety of women. Midwifery practice occurred as an unobtrusive and covert undertaking that took place in the private setting, but which had consequences in the wider public and social community. But while the communities that depended upon the midwife role were generally

230 T. Murphy-Black, (ed) *Issues in Midwifery,* pp.10-13.
231 National Health and Medical Research Council, *Review of Services Offered by Midwives*. See also, National Health and Medical Research Council, *Options for Effective Care in Childbirth*, (Canberra: Commonwealth of Australia, 1996).

appreciative of it, the nature of that role enabled members of the medical profession to criticise and deride it. It was in an atmosphere of censure and ridicule of midwifery practice by lay midwives that confronted the state when it sought ways to increase its Caucasian population through childbirth.

CHAPTER TWO

THE ROLE OF MIDWIFE AND THE CULTURE OF CHILDBIRTH AUSTRALIA 1788-1912

> Let us first recall those who have cared for the body. The nurses and midwives who worked in the country towns and small communities, who when they saw that there was a need, and no one else to tackle the task set to with a will. Those small, almost insignificant women who have been overlooked and almost forgotten.[1]

The previous chapter has demonstrated that the role of midwife is associated with a long history that existed almost exclusively as the sphere of women until the Middle Ages when the concept of the male accoucheur began to encroach upon childbirth culture. The literature has demonstrated that, while the presence of male physicians and the supervisory role of the state were strong and consistent influences on the work of midwives, the woman midwife dominated childbirth as the principal birth attendant. But the birth attendant role was not imbued with the power and authority associated with the male accoucheur. It was instead, firmly grounded in the work of women and, as such, was subject to control.

This chapter focuses on the emergent role of midwife in Australia. It demonstrates that attendance in childbirth was a function that was fulfilled initially by any friend or relative, including convicts, who

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1 Queensland Women's Historical Association, (hereafter QWHA), *Body, Mind and Soul: Recalling the Unsung Carers of the Community, the Bush Nurses, Teachers and Pastoral Workers*, (Bowen Hills: Queensland, 1998, John Oxley Library).

were prepared to take on the task.[2] With the establishment of Female Factories there was a need to provide for formal midwifery services. Hence, the Factory midwife emerged as a structured institutional role that was under the control of the state.[3] By the mid-nineteenth century, there were two, clearly distinct, roles that women midwives undertook. One was that of midwife in the community who was usually an untrained person who fulfilled the role on a regular basis. The other was that of midwifery nurse who worked in conjunction with a medical practitioner and who may or may not have undertaken a course of instruction in midwifery at a lying-in institution.[4]

This chapter demonstrates that, in the years between the first settlement in 1788 and the regulation of midwives in the early twentieth century, the role of the midwife in Australia lacked organisation, cohesion and consistency. At the outset, women who had no previous exposure to childbirth except as mothers themselves adopted the role of midwife.[5] In the 1840s, when Australia was opened to free settlers, British and European women who had worked as midwives before, some of whom had received training in midwifery in their home countries, boosted this group.[6] A pattern emerged whereby some women worked as midwives on a full time occupational basis whilst

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2 J. Revitt, *With Courage and Devotion: A History of Midwifery in New South Wales,* pp.21-24.
3 Ibid., pp.24-26.
4 A. Thornton, "The Past in Midwifery Services", *The Australian Nurses' Journal*, (Vol. 1, No. 9, March 1972), pp.6–21.
5 J. Revitt, *With Courage and Devotion: A History of Midwifery in New South Wales,* pp.21-26
6 B. Schultz, *A Tapestry of Service: The Evolution of Nursing in Australia Volume I Foundation to Federation 1788–1900*, (Melbourne: Churchill Livingstone, 1991), pp.34-35.

others were called upon at the last minute to adopt a role of which they had limited knowledge.[7] The chief characteristic of those foundations is the absence of any form of organised or structured model.[8]

The First Fleet 1788

When plans were made to put together a fleet of ships that would transport convicts from Britain to Australia, no consideration was given to the requirements of women during childbirth. While official records demonstrate inconsistencies in relation to the actual numbers of women on the First Fleet, women were a significant presence constituting approximately one third of the complement. Clark relies on official records taken three weeks prior to departure of the First Fleet to arrive at 565 men, 153 women, 6 boys and 5 girls,[9] while Crowley puts the figure at 548 men and 188 women.[10] This number includes about thirty women who accompanied their husbands who were part of the ships' company and an estimated thirty-seven children.[11] The majority of women on the First Fleet came from the domestic servant class with a few having worked as spinners or weavers prior to transportation.[12]

Despite the lack of provision for childbirth, two babies were born before the Fleet left Portsmouth and a number of babies were born

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7 Queensland State Archives (hereafter QSA), Justice Department, JUS/N169 436/1889, JUS/N109 84/455, JUS/N482 540/1911, JUS/N224 206/1894.
8 QSA, 1859 – 1886, JUS/N19 68/170: JUS/N54 77/238: Justice Department 1887 – 1897, JUS/N224 206/1894: JUS/N42 74/321.
9 C.M.H. Clark, *A History of Australia Volumes I & II: From the Earliest Times to 1838*, (Victoria: Melbourne University Press, 1962), p.76.
10 F.A. Crowley, *A Documentary History of Australia Volume I: Colonial Australia 1788–1840*, p.1.
11 C. M. H. Clark, *A History of Australia Volumes I & II: From the Earliest Times to 1838*, p.76
12 P. Robinson, *The Women of Botany Bay*, (New South Wales: Macquarie Library, 1988), pp. 75–176.

during the voyage to Australia. The figures vary between eighteen births including one miscarriage and two stillbirths,[13] to twenty-five births including miscarriages and stillbirths.[14] Even as the fleet sailed into Sydney Cove on 26 January 1788, a baby was born aboard ship.[15] The Fleet included qualified and unqualified medical practitioners, the majority of whom had made the navy their career.[16] Holden, who, in his study of the children of the First Fleet, describes the First Fleet as a "floating nursery", maintains that a prominent feature of the voyage was a communal culture wherein women served as birth attendants.[17]

Although it has been suggested that in the absence of midwives a Ship's Surgeon may occasionally have been called to attend the births that occurred aboard ship and in the early months of settlement, this was a rare occurrence. The surgeon, William Balmain, is said to have acted as accoucheur to a convict, Mary Tilley, aboard the Lady Penhryn whilst it was docked in Portsmouth.[18] Only one Ship's Surgeon, Arthur Bowes Smyth, had some knowledge of midwifery practice. While possessing no formal medical qualifications, Bowes Smyth had worked as a surgeon in an English village where he gained experience as a midwife.

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13 J. Revitt, *With Courage and Devotion: A History of Midwifery in New South Wales,* p.16.
14 R. Holden, *Orphans of the History: The Forgotten Children of the First Fleet*, (Melbourne: Text Publishing, 2000), pp.101-116.
15 C. M. H. Clark, *A History of Australia Volumes I & II: From the Earliest Times to 1838*, pp.86–87.
16 J. Pearn, "First Fleet Surgeons: A Band of Brothers Disparate". In J. Pearn, (ed) *Pioneer Medicine in Australia,* pp.33-55.
17 R. Holden, *Orphans of the History: The Forgotten Children of the First Fleet*, p. 101.
18 J. Revitt, *With Courage and Devotion: A History of Midwifery in New South Wales,* p.14.

Holden points out that the First Fleet was so ill prepared for the women it carried that in addition to neglecting to provide midwives there was no equipment suitable for use during confinements and no materials for women or infants for the period following birth.[19] While the Second Fleet carried women intending to work as midwives in the new colony, in 1788 at the time of the landing of the First Fleet, childbirth in New South Wales constituted an unavoidable occurrence whose outcome was left very much to chance. The end result was that maternity care was delivered by birth attendants who were ill-prepared for the task, did not share a common vision regarding the social conceptualization of midwives, and who stepped in to aid the "needy" rather than to provide an identifiable community service.

The Convict Midwife

From 1788 until the early years of the twentieth century, the culture of childbirth that developed among the non-indigenous population in Australia emerged as an uncoordinated and inconsistent response that was met, in part, by women of the convict class. Perrott, referring to an employment schedule of convict women compiled from correspondence by Governor King during the period 1800 to 1806, lists three midwives and twenty-two hospital nurses.[20] In the muster of 1806 only three women were recorded as midwives; and of this number, two were ex-convict women and the third was one who "came free".[21]

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19 R. Holden, *Orphans of the History: The Forgotten Children of the First Fleet*, pp.101–116.
20 M. A. Perrott, *A Tolerable Good Success: Economic Opportunities for Women in New South Wales 1788–1830*, (Sydney: Hale & Iremonger, 1983), pp.106–107.
21 Ibid., pp.107 & 110.

One convict woman who became well known as a midwife was Phoebe Norton. Phoebe was a convict on the First Fleet who had been transported to Australia for petty theft. In the years after her arrival she is reported to have assisted in the births of hundreds of babies and was recorded in the Parramatta census of 1814 as 'midwife'.[22] Another woman, whose midwifery career began as a convict, was Margaret Catchpole who arrived in Sydney in 1801 following a conviction for horse stealing.[23] Margaret possessed skills in nursing that she utilised in the care of women during the lying-in period and she considered herself fortunate to be assigned work in the household of the Commissary where her abilities as a nurse and housekeeper were valued. As her reputation as a midwife grew, she was called and recalled to attend upon middle class women including those from prestigious pioneering families.[24] The convict backgrounds of the early midwives clearly did not preclude their selection as childbirth attendants, even when their appointment was to the Governor's house. Ann Reynolds, who arrived in Australia as Ann Willis in 1791, attended Elizabeth MacQuarie, wife of Governor MacQuarie, during her childbirth in 1814 in the capacity of maternity nurse and assistant to the medical practitioner, William Redfern.[25]

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22 J. Revitt, *With Courage and Devotion: A History of Midwifery in New South Wales,* p.34.
23 P. Clarke, D. Spender, *Life Lines: Australian Women's Letters and Diaries, 1788–1840,* (St. Leonard's: Allen & Unwin, 1992) pp.10-16.
24 iIbid., p.12.
25 J. Revitt, *With Courage and Devotion: A History of Midwifery in New South Wales,* p.22.

The Moreton Bay settlement 1824

The Moreton Bay settlement began at 'Red Cliff Point' in September 1824. The settlement was under the command of Lt. Henry Miller whose directive was to set up a convict township that would remain isolated from the general population and be constantly disciplined and controlled by military personnel.[26] There were approximately fifty-four people in the first party that arrived in Moreton Bay of whom thirty were male convicts. The initial group of settlers to Moreton Bay included wives, children and servants of military personnel as well as a number of civilians who acted as expert advisers.[27]

Two babies of European origin were born within the first weeks of settlement at Redcliffe. The first of these is claimed to have been that of Amity Thompson whose birth took place on 21 September 1824. The second birth is reputed to have been that of Charles Miller, son of the military commander.[28] As no midwife accompanied the first party, it is thought likely that wives of the military detachment assisted at the births. Although Walter Scott acted as commissariat storekeeper and surgeon, there is no indication that he became involved in the births. While details of these births are scant, Patrick suggests that it is likely that Amity Thompson would have been born in a tent or slab hut and Charles Miller in the commandant's prefabricated cottage.[29]

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26 W. R. Johnston, *Brisbane: The First Thirty Years,* (Brisbane: Boolarong Publications, 1988), p.14.
27 Ibid., pp.14– 6.
28 R. Patrick, *The Royal Women's Hospital, Brisbane-The First Fifty Years,* p.1.
29 Ibid.

Despite the efforts of this first party, the conditions at Redcliffe presented obstacles that made the site less attractive than had first seemed.[30] Its situation exposed it to climatic elements that hindered the growing of food and compromised safe anchorage. There was an abundance of mosquitoes and a shortage of fresh water. The Aboriginal people in close vicinity to the settlement were antagonistic and illness amongst the convict group reduced the availability of labour. By comparison, the banks of the Brisbane River offered a favourable location with fresh water and lush vegetation. In the early months of 1825 the settlement was moved from Redcliffe to the area that subsequently became the business district of Brisbane.

When female convicts arrived in Brisbane in 1827, convict women acted as midwives at their confinements.[31] Those women convicts, together with the wives and children of serving convicts, were housed in a Female Factory that was situated at first on the site of the present Brisbane Post Office in Queen Street and later at Eagle Farm.[32] The numbers of women housed at the Female Factory in the Moreton Bay region did not reach those of the Parramatta Factory, nor did it gain the same reputation as a lying-in facility. It was, however, associated with recalcitrant inmates and harsh treatment that were features attributed to the settlement as a whole.[33]

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30 W. R. Johnston, *Brisbane:The First Thirty Years*, pp.18 – 19.
31 R. Patrick, *The Royal Women's Hospital, Brisbane-The First Fifty Years*, pp.1-3.
32 M. J. Thearle, H. Gregory, "Choices for Childbirth: Midwifery in Nineteenth and Early Twentieth Century Queensland", *Unpublished Manuscript, 1988*, (John Oxley Library).
33 W. R. Johnston, *Brisbane:The First Thirty Years*, pp.1–31.

The emergent role of midwife

Thornton, in her appraisal of midwifery services in Australia during the period 1788 to 1920, identifies three categories of midwife. The first type of midwifery practice was performed by the "accidental midwife" to denote the impromptu and unready nature of the role.[34] These midwives were plausible in the role of midwife by virtue of their maturity and parity and they brought to the childbirth scene knowledge and skill gained from experience of their own childbirth. Their practice as birth attendants took place on either a regular or irregular basis, depending on their particular circumstances. Harriet King was the mother of eight children and manager of the family property of 3780 acres, but when her sister-in-law was due to give birth she stayed in Parramatta with her for a protracted period.[35]

The second category of midwife Thornton describes was the "paid midwife".[36] This category had its origins in the Female Factory, the first of which was built in Parramatta and completed in 1804.[37] The Female Factory constituted the first form of institutional childbirth in Australia and was one of the first maternity institutions to employ a permanent midwife. There were a number of Female Factories in Australia, but the principal ones were located at Parramatta in New South Wales and at Cascades in Hobart.[38] The initial purpose of the

34 A. Thornton, "The Past in Midwifery Services", *The Australian Nurses' Journal* pp.19–26.
35 M. Wiedenhofer, (ed) *Colonial Ladies*, (Victoria: Currey O'Neil, 1985), p.92.
36 A. Thornton, "The Past in Midwifery Services", *The Australian Nurses'* Journal, pp.9-16.
37 M. Dixson, *The Real Matilda: Women and Identity in Australia 1788-1975*, (Victoria: Penguin Books, 1978), p. 128.
38 K. Daniels, *Convict Women,* (New South Wales: Allen & Unwin, 1988), p.107.

Female Factory was to act as a house of correction where women were employed in laundering or weaving until they could be assigned as servants or were selected as wives.

Over time, the Factories held women who had been employed but had been returned to the Factory through unsatisfactory conduct or pregnancy or both and women who had committed a minor offence since arriving in Australia.[39] Thus, the Female Factory was a multi-functional institution that was penitentiary, labour exchange, lying-in premises and nursery and, to a lesser extent and for a shorter period, an infant school. It seems that none of these functions was particularly successful. The Factories were criticised for their failure to correct offending behaviour in women and to ensure their compliance as employees and were, at the same time, associated with high infant mortality rates.[40]

The Factory Midwife

The Factory midwife represents a prototype of the hospital midwife in that she was employed by the government and took direction from the medical practitioner. Although this group of midwives was not large, it set an ideological precedent in terms of both the practice of midwives and the way in which they were perceived. In 1807, the Parramatta Factory recorded the employment of seven women as “hospital nurses” and three

39 P. Robinson, *The Hatch and Brood of Time: A Study of the First Generation of Native-Born White Australians 1788–1828 Volume 1*, (Melbourne: Oxford University Press, 1985), p.79.
40 M. Dixson, *The Real Matilda: Women and Identity in Australia 1788-1975,* pp.129–130.

in the care of orphans.[41] The administrative role fulfilled by the Factory superintendent or matron was acknowledged as one that was pivotal to Factory management. The reward for the responsibility of the position was reflected in the wage paid. In the late 1820s, the position of matron attracted a salary of two hundred pounds a year, a sum fifty pounds greater than that awarded the storekeeper and master-manufacturer.[42] By comparison, a non-convict midwife would be paid fifty pounds a year, while a convict midwife could expect to receive nineteen pounds a year.[43] When, in 1827, the matron of the Parramatta Factory elected to retire, Governor Darling issued a directive to appoint two people in her place, a matron and an assistant. At that time, 1828, the factory housed four hundred and ninety persons and it was proposed that a permanent midwife should be employed at a salary of twenty pounds a year. By the end of the year, the factory hospital held forty-nine women and employed six convicts as nurses to attend them.[44]

In 1838, Sir William Molesworth chaired a Select Committee of the House of Commons that was convened for the purpose of reporting on 'the nature and effects of the punishment of Transportation'.[45] Molesworth's discussion of the assignment of convict women as servants reveals the extended role of the female factory as a lying-in institution:

> Assigned convict women, who are with child, are generally returned to the factory when near their period of confinement; they are placed in a

41 P. Robinson, *The Women of Botany Bay*, p.108.
42 J. Revitt, *With Courage and Devotion: A History of Midwifery in New South Wales*, p.25.
43 Ibid., p.25.
44 B. Schultz, *A Tapestry of Service: The Evolution of Nursing in Australia Volume I Foundation to Federation 1788*–1900, pp.11–12.
45 W. Molesworth, *Report from the Select Committee of the House of Commons on Transportation,* (London: Henry Hooper, 1838, Facsimile edition 1967), p.iii.

> separate class, intermediate between the punishment class and that of the women who are waiting to be assigned. This class appears to be a very numerous one, as, out of 590 females in the factory at Parramatta in 1836, 108 were nursing children; what portion of the remainder were pregnant women is not stated; at the same time there were in the factory 136 children between the ages of one and three years, the illegitimate children of convicts. The factory at Parramatta is, therefore, in reality a lying-in hospital;…[46]

At its peak in July 1842, one thousand two hundred women were contained in the Parramatta factory with a proportionate increase in the number of infants and children.[47]

The Nurse/Midwife

The third category of midwife was the "monthly nurse", a title that denotes a woman who received formal "training" as a midwife.[48] It was customary for that training to take place in a hospital and to extend over a period of three months. The monthly nurse was then able to work as an assistant to a medical practitioner and, as the term suggests, was usually employed by the woman for a period of one month. The employment would normally commence a week before the birth of the baby and continue until three weeks after the event. While many "respectable families" employed a monthly nurse, the less wealthy were dependent upon the services of a local woman who was prepared to act in the capacity of nurse or midwife.[49]

Thornton does not elaborate on the type of "training" that the monthly nurse might receive, but she refers to a letter written to the Melbourne newspaper, *Argus*, in 1869 by a woman who, at the

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46 Ibid., p.15.
47 B. Gandevia, *Tears Often Shed,* (New South Wales: Pergamon Press, 1978), pp.22-23.
48 A. Thornton, The Past in Midwifery Services", p.21.
49 R. Teale, (ed) *Colonial Eve: Sources on Women in Australia 1788–1912,* (Melbourne: Oxford University Press, 1978), pp.121–122.

completion of a period of three months' training as a monthly nurse, was pleased with the level of competence she had achieved.[50] It is likely that this 'training' took place at the Melbourne Lying-In Hospital, which, in 1862, established a course of instruction that culminated in the award of "ladies monthly nurse".[51] McCalman points out that the monthly nurse was regarded as a midwife and she earned this award after witnessing one hundred instances of childbirth and "delivering babies under supervision.[52] Women who enrolled in this certificated course of instruction paid £8. 2s. 6d. for the privilege.[53] But the numbers of trainees were small, with only thirty-four women completing the course in the first ten years of its establishment.[54]

The monthly nurse role also existed in Brisbane. In August 1864, an advertisement appeared in the Brisbane Courier that differentiated between the role of nurse and monthly nurse. The advertisement read:

> WANTED a NURSE GIRL; also, a MONTHLY NURSE. None but competent persons need apply.[55]

There was no formal training in place for midwives in Queensland at this time, but the phrasing of the advertisement suggests a communal understanding of the role of monthly nurse and anticipation that applicants would be aware of what was expected of them. The advertisement also implies that the nurse, whose qualification for the post required no more

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50 A. Thornton, The Past in Midwifery Services", p.21
51 J. McCalman, *Sex and Suffering: Women's Health and a Women's Hospital: The Royal Women's Hospital, Melbourne 1856–1996*, (Victoria: Melbourne University Press, 1998), p.20.
52 Ibid.
53 Ibid.
54 Ibid.
55 *The Brisbane Courier*, (hereafter BC) (Vol. XIX No.2036, Saturday, August 6, 1864), p.1.

than adolescence and the female gender, was an occupation that might be filled by the relatively unskilled. However, the monthly nurse seems to have fallen within the construct of a specific occupation located within the classification of a trade. This was in keeping with LIGHTERS for the Town Hall, a WHEELWRIGHT for a "Blacksmithy" and the occupation of "GENERAL SERVANT".[56]

Donnison emphasises that, while the monthly nurse role was a feature of childbirth culture in Britain since at least the time of Henry VIII, a clear distinction was drawn between the role of the monthly nurse and that of the midwife, with the monthly nurse holding a far less prestigious position so that, according to Donnison, in seventeenth century Britain, the monthly nurse was employed:

> …to perform the more menial tasks during the birth, and to nurse the mother and infant for the following month.[57]

Accordingly, whereas in Britain and Europe the role of the midwife existed as a clearly defined and firmly anchored social function that had matured over time, in Australia it developed in an unsystematic form where an assortment of women took on the practice. Despite the lack of clarity in relation to the structure of the midwife role and the functions that lay midwives performed, they were the most likely people to be called upon by women in childbirth.

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56 Ibid.
57 Ibid.,p.23.

Social representations of the lay midwife

The role of the midwife carried with it two conflicting impressions of midwives. Midwives are portrayed either as clean and caring women who made a positive contribution to the lying-in process or they are reviled as perpetrators of maternal and infant death. These divergent viewpoints are reflected in depictions of nineteenth century midwifery practice. The first appears as part of a discussion by Teale in 1978 in her exploration of the role women played as wives and mothers in Australia during the nineteenth century:

> Those women whose husbands were not so well off remained at the mercy of the local mid-wife, the proverbial Mrs Gamp, who was usually totally untrained…Such women had no conception of surgical cleanliness; they sometimes transmitted puerperal fever; they could through ignorance, strangle the child or cause its death by improper feeding; and their attempts to tie the umbilical cord or remove the placenta made maternal death from 'rupture of the uterus' a frequent autopsy finding.[58]

Williamson rebuts this portrayal, saying that it is a biased perspective derived from medical discourse.[59] She argues that while some midwives were poor practitioners they were, "no more incompetent or ignorant than were doctors themselves".[60] In support of her stand, Williamson draws upon later studies that, she believes, are more enlightened and more accurate. As Williamson points out, deaths from puerperal fever were as much a problem to the medical practitioner as to the midwife, but what is often forgotten is that the conditions in which the pregnant or newly confined woman lived were not conducive to healthy women or to a good pregnancy outcome.

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58 R. Teale, (ed) *Colonial Eve: Sources on Women in Australia 1788–1912,* p.122.
59 N. Williamson, "'She Walked…With Great Purpose' Mary Kirkpatrick and the History of Midwifery in New South Wales". In M. Bevege, M. James, C. Shute, (eds) *Worth Her Salt,* (Sydney: Hale & Iremonger, 1982), pp.403-404.
60 Ibid., p.3.

Williamson contends that, rather than midwifery practice being the cause of maternal and infant mortality, other factors such as increased risks associated with multiparity, inadequate knowledge of the physiology of childbearing, and the lack of public health, played a part.[61] She maintains that the risks inherent in childbearing, unsophisticated medical practice and poor standards of public hygiene were less frequently linked with deaths in childbirth than was the practice of midwifery by women. Refuting damaging claims against midwives on the grounds that puerperal infection was not much alleviated until antibiotic therapy was introduced in the 1930s, Williamson cites a doctoral study by Thame to support her argument.[62]

Thame, in identifying the factors that contributed most significantly to the high maternal mortality rate in New South Wales during the period 1900-1940, found three principal causes of maternal death. The first was the prohibitive costs of employing either midwife or medical practitioner that led to reluctance on the part of the woman to obtain appropriate expertise for her confinement. Second, poor obstetric training inhibited the ability of medical practitioners to meet the challenge that childbirth often presented. Third, these factors combined with the inability of midwives to use instruments or administer an anaesthetic to solve a problem that only became manifest during childbirth.[63]

Williamson gives as a demonstration of the expertise exhibited by midwives during this time, the career of Mary Kirkpatrick who worked as a

61 Ibid., pp.6-12.
62 Ibid., pp.3–5.
63 Ibid., p.9.

midwife in the Kempsey district of New South Wales from the late 1890s to the 1930s. It is not altogether clear which sources Williamson has accessed to construct her account, but it appears that some are based on interviews with Mary Kirkpatrick's granddaughters and in cooperation with them and Mary Kirkpatrick's grandson.[64] Mary Kirkpatrick is cast as an accomplished midwife who held high standards of cleanliness and possessed considerable skill. Williamson draws on an example whereby a set of twins was born. The first died and the second was in a poor state. All but Mary Kirkpatrick had given up hope that the child would live, but she used her initiative and knowledge to treat the infant. Wrapping him in heated clothing and placing him in the warm oven of a fuel stove, Mary Kirkpatrick is reputed to have saved the infant's life.[65]

Vindication of midwives practising in the years prior to registration receives support from southern New South Wales.[66] A compilation of stories of childbirth in the Glenroy district has been constructed from memories either of relative of midwives who have provided oral accounts, or from the diaries of midwives or their relatives. The accounts depict the midwife role in positive terms and position it as a respected social function. One midwife, Mary Cobden, recorded in her diary a total of ninety-one births during the period 1900 to 1923, including a number of twins.[67] The mother of eleven children, Mary Cobden's work as a midwife involved her in general household chores for a period of time after the baby had been born. She also acted as

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64 Ibid., p.12.
65 Ibid.
66 E. Shepherd, *The Midwives of Rosewood and Other Birth Stories.*
67 Ibid., pp.11-13.

nurse to the dying and mortician to the recently deceased. It was a period when midwives travelled to their "cases" on horseback or by horse and buggy, some journeying distances of up to fifty miles. These testimonies, that *now* act to support the work of lay midwives, were neither visible nor audible in the nineteenth and early twentieth centuries. Midwives and childbearing women comprised a silent majority that was powerless to defend itself against criticism from outside or to participate in the forging of policies that would determine the way in which women would birth and midwives would practice.

A feature of the work of lay midwives in Australia during the study period was their popularity with women. While it is unclear whether that popularity was based on preference or necessity, it was a custom deplored by many medical men. Nisbet, a medical practitioner from Townsville, claimed that of the five hundred and three births registered in the Townsville area in 1890, midwives alone attended seventy-three percent. Nisbet clearly abhorred this practice, complaining in 1891 that:

> There is in Queensland, an extraordinary desire among women of the lower classes to dispense with medical assistance in their confinements, preferring to place their own lives and those of their unborn children unreservedly in the hands of any woman with enough self-confidence to undertaken the risk.[68]

Nisbet's observation does not take into account the large numbers of working class women who made up the female majority in Australia. Nor does it acknowledge the limited choice available to women of this more impoverished class. The concept of childbirth being "women's business" appears to have held more sway amongst working class women who

68 W. B. Nisbet, "The Education of Midwives", *AMG*, " p.270.

were, as a consequence of both attitude and financial means, more likely to be attended by an untrained midwife.

In 1904, the Royal Commission on the Decline of the Birth-Rate and on the Mortality of Infants in New South Wales heard that, of the 1,923 women who recorded their occupation as midwife on the New South Wales census of 1901, approximately 200 had undertaken a course of training, rendering in excess of 1,700 untrained.[69] In Victoria in 1908, the situation was perceived much the same with one medical practitioner commenting that:

> During a discussion on 'Midwifery Nursing' which took place some years ago before the Medical Society of Victoria, it was pointed out that not more than two-thirds of the mothers in this State were attended by medical men."[70]

In the same article, the argument was put that in Victoria in 1908 it was lamented that over one third of all births in the state were attended by midwives, a figure estimated to represent approximately ten thousand women. The writer was unsure, in this case, whether women were attended by untrained midwives, "…from choice or necessity".[71]

The lay midwife in Queensland

In Queensland as in other parts of Australia throughout the nineteenth century, the term "midwife" was, with few exceptions, attributed to women who acted as childbirth attendants by virtue of having fulfilled that role on previous occasions. Primary sources suggest that the term "midwife" was applied loosely to any woman who

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69 RCDBR, Vol. I, p.32 (114).
70 Anon. "The Registration of Midwives", *Intercolonial Medical Journal*, (Nov. 20, 1909), p.573.
71 Ibid.

habitually attended another during their confinement. Indeed, the title "midwife" carried no real distinction from that of "nurse" in many accounts, although those practitioners who had made a lifetime work of caring for women in labour might be accorded or adopt the title of "midwife". [72]

In some communities in Queensland, the midwife was portrayed as an indispensable social asset whose skill and competency were highly valued. In others, the midwife was simply a necessity without which the woman would have to birth alone or with the help of her husband. In most cases, the midwife relied upon rudimentary knowledge of the processes of childbirth and midwifery practice was unsupported by established frameworks. It was a practice that took place behind the closed door or tent flap and without benefit of an accompanying structure that delineated the midwifery role. Therefore, the "midwife" might be a woman neighbour called in when the birth of the child was imminent or a woman relative who had agreed to take on the confinement duties. In these circumstances, the midwife did not receive formal remuneration for her assistance.

Conversely, midwifery might be the gainful employment of a woman who had acquired knowledge and skill of childbirth through repeated attendance on women.[73] In this case, it was customary for the midwife to attend upon the woman during the birth and in the days or weeks that followed. Some took over the domestic work until the

72 QSA, Justice Department 1859 – 1886, JUS/N19 68/170: JUS/N54 77/238: Justice Department 1887 – 1897, JUS/N224 206/1894: JUS/N42 74/321.
73 QSA, Justice Department 1859 – 1886, JUS/N118 85/236.

woman was able to resume her household management. Others put aside a room or rooms in their own homes where the confinement would take place and where mother and baby would remain until they were ready to return home. These lying-in facilities existed sometimes with support from local doctors, while other midwives were employed in small lying-in facilities as the assistants of medical practitioners.[74] The dire need for women to act as midwives is sometimes overlooked, but in rural areas where there were many miles between homesteads, these women fulfilled a significant role in the community.[75] In many instances, the closest medical practitioner could be reached only after a day's ride by horseback. In these circumstances, the willingness of a woman to act as midwife and the skill with which she performed that role could mean the difference between life and death.

Accounts relating to nineteenth and early twentieth century midwives predominantly rely on the memories of others. Midwives did not write about themselves. Therefore, any insight into the work of midwives and their social role is dependent upon stories about them that derive from an oral tradition in which history is passed down by word of mouth. These memories often emphasise the respect and affection with which the midwife and her work were recalled.[76] Midwives are attributed with assisting large numbers of infants into the world despite the difficulties they might encounter in reaching the birth venue. These representations anchor the role of midwife as an informal birth attendant who was known

74 QSA, Justice Department 1898 – 1912, JUS/N484 586/1911.
75 QWHA.
76 QWHA.

in the local community to be available to meet the need as and when it arose. The following passage, contained in a compilation of stories published by the Queensland Women's Historical Association, illuminates the social connotations of the midwife role:

> In most instances the nurse was a relative or neighbour who had little or no formal training, but had learned the skills of midwifery and bush nursing through experience – practice and the guidance of an older woman. Often they were the only help at hand. The doctor, if there was one within a days-ride, seldom arrived in time, and then departed to tend another patient after a few hours.[77]

The number of births assisted by lay midwives was considerable. Elizabeth Ranson, who is described as a "district midwife", lived and worked in the Woodford area and is reputed to have acted as accoucheur in at least one hundred births during the 1880s.[78] Another midwife, Susan Raverty, is said to have been asked to work as a nurse and midwife for the district of Nanango after she had received six weeks training in the Nanango Hospital during the early 1900s. Susan was the midwife to over two hundred and forty babies.[79] Mary Mackenzie, who arrived in Brisbane from Scotland in 1900, is reported to have spent long hours travelling on horseback, often at night, irrespective of the weather, in order to deliver babies. Mary Mackenzie was fondly remembered as, "the midwife who delivered us all".[80]

Another historical society that has concentrated its efforts on the work of women in its community is the Rockhampton and District Historical Society. In a talk given to the Society in 1977, Mary Bradford

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77 QWHA, p.4.
78 Ibid., p.8.
79 Ibid., p.6.
80 Ibid., p.8.

drew a verbal picture of the lives of women in Rockhampton in 1900. Mary Bradford's synopsis of midwives is illuminating and consistent with concept that the midwife played an essential role as a member of the community in which she lived:

> Nurse Polly Birrell had a Private Maternity Home near the corner of Talford and Archer Streets. She was helped by her mother as cook and sister Lizzie who looked after the babies. Doctor Parry was often called on to attend at night, when he would ride his bicycle if he thought there was urgent need of him. If not, he walked from his home in Denison Street.[81]

Although the midwife managed a lying-in facility she is accorded the title of nurse. She has some immediate female family members to assist her, but, as nurse/midwife, is the central figure. The medical practitioner, on the other hand, is depicted as a somewhat remote and transient figure that attends by request and is a visitor to the scene. This portrayal of the midwife is consistent with the findings of the Queensland Women's Historical Association, which depicts the midwife under the title of nurse and as a versatile and important member of society:

> Many of these nurses lived with the family for as long as they were needed and took over all the domestic tasks. Some actually provided a type of hospital care with a room or two within their own homes and which was set aside for mothers and babies. [82]

A narration by Agnes Little, published in 1992 and devoted to her life in the Mount Molloy township, throws light on the hardships with which some women were confronted. Agnes, whose birth in August 1912 was attended by her grandmother,[83] draws on family memories to describe the

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81 M. Bradford, "Women in Rockhampton at the turn of the century 1900", (Typescript of talk given to the Rockhampton and District Historical Society, 1997), p.2.
82 QWHA, p.4.
83 A. Little, *Days Gone By,* p.7.

lives of women in the Mount Molloy area in the 1890s. Agnes recalled that:

> As was the custom in those hard days, many teamsters took their wives – and brides – and families with them as they travelled the long rough dusty roads. Children were born under the wagons, and some died by the roadside. My mother had two miscarriages on this road.[84]

Agnes goes on to describe the death of her mother's friend in childbirth:

> My mother's friend, Mrs. Mathieson, who was travelling the road with her and her husband, died in childbirth under the back of the bullock wagon on the Little Mitchell River. My half-brother, Billy Lee, rode for the midwife when Mrs. Mathieson took ill. He road fast the seventeen miles to Mareeba leading a saddle horse for the midwife, Mrs. Minogue. But by the time they arrived back at the camp, Mrs. Mathieson was dead. …
>
> When my mother was going to have her baby, she thought she may die too. She was living in Kingsborough and Willie had to ride the thirty miles to Mareeba to fetch the midwife, Mrs. Minogue.[85]

Agnes' accounts underscore the spontaneity of birth and conditions prohibitive of forward planning and obtaining early assistance. The unpredictability of childbirth was compounded by distances between communities and also by a scarcity of midwives.

A significant characteristic of the work of women birth attendants was the relatively obscure nature of their work. That obscurity relates both to the actual functions they performed and the lack of surveillance to which those functions might be subjected. There was no way of knowing what was going on in the birth room and whether or not the midwife's actions were conducive to safe childbirth and a healthy neonate.[86] As a consequence, the hidden arena of childbirth and the concomitant impossibility of monitoring the work of midwives represented disturbing factors to the medical profession and the state in their efforts to combat

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84 Ibid., p.9.
85 Ibid.
86 QSA, Justice Department JUS/N36, 73/56.

loss of maternal and infant life. The preference women showed for relatives, friends, or neighbours to attend them in labour rather than medical men was compounded by a limitation of facilities especially in rural areas and prohibitive distances between homesteads. The result was a disjointed and unsystematic response to a pressing need that was met by a variety of people, the vast majority of whom were women who were devoid of any formal training and whose principal attribute was their gender.

The hidden arena of childbirth

The testimonies submitted at Inquests into the deaths of mothers or infants offer insight into the actual work of midwives in Queensland during the study period and to the difficulties of surveillance that came to be connected with their practice. In the following accounts, childbirth emerges as an event for which women often did not prepare. Whether that lack of provision was due to naivety, ignorance, irresponsibility, or the consequence of absence of facilities, is unclear. What is apparent is that a high incidence of deaths occurred in childbirths that took place when labour and birthing was un-catered for and an estimation of the true cause of death was almost impossible when childbirth occurred in a community setting.

The accounts highlight certain characteristics of childbirth in Queensland that tended to represent commonalities in childbirth culture. First, the midwife relative, who was often the mother or mother-in-law and who sometimes practised in conjunction with a local woman who acted as midwife, was a strong feature of midwifery practice. Second, in the

absence of a relative, a friend or a neighbour often fulfilled the midwife role on an ad hoc basis. Third, the home as a birth venue lent itself to secrecy and concealment. The notion that the midwife learned through something of an apprenticeship system under "the guidance of an older woman"[87] is not reinforced by the formal testimonies that support this thesis.

While there are some similarities between the role of the lay midwife in Queensland and the "handywoman" role that existed in Britain until the 1930s, there is no evidence to suggest that an experienced childbirth attendant mentored the lay midwife. The handywoman role was one in which a local woman would act as midwife and nurse caring for the well woman in childbirth as well as the sick and the dying.[88] These women are portrayed as well respected and skilled and they were the women people turned to at time of need.[89] The attraction of the handywoman in Britain has been linked to poverty among the working and destitute classes and the prohibitive cost of calling in a medical practitioner.[90] The handywoman was also valued for the domestic chores she was prepared and able to undertake. These were factors that were present to a greater or lesser extent in the accounts of childbirth in Queensland.

It is feasible that, when lay midwifery practice was transformed into a trained *midwifery nurse* role, the exemplar upon which the enterprise was modelled was that of the monthly nurse. The purpose in so doing was to

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87 QWHA, p.4.
88 N. Leap, B. Hunter, *The Midwife's Tale: An Oral History from Handywoman to Professional Midwife*, (London: Scarlet Press, 1993), pp.1-33.
89 Ibid., pp.1–43.
90 E. Fox, "Midwifery in England and Wales before 1936: Handywomen and Doctors", *INHJ*, Vol. 1 No. 2 Autumn 1995, pp.19–28.

remove from society the multifaceted lay midwife/handywoman and to replace her with a predictable worker who accepted without question the medical ethos that underpinned her training. The alternative was to sanction the independence associated with the work of lay midwives who were free to function outside the parameters of medical thought and without deference to medical opinion.

The following six accounts illuminate the lay midwifery role, as it existed in Queensland during the period 1868 to 1895. Details of these deaths appear in Appendix Three. The accounts serve to support the assertion that great reliance was placed upon women in the local community to act as childbirth attendants and that such dependence was not necessarily associated with previous training or experience as a midwife. The accounts have been chosen for the insight they provide in demonstrating the ways in which childbirth was facilitated or managed by women who adopted the role of midwife.

The neighbour as midwife: the infant of Mrs. Pillow

The role of neighbour as midwife was one that was taken to the extreme in Roma in 1868.[91] On the 21st of August 1868, a Magisterial Inquiry was held in Roma into the death of the infant of a woman identified only as Mrs. Pillow. Anne Dunn relays the circumstances in which she became introduced to this woman and the reasons that led her subsequently to agree to take the woman in for the night:

> I am a married woman. I live in the town of Roma in a tarpaulin tent. On the evening of the twentieth of August last a woman came to my tent in company with another young woman. I don't know this woman's name. She told me she lived at Mr. Plowman's. The first woman who gave me

91 QSA, Justice Department, JUS/N19 68/170

> the name of Masie said to the other. She then asked me if she could stop in my place. I asked her if she was the servant who lived at Mr. Clunes, she said yes. I told her that my tent was very small and that I could not allow her to stop there. She then said she would be much obliged if I would let her stop for the night and that she would telegraph her husband. She said her husband's name was Pillow. I then told her she could stop for that night.

At about three o'clock in the morning, Anne Dunn was awakened. It seems that she had some idea that Mrs. Pillow was pregnant as her ensuing account suggests:

> I awoke during the night and heard Mrs. Pillow moving about. I asked what was up with her and if she was in labor (sic). She said, "No I have two months to go." Mrs. Pillow was some time after this fidgeting and moving in her bed. I don't know how long she remained in this state, I can't guess. I then saw Mrs. Pillow outside her bed. I said, "My good woman, you must be sick." She said, " I think I am."

Anne Dunn left immediately to get a local woman to assist her. She does not provide details of the woman's ability or the reason behind her selection. It seems, from the woman's statement, that she was no stranger to confinements. When they arrived back at the tent about ten minutes later there was a light in the tent and they saw Mrs. Pillow on her knees beside the bed. Anne Dunn asked Mrs. Pillow how she was, but received no answer. Anne Dunn stated that a further ten minutes or so elapsed before she suggested to Mrs. Pillow that she move from that position at which time Mrs. Pillow informed them that the child had been born.

From the swollen appearance of the baby, Anne Dunn believed at first that the child was dead. She wrapped it up and after a while it began to scream. She gave the baby to its mother and went outside to boil some coffee where she remained for hour or so. Anne Dunn stated that when she returned to the tent, Mrs. Pillow told her that the baby was

dead. Anne Dunn looked at the baby and found it to be dead and quite cold. She then went to Mr. Clunes and told him that his servant had caused her a "good deal of trouble". Mr. Clunes said that Mrs. Pillow was no longer in his employ and he suggested to Anne Dunn that she should report the night's occurrence to the police. When the medical practitioner, Charles Moran, examined the body of the infant he was satisfied that the baby girl had died from natural causes as a result of protracted labour.

Mrs. Pillow was not required to submit a statement and the true circumstances of her situation are unknown. It seems unlikely that she was married and living away from her husband as a servant. It is more likely that she was pregnant and without support. Perhaps she had recently been turned out from her position with Mr. Clunes and was left to seek charity from a comparative stranger. It appears that she was surprised by the early date of her confinement, but it may be that she was naïve or that the confinement was premature. Perhaps her labour had already commenced and she knew nothing of what to expect. If, as the medical evidence suggests, the labour was protracted, it is feasible that Mrs. Pillow was in labour for a considerable period of time before she gave birth. Whatever her reason for leaving things to chance, her circumstances put the onus on strangers to provide for her.

Relatives and neighbours as midwives: the infant of Susan Gardner

Unlike Mrs. Pillow, Susan Gardner, unmarried, had a strong source of support in her mother, Mary Ann Gardner. When Susan Gardner of Dalby went into labour in 1873, her mother asked if she would like to have a doctor to attend her. Susan declined, saying that she "would rather

have a woman".[92] Mary Gardner called across to her neighbour and asked her to look after Susan while she went for a local woman who she knew acted as nurse during confinements. The nurse was unavailable, so Mary Gardner and her neighbour, Sarah Freestone, acted as midwives to Susan. Mary Gardner explained that everything went well until between one and two in the morning. The baby's head was born and then:

> …my daughter's pains left her – I did my best to get the baby born. It was some eight minutes from the time the head appeared until the baby was born. After the baby was born I thought I saw it gasp, but it did not cry out. I did my best to bring the deceased too but I did not succeed.

Despite the efforts of Mary Gardner and Sarah Freestone, the baby did not live. The words of Sarah Freestone suggest the despair that accompanied their futile attempts to resuscitate the infant and emphasise the limited means the impromptu midwife had at her disposal:

> I assisted Mrs. Gardner in doing everything we could think of to make the baby breathe but without any effect.

The official verdict of the Magisterial Inquiry was that the baby died as a result of "…pressure upon the umbilical cord from delay in the second stage of labour". On this occasion, there was no evidence recorded from a medical practitioner, but the magistrate followed his signature with the initials, "MD. JP." which suggests he was both a doctor of medicine and a Justice of the Peace.

Rosie Bray

The combination of relative and neighbour was also a feature of the confinement of Rosie Bray who lived in Mount Morgan, near

92 QSA, Justice Department, JUS/N36, 73/56.

Rockhampton.[93] On 15th June 1895, Rosie Bray went into labour prematurely. There are no details of the birth itself but it seems she was alone with her husband's sister at that time. After the birth a local woman and a doctor were called for, but only the neighbour, Mrs. Newton, was able to attend. Patrick Bray, husband of Rosie and father of the child, outlines the circumstances of Rosie's confinement:

> …I am a laborer (sic) residing at Hamilton Creek. I remember Saturday the 15th of this month. I left my camp about 8 am that day and went up Brays gully woodcutting leaving my sister Bridget and Rosie an aboriginal who lives with me as my wife at home. Rosie was unwell when I left. She complained of a toothache. She was with child but did not expect it to be born for a couple of months. About 10 o'clock that day I received a message from my sister Bridget telling me my wife was ill. I came home and found my wife had given birth to a female child. I went and brought a Mrs. Newton to my place who lives near me. She attended to my wife and child.
>
> On account of the condition of the child I came to Mount Morgan for a doctor. I saw Dr. MacKenzie but he could not come with me. I went home without him and the child was the same way when I returned and she died about 10 o'clock that night. I reported the matter to the police and obtained a Magistrates Order for the burial of the child. The child was weakly from birth and was about a seven or eight months child. I buried the child on the 16th Inst. My mother also attended to the child. Mrs. Newton as soon as she saw the child told me she did not think it would live as it was born before its time.

The evidence of Rebecca Newton supports Patrick Bray's account. There is no further information about Mrs. Newton but unlike the statements of Patrick and his mother that were acknowledged with a mark, Rebecca Newton's signature was firm and legible. She testified:

> I am the wife of William Henry Newton and reside with my husband at Hamilton Creek. I know the last witness and Rosie an aboriginal who lives with him. I remember the 15th of this month. He came to my place about 11 o'clock that day. He told me Rosie had a baby. I went to his camp and saw the baby. I washed and dressed it. I did what I could for mother and child. The child was very weakly and appeared to me to be an eight months child. I did not expect it to live and I told the father it would not live. I left and next morning saw the child again it was then dead. I advised the

93 QSA, Justice Department, JUS/N233 193/1895.

> father as soon as I saw the child to get a doctor as it was in convulsions. I am sure a doctor could not save its life if there was one present.

Mrs. Newton makes a number of points that are of particular interest. First, she states that she washed and dressed the baby. This act appears in other cases as a ritual that the birth attendant performed soon after birth irrespective of the condition of the child. Although Rosie's infant was clearly unwell the cleansing and wrapping of its body was completed. Second, Mrs. Newton exhibits confidence in assessing the child and in advising medical aid. This confidence may have come from her status in the community, or from her familiarity with the midwife role, or perhaps both.

Another person involved in Rosie's postpartum care was her mother-in-law, Mary Bray. Mary was a nurse who routinely attended women during confinements. She returned from Mount Morgan just after the baby had been born. She realised its fragile state and recognised that it was suffering convulsions. In her statement, Mary said that although she had not expected the infant to live she did everything she could for it. Mary Bray extended her nursing role to baptism of the infant, her grandchild, who died about 10 p.m. that night.

The nurse-midwife: the infant of Catherine Rawcliffe

On the 18th December 1876, an Inquest was held in Toowoomba into the death of a female infant born to Catherine Rawcliffe.[94] The issue here was that the baby had been reported to be stillborn, but this finding was in contrast to that of the medical practitioner who conducted the post mortem. Isabella Head, a woman who claimed to have thirty-five years'

94 QSA, Justice Department, JUS/N51 76/336.

experience as a midwife, had attended the birth. She noted her occupation as “nurse” and signed her name with a cross. According to her statement, she arrived at the house in Herries Street about ten minutes before the child was born. Mrs. Head recalled:

> The child when born was dead. It was well up to its time. The child never moved, had no symptoms of living. The child was delivered in the usual way and the mother did not seem to suffer much. I washed it and dressed it. I cut and tied the cord. I put a napkin on, we always do that. The child had no motion while I had anything to do with it.

Despite the evidence of the midwife, the medical practitioner who had been appointed by police to examine the body of the child was adamant that the baby had been alive and that the infant might have been saved had a medical practitioner been in attendance. The medical practitioner, William Armstrong, contested the midwife’s claim, stating that:

> I made an external examination of it and could see no mark of violence. Upon looking at the cord I found it had been cut and tied in the usual manner when children are born alive. It seems to have been washed and dressed as usual with living children and on examination find (sic) that the child had a motion on the napkin. There were also marks of external blood upon the cord. From these circumstances I am under the impression the child was born alive. If a medical man had been called in probably the child’s life might have been saved.

The implication is clearly that the midwife was in error, but it is difficult to image how such a mistake could be possible. On the one hand, the claim is made that the infant was stillborn and had probably been dead for a number of hours prior to birth. On the other hand, the infant is not only supposed to have been born alive, but it is claimed that his life was jeopardised by failure to procure the services of a medical practitioner. The midwife was adamant that as far as she was able to ascertain, the baby had been born dead. Not only was she sure of this, but she

maintained that, by her estimation, the baby had been dead for about twelve hours before it was born.

In circumstances where, in the absence of a medical practitioner, childbirth resulted in the death of the infant, there was clearly room for doubt regarding the cause of death. At the same time, the small numbers of medical practitioners in comparison with lay midwives, the sheer size of the state and the sparsity of its population, all contributed to the invisibility of childbirth. The difficulty in determining the accountability of those who attended childbirth was to become the focus of criticism by those concerned with promoting the population by increasing birth rates.

Amy Dagg

The broad parameters of midwifery practice whereby the midwife extends her role to accommodate the needs of the individual mother and infant she attends was often a feature of lay midwifery. On the 25th June 1895, at Oakley Flat, Caboolture, Amy Dagg gave birth to a premature baby who died soon after.[95] The midwife, Norah Talty, explained her role in the birth:

> I acted as nurse at the birth of the deceased infant which took place on the twenty-fifth instant at about four o'clock p.m. Mrs. Donovan the grandmother of the deceased sent a message to me on the twenty-fifth instant and requested me to go to her place which is about two miles from my place. I went there at about 3.30 p.m. same date. Mrs. Donovan said my daughter is in labor. I then examined her and discovered that she was about to be delivered of a child and I remained with her attended to her until the child was born about half an hour after my arrival.

Mrs. Talty assigned her mark to the above statement that indicates that she was not a literate person and yet her statement suggests that she had achieved a level of expertise as midwife albeit at a practical rather than

95 QSA, Justice Department, JUS/N234, 201/1895.

theoretical level. Doing their best within the limitations of their knowledge, many women who acted as midwives to family or friends were already disadvantaged so that if the birth became complicated, they were often bereft of the means to alter the course of events. Mrs. Talty went on to state:

> I have on several occasions nursed women in their confinement. When the child was being born I discovered that the navelstring was round the neck which I removed immediately. The child cried out a little after its birth and appeared very weak. I washed and dressed it as soon as possible after the birth and nursed it for about an hour and gave it some brandy and water, but it did not appear to be able to swallow any of it. I then put it into bed with its mother. It was then warm. I remained at Mrs. Donovan's until about six o'clock p.m. and then I left for home. Before leaving I saw the baby it was then alive but I concluded that it could not live.

Here, the midwife has identified herself as one who is accustomed to attending women in childbirth and she demonstrates an understanding of the implications that an umbilical cord so positioned might have. As Mrs. Talty recalled, she spent some time with the baby about whom she was clearly concerned. She was limited in both her treatment options for the child and in the scope of her diagnostic powers, although neither of these failings can be condemned given the lack of training opportunities in 1895.

When Mrs. Talty revisited the home the following day, she found the baby dead. In her evidence, Mrs. Talty expained that:

> I went up to Mrs. Donovan's the following morning to see the child and to attend on it. Mrs. Donovan informed me that the child died the previous night. I then examined the child and found it dressed and lying in bed just as I had left it the previous evening. From my experience of infants I am certain the child had not come to its proper time. In my opinion it was a six month child…As a rule seven months children live but I have never heard of a six months child living.

The difficulties of surveillance in the home are once again apparent from this account. The word of the midwife must stand as the only independent witness against infanticide and yet the practice of the midwife must also

receive scrutiny as a potential source of mistreatment leading to death. In this instance, it is likely that the baby was indeed premature and unable to suckle. Its chances of survival in the late nineteenth century were small, regardless of the place of birth or the skills of the carer. Yet, the potential for unlawful practices leading to reductions in birth rates was always present as the following and final account demonstrates. The final account is indicative of the conditions that prevailed in the childbirth culture of rural Queensland.

Julia Degen

The account begins with evidence submitted by Julia at Northbrook Creek on the 5th day of August 1895 and it is included here at length for its usefulness in highlighting the reproductive lives of women and the attitudes they held towards childbearing. Julia Degen was twenty-nine years old when she made her statement:

> I am the wife of Christian Degen. I am separated from my husband. I am living with Rudolph Kucks, farmer, Kipper Creek and have been for the last eleven years. I am the mother of the deceased female child the subject of this enquiry. I have been the mother of ten children, three of which are alive one of whom are by my husband. The other two are by Rudolph Kucks. When I came to live with Rudolph Kucks there was a child born soon after. My husband was the father of that child. It lived four months and a half. There was no doctor present but I had a professional nurse in attendance. I shewed it to a doctor at Ravenswood Junction where I was then living – the doctor said it died from natural causes.

The matter-of-fact attitude with which Julia Degen alludes to her frequent pregnancies and the deaths of infants she suffered illustrate the attitude towards childbirth attributed to working class families. Although not yet thirty years of age, Julia had already lived probably sixteen years of fertile

life and had borne ten children. Julia went on to recall:

> The next child was born at the residence of my father Carl Stankey, Glamorgan Vale – my mother acted as nurse – she having attended other women during confinement. There was no doctor present, the child was stillborn – I do not know whether it was registered or reported to the Police – I do not know the cause of death.

Here, Julia demonstrates the normality of being attended by a midwife relative in the absence of a medical practitioner. Her casual reference to her stillborn infant underscores an inevitability borne of acceptance and reveals something of the complexities in differentiating between stillbirths and live births whose deaths were contrived. Julia continued:

> My third child that died was born at Kipper Creek. I had no nurse at all. I attended upon myself. My fourth child that died was born at my father's residence, Glamorgan Vale – my mother being the nurse. The child died about an hour and a half after birth – there was no doctor present. The death was reported to the Wivenhoe Police – and an inquiry held. I do not know the cause of death of that child. My fifth child that died was born at the residence of Jacob Schey, Silkstone, near Ipswich. Mrs. Holmes, professional nurse, being in attendance. There was no doctor present. The child lived about ten minutes. I had also a miscarriage at my father's residence. My mother attended on me – I do not know if Mrs. Holmes wanted to send for a doctor for the child that died at Silkstone. I never heard she did want to send for a doctor. The death of the child was registered at Ipswich by Rudolph Kucks or by the Ipswich Cemetery Sexton – I never hear of Jacob Schey or any other person having reported the death to the Ipswich Police…
>
> I never consulted a doctor as to the cause of death of my several children, the Ravenswood death excepted. Rudolph Kucks never did consult a doctor either, as our means would not permit of it. I am a strong healthy woman and I have never been sick since I was a girl and I am now twenty-nine years of age.

Julia Degen's final statement regarding her health would seem to contradict her childbirth history; she certainly had poor luck bearing and rearing children. However, according to Julia, each infant was assessed as being frail from the time of birth and in two cases, was pronounced premature, or to have been "born before its time".

The accounts support the view that childbirth was, for the most part, an unrecorded and uncontrolled event that took place in relative privacy and with little exposure to outside influences. In these circumstances, it would have been difficult to place any accurate figure on the numbers of babies born or the frequency of deaths in infancy. It was incumbent upon a close relative, usually the father of the child, to register a birth or a death. In rural areas in particular, where there were few medical practitioners available to certify the cause of death, it is likely that a proportion of infant deaths went unreported.

The testimonies relating to childbirth in rural areas suggest that the process of giving birth was viewed as a normal part of life that did not routinely include the presence of a medical practitioner. It was only when complications were apparent that a doctor might be summoned. In the usual course of events, the people who were essential to the process were women who, as relatives or midwives or both, had a distinct function to fulfil as assistants to the “labouring” woman. Whether these assistants were resident with the women or were called in immediately before or after the time of birth, there were specific tasks that they performed. Integral to their role were vaginal examinations to assess the progress of labour and the implementation of measures to rectify situations that might be life threatening to the infant such as when the umbilical cord was wrapped around the neck of the infant.

The accounts demonstrate that women who were called upon to act as midwives for the most part performed the task to the best of their abilities. Within the scope of their skill and experience, they sought to

facilitate the birth and to aid the recovery of mother and baby. It was only when childbirth ended in death, that midwives' lack of clinical acumen became a focus of attention. Perhaps a phrase that most aptly sums up the contribution made by lay midwives in rural Queensland prior to the implementation of reforms, is one found on the headstone of Mrs. Janet O'Connor whose contribution to the women and children of her local community was acknowledged in the words, "*She did what she could*."[96] Taking into account the diverse nature of childbirth, the extreme conditions in which childbirth took place, the distance involved in travelling to the birth, and the absence of other options, this phrase aptly summarises the role of lay midwives in Queensland.

But there came a point in the social and political development of Queensland, and elsewhere in Australia and overseas, when it was not enough for lay midwives to do what they could. By the early twentieth century, the majority of developed societies had identified the need to reform childbirth practices and to make attempts to stem the associated loss of life.[97] Contributing factors to this decision were the ascendancy of the medical profession in the culture of childbirth and the loss of maternal and infant life. The following chapter deals with the first of these factors in addressing the increasing presence of medical practitioner in childbirth.

Conclusion

As this chapter has shown, the emergent role of midwife in Australia was influenced and to some extent determined by the lack of provision for

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96 QWHA, p.4.
97 M. Tew, *Safer Childbirth? A Critical History of Maternity Care* 2nd edition, pp.52-56. See also, J. Alexander, "Midwifery Graduates in the United Kingdom". In T. Murphy-Black (ed) *Issues in Midwifery,* pp.21-175.

childbirth in the new colony. The omission on the part of the British government to provide childbearing women with trained midwives contributed to the development of a largely unregulated midwife role in Australia. When women began to practice as midwives in New South Wales, they did so on the basis of need and it was on this basis that other women took on the role of midwife throughout the new colony. The resultant haphazard practice exacerbated the controversy that has surrounded the role of the midwife throughout its history.

In Australia, there was perhaps more basis for the negative connotations that were directed at the work of lay midwives. Not only had the role of midwife stemmed from a community need, it had been met by an assortment of people, including convicts. It was a job that was taken on almost exclusively by women, mostly of the working class. It was located in the home and it serviced the poorer members of the community. For a time it bridged the gap between the woman and the medical practitioner, but once a more advanced social infrastructure was in place and the government became better organised, it was only a matter of time before childbirth became a concern of the state. Once that happened the role of the midwife and the social model of childbirth were bound to change.

The next chapter addresses the acceleration of the presence of medical practitioners in matters of childbirth and their growing recognition as experts in midwifery practice. The chapter demonstrates that the professionalisation of medicine that occurred in the second half of the nineteenth century saw the ascendancy of medical practitioners in

childbirth. The conceptualisation of medicine as a profession was supported by legislation that enabled medical practitioners to determine their occupational structures, training and practice and to enhance the already credible position of its practitioners as experts in illness. The lay midwife was no match for the medical expert when medical and state objectives converged on childbirth to redefine it as a public event.

CHAPTER THREE

THE MEDICAL PRESENCE IN CHILDBIRTH AND THE RE-DEFINITION OF REPRODUCTION AS A MEDICAL EVENT

> Had I been called in at an earlier period as when the woman was first taken ill, the probability is I could have saved her life. I am qualified under the Queensland Medical Board.[1]

The previous chapter has depicted the work of midwives as essentially informal and ad hoc and the role of the midwife as untrained and unstructured. This chapter demonstrates that medical practice and the medical practitioner originated and existed quite differently. As the thesis has thus far indicated, male physicians had a long and sustained association with childbirth and, as some writers have argued, that participation was wrought upon knowledge and expertise divulged only to the professional group.[2] It was that grouping and the elevation of medicine from an occupation to a profession that enabled medical practitioners to strengthen their grasp of childbirth. The patriarchal social order, in which the medical role was rapidly developing, valued what the medical man had to offer and bolstered his status as an expert.[3] The resultant rise in the social acceptance of medicine as a body of knowledge saw its practitioners establish territorial boundaries, which effectively delineated their professional practice.

This chapter looks at the way in which the medical profession interpreted and understood childbirth. It traces the origins of male

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1 QSA, Justice Department, JUS/N31 71/178, (1871).
2 A. Rich, *Of Woman Born: Motherhood as Experience and Institution*, pp.130-139.
3 M. Foucault, *The Birth of the Clinic: An Archaeology of Medical Perception,* translated from the French by A. M. Sheridan Smith, (New York: Vintage Books,1994), pp.34-63.

involvement in childbirth and assesses the impact of the medical profession on childbirth in the late nineteenth and early twentieth centuries. It argues that, for the medical profession, childbirth was a malady that required a strategic approach in order to overcome its inherent problems. As the involvement of the medical profession increased, childbirth became reconceptualized from a life event in which the woman midwife played a dominant part, to a disorder that required attendance by a medical practitioner. It was a childbirth culture in which the "condition" of childbirth presented challenges that were met with procedures and treatments exclusive to medicine.

This chapter examines the *condition* of childbirth and the types of problems that confronted the mother in the *ordeal* of childbirth. It portrays the medical profession's approach to childbirth as a medical problem that was inherently unpredictable and which required "proper" management in order for a satisfactory outcome to be achieved. The chapter traces the ascendancy of the medical profession in the culture of childbirth. The chapter considers the professional practice parameters within which the medical practitioner functioned and the options available to him in his "treatment" of childbirth. The chapter adopts a medical perspective to appraise the childbirth complications that were cited by archival evidence as the most frequent causes of maternal and neonatal deaths.

At first, broadly between the seventeenth and early twentieth centuries, the management of childbirth involved reactive treatment to a problem that had arisen during the course of childbirth and for which the medical practitioner was called often after the difficulty had been identified.

By the 1920s, the medical profession was firmly on its way to substituting reactive treatment with proactive measures such as the establishment of antenatal care and the hospitalisation of women during childbirth.[4] The medical profession was able to achieve these results because it became an organised collective within a formal structure that was based on professional ideals. That structure and the enhanced skill that was a feature of their practice enabled medical practitioners to gain so firm a grip on midwifery practice that they were eventually able to claim it for themselves.

The male accoucheur

The male accoucheur was a product of the Renaissance. It was during that period, roughly between 1500 and 1660, first in Europe and then Britain,[5] that the forerunner to the obstetrician, the man midwife, became a practitioner in childbirth. Characteristic of the Renaissance was the spirit of humanism that emanated throughout the societies of Europe.[6] The humanist scholars returned to the ideals and philosophies of Greek and Latin civilizations with a new attitude of inquiry and a renewed interest in science that led to advances in medicine and alchemy.[7] Starting in Italy, what has been referred to as a "rebirth of classical learning" spread across Europe and then to Britain.[8]

In 1513, Eucharius Roesslin, a German physician, published a text that relied heavily upon ancient teachings and which appeared for the first

4 W. Selby "Motherhood in Labor's Queensland 1915–1957", pp.87-142.
5 M. Wynne-Davies (ed), *Bloomsbury Guides to English Literature: The Renaissance*, (London: Bloomsbury, 1992), pp.2-3.
6 J. Davies, *A History of Wales*, (London: Penguin Books, 1994), p.250.
7 Ibid., p.250.
8 M. Wynne-Davies, *Bloomsbury Guides to English Literature: The Renaissance* pp.2-5.

time in English in 1541 under the title, The Byrth of Mankynde.[9] In 1551, the French physician, Ambroise Paré reviewed the classic literature that described the method whereby a foetus may be turned within the uterus and subsequently wrote an obstetrical paper on the procedure.[10] In the atmosphere of renewed appreciation for classic teachings that the Renaissance represented, greater interest began to be paid to the role of men in midwifery.

The term "man midwife" was first introduced into the English language in the early 1600s.[11] During the next century, men became increasingly involved in childbirth, not simply when complications arose, but in the normal childbirth of the wealthy. This involvement was assisted in 1663 by the new tendency amongst French aristocrats to employ a male midwife rather than a female midwife. The term "accoucheur" that emerged has remained within the language of midwifery and obstetrics since.[12] Few physicians were practiced in midwifery, but those who were soon found they were in demand. Their popularity in a market that was short in supply enabled them to exercise selectivity and to accrue rapid financial reward.

In 1726, Joseph Gibson was appointed Professor of Midwifery in Edinburgh, Scotland. For the first time in Britain, the practice of midwifery was given formal status and afforded medical practitioners the opportunity to take a course in midwifery education.[13] In 1739, Sir Richard Manningham, a man-midwife, founded a charitable Lying in institution cited

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9 J. Donnison, *Midwives and Medical Men: A History of the Struggle for the Control of Childbirth 2nd edition*, p.20.
10 A. Rich, *Of Woman Born: Motherhood as Experience and Institution*, p.139.
11 J. Donnison, *Midwives and Medical Men: A History of the Struggle for the Control of Childbirth 2nd edition*, p.23.
12 A. Rich, *Of Woman Born: Motherhood as Experience and Institution*, p.139.
13 J. Donnison, *Midwives and Medical Men: A History of the Struggle for the Control of Childbirth 2nd edition*, pp.34-37.

within a London hospital, St. James' Infirmary, Westminster. The institution was designed to provide married women with an attendant during childbirth and to instruct both men and women in the practice of midwifery. It was during this period that male practitioners of midwifery began to be recognised for their expertise; Ould in 1742, Smellie in 1752 and Hunter in the 1760s and were provided with newly established lying-in hospitals that acted as teaching venues for the new "scientific" midwifery.[14] In London alone, Smellie gave lectures to in excess of nine hundred male students during the 1740s. The large population of the British Isles and the close proximity of its towns and cities assisted the dissemination of these teachings so that, by the 1770s, the practice of midwifery by women was under severe threat.[15]

The threat posed by medicine was strengthened in 1773 when the obstetric forceps became available to male practitioners.[16] The forceps had been invented in approximately 1598 in England by two male midwives who were brothers.[17] The Chamberlen brothers, both known by the name of Peter, kept the invention to themselves for almost a century.[18] Rich claims that the Chamberlen brothers were profiteers who, in preserving their secret through succeeding generations of male midwives, were responsible for the needless death of numerous women and foetuses.[19] In 1721, Jean Palfyne, a Belgian barber-surgeon presented his image of the Chamberlen forceps to the Paris Academy of Science, but it was not until 1773 when the surgeon

14 A. Wilson, *The Making of Man-Midwifery: Childbirth in England, 1660-1770,* p.4.
15 Ibid.
16 A. Rich, *Of Woman Born: Motherhood as Experience and Institution*, p.145.
17 J. W. Leavitt, *Brought to Bed: Childbearing in America 1750 to 1950,* p.263.
18 A. Rich, *Of Woman Born: Motherhood as Experience and Institution*, pp.142-143.
19 Ibid., p.144.

and man-midwife Edward Chapman disclosed the actual design of the forceps that they became available to other male practitioners.[20] As Rich points out, the obstetric forceps were withheld almost exclusively from women midwives.[21] A notable exception applies to Swedish midwives who employed instrumental interventions, including forceps, as early as the 1830s and continue to do so.[22]

The basis of obstetric practice in Australia

The origins of obstetric practice in Australia derived from Britain and it was to Britain that the medical profession in Australia looked for precedent. During the nineteenth century, branches of the Medical Council for Great Britain and Ireland had been set up in Australian colonies and it seemed natural to these satellite bodies that they should seek guidance from Britain on matters of policy and practice.[23] Britain was also the principal training location for doctors practising in Australia and its influence was enmeshed within medical culture. In a list of medical practitioners resident in Queensland in 1912, the majority had obtained their qualifications overseas, predominantly in England, Scotland or Ireland.[24]

As the previous chapter has highlighted, Britain imposed not only a philosophical influence upon Australian medical practice, but also a legal structure. In the years between 1858 and 1886, medical practitioners in Australia were subjected to controls on their practice that had hitherto been

20 Ibid., pp.144-145.
21 Ibid., p.145.
22 H. Marland, A. M. Rafferty, *Society and Childbirth: Debates and Controversies in the Modern Period*, pp.45-46.
23 *The Medical Act [1858],* (21 & 22 Vict. c. 90).
24 *Queensland. Government Gazette*, (Vol. XCVIII, Thursday, 4th January, 1912, No. 4).

absent.[25] Those controls, originating in Britain, were imposed as part of a professionalisation process aimed at standardising the services offered by medical practitioners. Prior to this period, medical practitioners in Australia fell into two groups; one qualified the other unqualified[26] and, as the literature review has indicated, the role of the medical practitioner was ambiguous. When Medical legislation was introduced in Australia it acted not only to raise the standards of medical practice, but also to unify medical practitioners into a collective body.[27] This new professional guise afforded medical practitioners greater credibility and positioned them among a middle class elite.

Medicine as a profession

Wearing defines professionalism as an ideology whereby a particular group holds a specific sphere of knowledge and expertise.[28] The group guards its knowledge and expertise from the majority of the population by means of a system of codes, practices and rituals which serve both to mystify the expertise and shape and regulate the practice. Willis points out that in the nineteenth century a number of occupations began to lay claim to being professions.[29] The claim was made on the strength of their relationship to other occupations and the legitimacy of their working roles as imperative to the furtherance of national ideals. What this meant, in effect, was that professions were comprised

25 *The Medical Act* [1858], *Medical Act of 1867*, (31 Vic.No.33); *Medical Act, 1886,* (49 & 50 Vict.c.48, *Medical Act, 1886,* (49 & 50 Vict. c.48).
26 E. Willis, Medical Dominance: *The Division of Labour in Australian Health Care*, pp.36-37.
27 Ibid.,p.104.
28 M. Wearing, "Medical dominance and the Division of Labour in the Health Professions". In C. Gribch (ed), *Health in Australia: Sociological Concepts and Issues,* (Sydney: Prentice Hall, 1996), pp.216–220.
29 E. Willis, *Medical Dominance: The Division of Labour in Australian Health Care*, pp.8-9.

predominantly of men from middle class backgrounds whose family wealth afforded them educational and occupational opportunities over and above those available to the majority of the population. The concept of "profession" thus describes a way of comparing both related and non-related occupations and of categorising them according to their importance as a social role. An adjunct to professional status is the means it affords to exercise power and to effect control at both the individual and group level.[30]

The Medical Act of 1858 represents the first attempt on the part of medical practitioners to organise themselves into a formation that could be readily identified as professional and accountable.[31] The Act came about as a result of the disorderly state of medical practice as it existed in Britain. Poovey points out that, in 1850, as many as nineteen medical licensing bodies competed in Britain and during the period 1840 to 1858 a total of seventeen bills were presented to Parliament in an effort to establish some conformity within medical practice.[32] The intent was to reform the traditional and outmoded structure of medical practice in Britain; a similar structure to that which existed in Australia.[33] The tripartite nature of this structure had historically divided medical practitioners into physicians, surgeons, or apothecaries, but by the 1830s in Britain, the majority of doctors practised in all three areas and had begun to extend their practice to midwifery as well.[34] This occurred despite the characterisation of midwifery by the Royal

30 Ibid., p.9.
31 *Medical Act [1858]*.
32 M. Poovey, "'Scenes of an Indelicate Character:' The Medical "Treatment" of Victorian Women'", *Representations,* (14 Spring 1986), p.149.
33 E. Willis, *Medical Dominance: The Division of Labour in Australian Health Care*, p. 37.
34 M. Poovey, "'Scenes of an Indelicate Character:' The Medical "Treatment" of Victorian Women'", pp.149-150.

Colleges as “manual labour” associated with the “humiliating events of parturition”.[35]

In accordance with the terms of the 1858 Medical Act, whose stated objective was, “…to regulate the Qualifications of Practitioners in Medicine and Surgery”, The General Council of Medical Education and Registration of the United Kingdom was established with branch Councils in England, Scotland and Ireland.[36] The Act provided for the registration of medical practitioners and it was incumbent upon the Council registrars to maintain and update a register of medical practitioners. A schedule was drawn up to list the qualifications that would be recognised by the Council. In essence, those medical practitioners who had received a medical degree from any British university, or who had practised as a medical practitioner in Britain before the first day of October 1858, were eligible to apply for registration with the Council.[37]

The Act did more than hold a register of medical practitioners. A major provision of the Act determined the qualifications that would enable an applicant to present himself for examination. Success in the examination entitled the candidate to practice medicine or surgery. A significant aspect of the Act was that it regulated the practice of the medical practitioner by identifying professional boundaries. A medical practitioner who worked outside those boundaries was likely to have his name removed from the register.[38] The Act also allowed for the recovery

35 Ibid., p.150.
36 *The Medical Act [1858*].
37 Ibid., Section 18 & Schedule A.
38 Ibid., Section 28.

of fees by doctors in relation to medical attendance or practice.[39] Subsequent Medical Acts reinforced this provision,[40] but no such legislature existed for nurses or midwives even when they were able, under The Health Act Amendment Act of 1911, to establish their own private hospitals.[41]

In Australia, the 1858 Medical Act marked the beginning of the move to professionalise the practice of medicine. This Act also made provision for the regulation of apothecaries when it stipulated that a British Pharmacopoeia was to be compiled to direct the selection, preparation and administration of drugs.[42] The focus of this Act was medical and surgical practice and it related to apothecaries only insofar as the Medical Council that was established with this Act was responsible for controlling the contents of the pharmacopoeia.

In 1867, a further Medical Act was passed to "consolidate and amend the laws relating to medical practitioners, chemists and druggists".[43] This Act established a Medical Board of Queensland. The Medical Board was to be responsible for registering those people who practiced medicine and or compounded and or dispensed medicinal preparations.[44] A feature of the Medical Board was that membership was to consist of a minimum of three persons, all of whom were to be medical practitioners and one of whom was to act as president of the Board.[45] The way in which the Queensland Medical Board was structured enabled

39 Ibid., Section 32.
40 *Medical Act of 1867*, (31 Vic.No.33); *Medical Act, 1886,* (49 & 50 Vict.c.48).
41 *Health Act Amendment Act of 1911*, (2 Geo.V.No.26. Part VIII, Sections 67-81).
42 *The Medical Act* [*1858],* Section 54.
43 *Medical Act of 1867*.
44 Ibid., Sections 1–3.
45 Ibid..

medical practitioners to control and supervise the medical fraternity in a manner that was both autonomous and exclusive. The type of governance that was applied to the practice of medicine and its practitioners is in contrast with the extraneous controls placed upon midwives when their practice became subject to legislature in 1911. The *Health Act Amendment Act of 1911* established a Board for the registration of nurses and midwives but gave control of this Board to medical practitioners.[46]

The Medical Act of 1867 incorporated within it the role of the medical practitioner as expert witness at Inquests into deaths.[47] Section 12 of this Act provides for testimony by a medical practitioner residing in the locality of the deceased to be called upon to give evidence concerning the circumstances of death of any deceased person who had not been attended by a doctor either at the time of death or during the period immediately preceding death. The medical practitioner might also be required to perform post mortem examinations and to give evidence to the court convened by a coroner or magistrate.[48] The medical practitioner was able to claim a fee of one guinea for undertaking such an examination, a further fee of one guinea for attending the court and mileage at the return rate of sixpence per mile.[49] Failure on the part of the medical practitioner or practitioners to attend when summoned attracted a penalty of between £3 and £20.[50] The presence of the medical practitioner as expert witness into deaths associated with childbirth therefore positioned him in a crucial role as a clinician and an

46 *The Health Act Amendment Act of 1911,* (Part VIII, Section 82).
47 *Medical Act of 1867,* Sections 12–16.
48 Ibid., Section 14.
49 *Inquests (Death) An Act to Abolish Coroner's Juries and to Empower Justices of the Peace to hold Inquests of Death*, (30 VictoriÆ, No. 3, 17th July, 1866), Section 10.
50 *Medical Act of 1867,* Sections 15-16.

authority whose clinical opinion was sought by representatives of the state. Through such positioning, the medical practitioner was able to observe the work of lay midwives at first hand.

While the Medical Acts of 1858 and 1867 went some way to establishing medicine on a professional footing, the Medical Act of 1886 compounded the presence of the medical practitioner in the birthplace.[51] Under the provisions of this Act, medical practitioners were not only required to become proficient in medicine and surgery, but were required to pass examinations in midwifery.[52] For the first time in the history of midwifery and medicine in Australia, the lay midwife and the qualified medical practitioner were in a form of direct competition. According to this Act, midwifery was judged as equivalent to surgery and medicine, thus making it a credible and essential attainment for medical practitioners. While it may be argued that competition could not exist between the disparate groups represented by midwives and medical practitioners, the onus was now on the medical profession to attract the custom of pregnant and parturient women in order to meet the requirements of their own practice standards. The medical profession was now in a position to service an identified need and it supported legislation to control midwives with whom it was vying for business.

Childbirth as a medical condition

Medical discourse in the second half of the nineteenth century acknowledged the uncertain nature of childbirth. The diagnostic processes that medical practitioners employed in their assessment of the *condition*

51 *Medical Act, 1886*, (49 & 50 Vict. c.48).
52 Ibid.

and the choices open to them in arriving at a successful birth outcome, were discussed at length. Childbirth was becoming increasingly a part of medicine with the most interesting of "cases" being pondered and used to set an example for practice.[53] The mystery that surrounded the reproductive capacity of women stimulated a desire to understand pregnancy and childbirth and to facilitate its process. Poovey quotes a leading medical practitioner in Britain whose course of lectures formed the basis of *A Manual of Obstetrics,* an influential and popular text for students of midwifery in the mid-1800s.[54] The medical practitioner, W. Tyler Smith, had little practical experience in midwifery, but he held strong philosophical ideals about the importance of reproduction, asserting that:

> …the uterus is to the Race what the heart is to the Individual: it is the organ of circulation to the species.[55]

This analogy was in keeping with the sentiments of the New South Wales Royal Commission of 1904 where the reproductive capacity of women and working class women in particular, was the focus of intense inquiry.[56]

Wilson Love, honorary physician to the Lady Bowen Hospital, encapsulates the importance with which the medical profession viewed its role in childbirth when, in May 1893, he shared his reminiscences of almost thirty years of hospital history. Love obviously saw midwifery as an infant branch of 'medical science' that had begun to prosper only after it received attention from medical men:

> For many ages, and in most lands, the practice of midwifery was almost solely in the hand of women, usually old women – *femmes sages* – hence it is not wonderful that slow progress was made until the subject was

53 *AMG*, (April, 1892), pp.182–189.
54 M. Poovey, "'Scenes of an Indelicate Character:' The Medical "Treatment" of Victorian Women'", pp.144-162.
55 Ibid., p.145
56 RCDBR, Vols. I & II.

> taken up by men who devoted the full tide of their energies and intellects, not yet superannuated, to relieve the sufferings and dangers of maternity.[57]

Love points out that although midwives had been the primary carers in childbirth for centuries, they had made little contribution to the 'science' of midwifery. In the same way that midwives had failed to assist the progress of maternity care, women in general, he complained, had made little impression on life. Love protested that:

> I do not wish to be unchivalrous, but I would ask is it not the same in other fields where women compete with men – how many female composers, artists, authors, poets, in the front rank has the fair sex produced? The analogy holds good in midwifery.[58]

Love's dismissive comments set the pattern of his speech and it was a mode that was not unique to him. Much of the language used in arguments put forward by medical men in support of curtailment of the role of midwives contained patronising phrases demeaning the work of midwives and highlighting their shortcomings.[59] The medical profession had a point. In contrast to medical practitioners, midwives were a silent majority. There is no evidence that they communicated with each other about their practice experiences, or that they had any mechanisms in place to communicate in print. Certainly, a proportion of women who submitted statements at Inquests were illiterate signing their name with a cross.[60] Although the state introduced primary education by statute in September 1860,[61] and provided government aid for eleven primary schools, the average number of children attending was seven hundred and

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57 W. Love, "Records of the Lady Bowen Hospital, Brisbane", *AMG,* (May, 1893), p.145.
58 Ibid.
59 RCDBR, Vols. I & II. See also, *AMG,* (April, 1892), pp.182–189.
60 QSA, Justice Department, JUS/N33 72/67: JUS/N68 80/82: JUS/N109 84/455: JUS/N36, 73/56.
61 *An Act to Provide for Primary Education in Queensland*, (24 Vic. No. 6).

fifty seven[62] from an estimated mean population of 25, 788.[63] Women were not catered for at this time and, as Theobald points out, when education for women began in Queensland in 1875, it took the form of a state-funded department of the Brisbane Boys' Grammar School and was an option only for the affluent.[64]

The lack of recorded information by midwives about their work defeats any attempt to gauge the level of their knowledge about childbirth or the way in which they managed childbirth. Yet, childbirth management lay at the crux of the problem for, although childbirth is a natural event, it is also a precarious one. In 1892, a medical practitioner in Britain made the observation that:

> …midwifery is the most anxious and trying of all medical work, and to be successfully practised calls for more skill, care, and presence of mind on the part of the medical man than any other branch of medicine.[65]

This opinion is one that might be applied equally well to the midwife and one that was rarely heard in mitigation of a midwife's error of judgement. The inherent unpredictability of childbirth and the degree of chance associated with its eventual outcome existed in every confinement. The capricious nature of childbirth was underlined in an address to the New South Wales Branch of the British Medical Association and recorded in a medical journal in January 1912. The speaker was William Chenhall, Honorary Surgeon to the Royal Hospital for Women in Sydney. Chenhall, acknowledged that the point where surgery and obstetrics met presented

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62. *Statistics of Queensland for December, 1860*, (QSA, Blue Book, 1859-1860), p.28.
63 *Statistics of the State of Queensland* (hereafter SSQ) *for the year 1920 Compiled from Official Records in the Registrar-General's Office*, (Brisbane: Anthony James, Government Printer, 1921), Part VIII, Vital Statistics Table No. XVII.
64 M. Theobald, *Knowing Women: Origins of Women's Education in Nineteenth-Century Australia*, (Melbourne: Cambridge University Press, 1996), pp.91-92.
65 I. Loudon, *Death in Childbirth: An International Study of Maternal Care and Maternal Mortality 1800–1950*, (Oxford: Clarendon Press, 1992), p.163.

him with “some of the most perplexing experiences of practice”, making the observation that:

> Such points, relatively dependent upon the knowledge and experience of the obstetrician develop in many cases. Granted necessary knowledge and experience, many may be dealt with by the practitioner. Memory confirms some as the most perplexing experiences of practice. Natural variations of parturition within wide limits occur, and the experienced obstetrician will make due allowance, whilst alert to Nature’s faults and the importance of timely assistance.[66]

The wide variations in childbirth to which Chenhall refers made it imperative that the birth attendant neither lost vigilance nor failed to initiate appropriate action if difficulties developed. Treating the variations in the process of normal childbirth to which Chenhall alludes, were often beyond the scope of lay midwives.

Midwives often lacked even rudimentary education and were thus prevented from acquiring the theoretical knowledge that might have enhanced their diagnostic skills. As the previous chapter has shown, on many occasions midwives were called in to women late in childbirth, or they arrived late due to distance or terrain or both.[67] Those women who attended as neighbours, but who were included in the classification of “midwife” simply because they assisted at the birth, were even less likely to possess knowledge of differences between labours, frequently having only the experience of their own childbirth to rely on. Once the process of childbirth has commenced, the woman was ultimately committed to death or delivery. Whilst it was sometimes possible to anticipate that a difficulty might arise, it was often the case that complications occurred without

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66 W. T. Chenhall, “Some Meeting Points of the Obstetrician and Surgeon”, *AMG*, (Jan. 27, 1912), p.81.

67 A. Little, *Days Gone By*, pp. 6-9. See also, C. J. Ellis, *I Seek Adventure: An Autobiographical Account of Pioneering Experiences in Outback Queensland from 1889 to 1904,* (Sydney: Alternative Publishing Cooperative, 1981), pp.27-65.

warning, or without being recognised until a late stage had been reached.[68] In that instance, even the skills of the medical practitioner might be severely tested.

Loudon makes the point that, when viewed in comparison with other deaths during the 1890s, childbirth accounted for far fewer deaths amongst women of childbearing age than deaths from other causes.[69] However, Huff asserts that in Britain during the period 1837-1838, childbirth, typhus and consumption were recorded as being the principal causes of deaths in women aged between fifteen and sixty-five.[70] Clearly, childbirth was traumatic, dangerous and a source of premature death and, as Loudon argues:

> …deaths in childbirth have always been different from other deaths. Childbirth was the only major cause of mortality that was not a disease, and in that way it stood apart.[71]

In order to offset its unpredictable nature and to optimise its outcome, medical practitioners began to adopt a more interventionist stance than had previously been the custom. Late in the twentieth century, this attitude came to be connected with a propensity amongst medical practitioners who specialise as obstetricians to adhere to what became known as a medical model of care.[72]

It is claimed that the medical model contains three elements, those being, a desire to control nature, a mechanistic view of humans and a separation of disease from the human and social environment in which it

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68 QSA, Justice Department, JUS/N42 74/321: JUS/N482 540/1911: JUS/N109 84/455.
69 I. Loudon, *Death in Childbirth: An International Study of Maternal Care and Maternal Mortality 1800–1950*, p.163.
70 C. A. Huff, "Chronicles of Confinements: Reactions to Childbirth in British Women's Diaries", *Women's Studies International Forum,* (Vol. 10, No.1. 1987), p.64.
71 I. Loudon, *Death in Childbirth: An International Study of Maternal Care and Maternal Mortality 1800–1950*, p.164.
72 R. M. Bryar, *Theory for Midwifery Practice*, pp.74-103.

exists.[73] From this perspective, when the medical model is applied to human reproduction, childbirth is viewed as "a case" that is normal only in retrospect. The more unusual the case, the more interesting it becomes. The medical practitioner takes charge and places emphasis on preventing physical complications. In short, the medical model attempts to control the processes of childbirth in order to minimise the risk of not meeting the objective: the success of that objective judged by the survival of a "live, healthy mother and baby".[74] However, while midwifery practice came to be viewed as a legitimate concern of the medical profession, the knowledge medical practitioners brought to childbirth was, in many ways, as uncertain as that of lay midwives. But medical practitioners had access to the use of chloroform and forceps and it was these technologies that impacted upon the shift of control of childbirth from midwives to the medical profession.

Anaesthesia and analgesia in childbirth

The administration of chloroform during childbirth became a controversial issue in the early years of its use due to its effects in impairing consciousness and rendering women compliant. It provided women with relief from pain but at the same time enabled medical practitioners to undertake procedures on women without resistance.[75] Ether was a drug that had similar effects to chloroform and preceded its discovery. Its use to enable "painless surgical operations" to be performed was reported in the Moreton Bay Courier on 4 June 1847.[76] The report centres on the use of

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73 Ibid., p.81.
74 Ibid., p.119.
75 H.R. Woolcock, M.J. Thearle, K. Saunders, "'My Beloved Chloroform'. Attitudes to Child Bearing in Colonial Queensland: A Case Study", *The Society for the Social History of Medicine*, (10/3/ 1997), pp.437–457.
76 *The Moreton Bay Courier,* (hereafter MBC), (Brisbane: Vol. 1. No. 51. June 5 1847).

ether in London in the same year, promoting its efficacy in ameliorating the pain of surgical procedures. An example was given of a woman who was offered the anaesthetic prior to a surgical repair of her torn perineum following childbirth. The woman is condemned as foolish and ridiculed for her decision not to avail herself of the drug when she objects to its stupefying effects:

> At King's College Hospital, Mr. Fergusson operated on Tuesday on a woman for laceration of the perineum. The patient, after taking two or three inspirations, declined to go on, declaring that it would render her insensible; and, preferring to retain her sensibility at the expense of pain, Mr. Fergusson remarked, that their worthy physiologist, Dr. Todd, justly observed that "she illustrated the physiology of obstinacy".[77]

This newspaper report carries the message that the advantages of the anaesthetic outweigh any loss of modesty that its sedative effect might have. As an instrument of both information and propaganda, the newspaper served a vital part in sponsoring or critiquing topical issues. At this time, when the Moreton Bay settlement was in its infancy, the language of the newspaper reflected the dialogue of the educated and the interests of the affluent.[78]

Chloroform was first employed in the management of childbirth on the 8 November 1847, two days after its effects were discovered by James Simpson, who was a professor of midwifery at Edinburgh University.[79] Simpson immediately grasped the advantages of chloroform and within weeks of discovering its analgesic properties, he was using it routinely to treat the pain of labour. It has been argued that the introduction of

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77 Ibid.
78 MBC, (Brisbane: Vol. 1. No. 2. June 20 1846). See Also, MBC, (Vol. 1 No. 2. June 27 1846): (Vol. 1. No. 3. July 4 1846): (Vol. 1. No. 5. July 18 1846): (Vol. 1. No. 12. Sept. 5 1846): (Vol. 1. No. 12. Sept. 10 1846): (Vol. 1.No. 19. Oct. 24 1846): (Vol. 1. No. 32. Jan. 23 1847):(Vol. 1. No. 51. June 5 1847):(Vol. 1. No. 44. April 17 1847).
79 M. Poovey, "'Scenes of an Indelicate Character": The Medical "Treatment" of Victorian Women'", pp.137-168.

chloroform in childbirth enabled knowledge of the female body that had hitherto been impossible to obtain.[80] The acquisition of this knowledge was possible because, under the influence of chloroform, women became uninhibited and lost the propriety that had previously inhibited intimate examination by medical practitioners. Chloroform allowed a methodical examination that would otherwise have been impossible.

Poovey examined work published by Simpson in 1847 to argue that the use of chloroform removed the comprehension of pain from the woman and assigned it to the doctor, so that the woman's body became simply an indicator that the doctor could interpret with greater precision than the woman herself. Poovey stresses that from a practical perspective chloroform might facilitate birth, but its effects in rendering the woman pliable have far-reaching consequences. Simpson talks of the body that is "quiet and unresisting" and describes a state of relaxation and passivity that is total.[81] In this euphoric or unconscious state, the mother offers no obstacle as her baby is drawn from her. Poovey's concern is that chloroform:

> …enables the medical man simultaneously to conceptualise his necessarily intimate physical contact with a woman in abstract and euphemistic terms and to replace what Simpson described as the doctor's incapacitating vicarious suffering with a powerful feeling of have earned the thanks with which women rewarded his labour.[82]

The use of chloroform allowed for intervention in childbirth and discouraged questioning of the doctor's authority and or knowledge. Rather than being embarrassed or disturbed by what was taking place, the woman put herself in the hands of the medical practitioner whose expertise was confirmed by

80 Ibid., pp.143–147.
81 Ibid., p.141.
82 Ibid.

the satisfactory outcome. That outcome might include a pain-free labour, a shorter labour and arguably, a safer labour. The inhalation of chloroform induced sleep that both pacified and rested the mother and, at the same time, relaxed maternal tissue. The long painful labours of most first pregnancies were made more bearable while many of the complications that might occur in any labour were more readily overcome. Over time, the result was the re-positioning of the medical practitioner as the leading expert in childbirth, holding more knowledge than the women themselves and in possession of skills that were far superior to those of the midwives. Medical practitioners were assisted in this by the poor practice standards of some midwives and by women who sought out the new childbirth interventions that were offered.

Simpson had been aware of the advantages of gaining women's support for chloroform and of using their enthusiasm to promote the employment of chloroform during childbirth.[83] His wooing of consumers towards the use of chloroform caused almost as much discord as the chloroform debate itself. Nevertheless, the end result was that in using chloroform the interests of women and medical practitioner were served.[84] When Queen Victoria opted for chloroform during the birth of her eighth child,[85] she not only set a precedent for other women in Britain and its colonies, but also authenticated this drug as a justifiable means to an end. Through the use of chloroform and aided by midwifery forceps, medical

83 Ibid., p.154.
84 Ibid., p.156.
85 Ibid., p.137.

practitioners were able to create 'obstetrics' as a discrete branch of medical knowledge.[86]

Leavitt argues that the degree or amount of pain women experienced in childbirth was related directly to their psychological state. Many women were fearful of pregnancy and pessimistic about its outcome. This fear and pessimism was frequently acknowledged in women's writings and is likely to have impacted negatively on their experience in the birth room. Leavitt makes the claim that:

> During most of American history, an important part of women's experience of childbirth was their anticipation of dying or of being permanently injured during the event.[87]

Leavitt suggests that once analgesia became established as a need in childbirth, it worked to bring about an acceptance of the medical practitioner in the birth room that had previously not existed. Gradually the strained atmosphere that had accompanied the presence of the medical practitioner was eliminated and he was able to work with the woman towards the common goal of a successful childbirth outcome. Leavitt explains that:

> The doctors were not always sure of their role and some of them exhibited significant discomfort. When women and doctors could agree on the administration of anesthesia, the relationship between them developed well, giving the medical attendant greater status and increased respect.[88]

In support of her contentions Leavitt gives, as an example, the work of William Shippen who was renowned for his skills as an obstetrician in Philadelphia in the latter years of the eighteenth century. Shippen had studied medicine in London and Edinburgh before returning to North America in 1762 where he established himself as an obstetrician to the

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86 H.R. Woolcock, M.J. Thearle, K. Saunders, "'My Beloved Chloroform'. Attitudes to Child Bearing in Colonial Queensland: A Case Study", p.437.
87 J. W. Leavitt, *Brought to Bed: Childbearing in America 1750 to* 1950, p.14.
88 Ibid., p.127.

wealthy.[89] In 1795, Shippen used opium to assist the birth of a baby who was delivering by the buttocks and whose leg had become the leading part during its descent through the birth canal. The mother was a member of a prestigious Philadelphia family and was grateful for the treatment she received. Shippen was her attendant during subsequent births and his remedies for her protracted labours included drawing off blood and administering liberal amounts of opium in its liquid form of laudanum and as a pill.[90]

It was successes of the sort recorded by Shippen that cemented analgesics and anaesthetics and the medical practitioners who employed them, in the changing culture of childbirth in western societies. The use of opium and subsequently, ether and chloroform, provided medical practitioners with a legitimate and unique role. They alone had the authority to acquire analgesia for the woman and the means of administering it.[91] The midwife, on the other hand, was able to provide little more than, "moral support and back-rubbing".[92] The pain relief choices available to women who did not opt for, or were not offered, chloroform were minimal. McCalman maintains that women "traditionally used alcohol" to the extent that some were intoxicated before they gave birth.[93] There is at least one coronial inquiry that bears out this observation.[94] For many women who were attended by a midwife and for whom anaesthesia or analgesia was not

89 Ibid., pp.38-39.
90 Ibid., pp.39-40.
91 Ibid., pp.126-127.
92 M. Tew, Safer Childbirth? A Critical History of Maternity Care, *2nd edition*, p.148.
93 J. McCalman, *Sex and Suffering: Women's Health and a Women's Hospital,* pp.23-24.
94 QSA, Justice Department, JUS/N109 84/455

an option, childbirth was, as McCalman terms it, "a purgatory of pain".[95] In such circumstances, it is unclear why midwives relied more on palliative measures rather than on pharmaceutical preparations.

There is evidence to show that midwives in Queensland were able to obtain medications to assist pain relief. In Logan in 1885, the midwife told the husband of the woman she was attending to provide his wife with either a doctor or with "some medicine". The husband returned with "some belladonna and aconite" which the midwife then gave to her "patient".[96] Under the provisions of *The Sale and Use of Poisons Act of 1891*, any person over the age of eighteen years who was known to the pharmaceutical chemist and who submitted name and address was able to purchase any drugs listed on the first or second part of the First Schedule of poison drugs.[97] The first part of this Schedule describes drugs and their derivatives such as aramic, strychnine, ergot, belladonna, chloral hydrate, opium, aconite and cyanide. The second part of the Schedule encompasses preparations such as chloroform, digitalis, nitroglycerine and carbolic acid.[98]

The preparations listed in Merck's Manual for use during labour are many and include atropine, codeine and morphine.[99] In addition to anaesthetics there were substances such as belladonna, cannabis, indica, chloral hydrate, opium and quinine, most of which were also recommended in the treatment of after pains.[100] In situations where after pains persisted and where morphine was ineffective, quinine at night and in the morning was

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95 J. McCalman, *Sex and Suffering: Women's Health and a Women's Hospital*, p.22.
96 QSA, Justice Department, JUS/115 85/79.
97 *The Sale and Use of Poisons Act*, (1891, 55 Vic. No. 31, 1891, Sections 3-5).
98 Ibid., Schedules.
99 Merck & Company, *Merck's 1899 Manual of the Materia Medica,* (New York: Merck & Company, 1899, Facsimile, 1999), p.185.
100 Ibid., pp.85, 141.

the preferred option. It was postulated that the use of ergot would "keep the uterus constantly contracted and prevent accumulation of clots and the consequent pain" although no explanation is given to qualify how a uterus maintained in a constant state of contraction by ergot can occur without pain.[101]

In the light of the provisions for the purchase of medications that might be used to assist labour and to minimise its pain, it would seem that other reasons existed to inhibit women as midwives and as mothers from utilising the full extent of these measures. It may have been due more to monetary constraints than choice. It has been suggested that for a time, only affluent women residing in urban centres in Queensland really had any option with regard to any aspect of their childbirth.[102] It was not until motherhood came to be conceptualised as an economic asset that "childbearing became a public and medical issue".[103] As the coronial and magisterial testimonies will demonstrate, brandy was widely used by both medical practitioners and midwives.

While the medical practitioner might inject brandy hypodermically as was the case in an attempt to resuscitate May Fraser in 1911,[104] the midwife gave it orally and topically. As an ingestible substance, the midwife might give brandy to mother and infant when a stimulant action was required. Nurse Talty gave the ailing newborn baby of Amy Dagg brandy and water as a restorative.[105] When, in 1873, Susan Gardner's labour was delayed during

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101 Ibid., p.85.
102 H.R. Woolcock, M.J. Thearle, K. Saunders, "'My Beloved Chloroform'. Attitudes to Child Bearing in Colonial Queensland: A Case Study", pp.456-457.
103 Ibid., p.457.
104 QSA, Justice Department, JUS/N482 540/1911.
105 QSA, Justice Department, JUS/N234 201/1895.

its second stage and her baby suffered hypoxia as a result, the midwife bathed the infant in brandy in an attempt to stimulate breathing.[106] In July 1895, the midwife gave Julia Degen "tea and a drop of warm gin" during her labour.[107]

One area in which the medical profession was able to demonstrate its ready access to treatments and to reinforce the notion that it held special or more expert knowledge was that of complicated childbirth. Coronial and magisterial accounts highlight certain abnormalities and complexities of childbirth that are borne out in medical discourse and which support the argument that the medical practitioner was able to initiate remedies that were either unavailable to midwives or outside the scope of midwives' knowledge and practice. The most prevalent complications are discussed below and are defined on the basis of current midwifery and medical texts. These conditions have been highlighted because they were identified from coronial and magisterial evidence as commonly associated with deaths in childbirth and their overview here is imperative to understanding the full implications of the midwifery role discussed in Chapter Four.

Antepartum haemorrhage

A recurrent finding of the investigations into maternal deaths during the study period was that haemorrhage had occurred during or after labour.[108] Antepartum haemorrhage is defined as blood loss from the genital tract that occurs after the twentieth week of the pregnancy.[109] There are

106 QSA, Justice Department, JUS/N36 73/56.
107 QSA, Justice Department, JUS/N234 235/1895.
108 QSA, Justice Department, JUS/N482 540/1911: JUS/N30 71/131: JUS/N54 77/238. JUS/N302 37/1902: JUS/N254 349/1897: JUS/N44 75/153: JUS/N17 67/230.
109 L. R. Leader, M. J. Bennett, F. Wong (eds), *Handbook of Obstetrics and Gynaecology*, *4th edition*, (London: Chapman Hall, 1996), p.89.

three classifications of this type of haemorrhage. In the first instance, the blood loss may be indeterminable or connected with a pre-existing condition of the birth canal. The haemorrhage is often not extreme and may resolve without treatment.[110]

Two other forms of antepartum haemorrhage involve bleeding from the placental site. When the placenta is situated in the upper segment of the uterus, abruption of the placenta may occur from an identified cause or sometimes in association with trauma or hypertension.[111] The extent of the blood loss relates directly to the area of separation and may be concealed within the uterus or readily apparent. The condition carries considerable risk for mother and foetus and, if untreated, the prognosis is bleak. The second type of placental bleeding defines placenta praevia, a condition in which the placenta lies in the lower part of the uterus and obstructs the passage of the foetus through the birth canal.[112] This condition often reveals itself painlessly and without warning, yet it may produce rapid and extreme blood loss. The aim in this situation is to maintain the pregnancy for as long as possible and a frequent outcome is birth by caesarean section in order to avoid severe haemorrhage and obstruction of the foetus through the birth canal.[113]

The incidences of antepartum haemorrhage that occurred during the study period were, therefore, difficult to treat at best and impossible at worse. The options available to women suffering from antepartum haemorrhage during the study period were limited and the tendency for women to give birth at home exacerbated this limitation. The next chapter will demonstrate

110 Ibid., pp.94-95
111 Ibid., pp.89-94
112 Ibid., pp.91-92
113 Ibid., p.92.

that when May Fraser bled profusely during her labour, the midwife omitted to call in medical assistance.[114] Although it is unclear whether such assistance might have made a difference, when the medical practitioner did arrive, the woman was in a moribund state and his action was limited to restorative treatment. When Sarah Ann Short developed what her husband described as "a violent haemorrhage" the woman called in to act as midwife, "took the pillow from her head to give her relief and to prevent as much as possible the flooding" and "placed cloths dipped in vinegar around the lower part of her body".[115] It seems that the attendant felt powerless to do anything more. While it might be argued that such unsophisticated strategies were unlikely to make a difference, pharmaceutical preparations were equally ineffective.

Merck's Manual of 1899 offers six substances for use in the treatment of uterine haemorrhage, including ice.[116] Antepartum haemorrhage is not specifically noted in any form, but the preparations recommended for the treatment of haemorrhage from this site are cornutine, creosote, hydrastis and strypticin. This directory was published in New York, but its treatments were consistent with those adopted across Western medical circles. Indeed, the Manual advertises awards made to Merck products that indicate the company's popularity in Britain, Europe and Australia. In 1879, Merck's Products received the Highest Award at an International Exhibition in Sydney and repeated its success in Melbourne in 1880 when it won the gold Medal: "Vitam Exccolere per Artes". The contents of Merck's Manual are, therefore, taken to be representative of the types of pharmaceutical preparations

114 QSA, Justice Department, JUS/N482 540/1911.
115 QSA, Justice Department, JUS/N54 77/238.
116 Merck & Company, *Merck's 1899 Manual of the Materia Medica,* pp.134, 180.

available in the treatment of childbirth and its complications. As far as Merck's Manual was concerned, the treatment options offered were intended for the exclusive use of the medical profession and, in particular, general practitioners or physicians.[117]

Postpartum haemorrhage

After the birth of the baby, the uterus is designed to contract strongly and to remain in that state until the blood vessels into which the placenta was embedded have sealed. Sometimes this mechanism fails and the uterus relaxes with a consequent loss of blood. On other occasions, part of the placenta remains adherent to the uterine wall, preventing the uterus from contracting as it should and sometimes causing severe blood loss.[118] Postpartum haemorrhage, both primary and secondary, was responsible for a significant proportion of maternal deaths in the nineteenth century.[119] Merck's Manual listed twenty-four ways in which postpartum haemorrhage might be treated.[120] While external pressure over the uterus, or ice to the abdomen, were within the province of the midwife, the majority of procedures were not. Examples of the techniques and substances used were the injection of hot water or iron perchloride into the uterus, the insertion of ice into the uterus or rectum and the administration of ergot hypodermically or by mouth.

Other preparations used to treat postpartum haemorrhage included atropine, capsicum, ether, quinine and, in circumstances where bleeding

117 Ibid., pp.1-5.
118 L. R. Leader, M. J. Bennett, F. Wong, *Handbook of Obstetrics and Gynaecology*, pp.230-231.
119 QSA, Justice Department, JUS/N302 37/1902: JUS/N254 349/1897: JUS/N44 75/153: JUS/N17 67/230:
120 Merck & Company, *Merck's 1899 Manual of the Materia Medica,* p.134.

was profuse, a mix of opium with brandy. Ergot was noted to be the most efficient treatment, but substances such as digitalis and iodine were also thought to be of help, but their precise actions are not clarified. Further means suggested to counter the problem of bleeding were compression of the aorta, a hot enema, ipecacuanha as an emetic and "mechanical excitation of vomiting".[121] The range of treatments available cover a diversity of medications and applications that often appear at odds. It is difficult to imagine, for example, the benefits of inducing vomiting or compressing the aorta, when attempting to counteract haemorrhage from the uterus or birth canal. In circumstances where the placenta remained wholly or partly attached to the uterine wall, the medical practitioner would insert his hand and peel the placenta from the uterine wall.[122] Hamilton of Adelaide reported twenty-one cases of retained or adherent placenta out of one thousand midwifery cases in the six-year period 1883 to 1890.[123] In an instance of severe postpartum haemorrhage caused by a partially separated placenta that occurred in Townsville in June 1910, the midwife did not carry out this manoeuvre and, according to the medical practitioner, the woman died as a result.[124]

Puerperal convulsions

Another condition that existed with some frequency was pre-eclampsia or in its later stages, eclampsia. According to twentieth century definitions, pre-eclampsia and eclampsia are conditions that derive from an excess of trophoblastic tissue and, when severe, are a cause of foetal and

121 Ibid.
122 J. Hamilton, "Midwifery Experiences", *AMG*, (April 1892), p.183.
123 Ibid., p.183.
124 QSA, Justice Department, JUS/N450 386/1910.

maternal morbidity and mortality.[125] In its most severe form, the only option is to deliver the baby at whatever stage of gestation has been reached in order to avoid the development of eclampsia and manifestation of severe convulsions and death.[126] It is only with the birth of the baby that the convulsions subside and in many instances, neither mother nor baby survived.

The coronial Inquiries that underpin this thesis locate four women whose deaths were linked directly to convulsions.[127] Hamilton came across seven instances where convulsions "complicated" childbirth, two of which ended in the death of the mother.[128] In 1892, Hamilton deplored his inability to counter the repeated convulsions that seized a young woman in labour. Hamilton had been called out at four o'clock in the morning to a woman who was said to be suffering from severe "pain across her stomach". Not realising that the woman was in childbirth, he had not take his midwifery equipment and was forced to sit "watching this poor woman having convulsion after convulsion every few minutes" while a messenger travelled twelve miles on horseback to retrieve the medical bag.[129] The messenger returned within an hour and a half and Hamilton administered chloroform and delivered the baby by forceps. Although he "…administered choral by the rectum, and kept her almost continuously under chloroform for 12 hours" the woman died eighteen hours after the convulsions had commenced.[130]

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125 L. R. Leader, M. J. Bennett, F. Wong, *Handbook of Obstetrics and Gynaecology*, p.128
126 Ibid., pp.134-136.
127 Appendix Five.
128 J. Hamilton, "Midwifery Experiences", *AMG*, p.183.
129 Ibid., p.184.
130 Ibid.

Other remedies that medical practitioners treating puerperal convulsions might call upon included “dry cupping over the loins”, placing ice to the head, cold to the abdomen, or mustard to the feet.[131] They might also elect to bleed the patient. McCalman explains that venepuncture was a pragmatic rather than scientific procedure at a time when the physiology of blood pressure remained unclear. She relates an incident that occurred at the Melbourne Lying-In Hospital in 1858 when its founder, Richard Tracy, was challenged by convulsions in a young pregnant woman that failed to respond to ten ounces of blood letting. He was eventually able to overcome the problem by administering chloroform at intervals and inducing sleep by these means.[132] While these techniques, along with saline purgatives and varatrum viride as an emetic and the use of nitroglycerin, would seem to be of questionable value, they took their place alongside chloral and opium as remedies for convulsions.[133]

Some medical practitioners employed chloroform or ether and while belladonna and morphine were popular options, nitrite of amyl was considered to be of “doubtful utility”. Hamilton describes the use of morphine injected hypodermically as “the only efficient treatment” of eclampsia.[134] In some cases, he combined, “…hypodermic injections of morphia followed by chloroform and as early a use of forceps as possible with very satisfactory results”.[135] Other preparations on hand were chloral, nitroglycerin, opium

131 Merck & Company, *Merck’s 1899 Manual of the Materia Medica,* p. 161.
132 J. McCalman, *Sex and Suffering: Women’s Health and a Women’s Hospital*, pp.26-30.
133 Merck & Company, *Merck’s 1899 Manual of the Materia Medica,* p.161.
134 J. Hamilton, “Midwifery Experiences”, *AMG* p.184.
135 Ibid., p.184.

and pilocarpine, although Hamilton had little faith in the effects of pilocarpine, preferring morphine to counteract eclamptic seizures.[136]

Puerperal infection

Perhaps one of the most commonly recorded complications of childbirth was infection. In this study, seventeen of the ninety-two Inquests were attributed to puerperal infection and a further two to peritonitis and one to inflammation of the bowels.[137] Puerperal infection that was linked directly to childbirth took the form of puerperal fever while the somewhat confusing term "puerperal mania" denotes an illness that McCalman describes as, "an unexplained phenomenon" that may be equated with "an acute toxic state."[138] Although these two conditions had different origins, they caused the deaths of substantial numbers of women until the adoption of antiseptic practices began to effect a slow decline.[139]

Puerperal fever

Puerperal fever came about as a direct result of unhygienic clinical practices by childbirth attendants.[140] The basic principles were that efficient hand washing, the use of topical antiseptics and the maintenance of childbirth equipment in a clinically clean state, minimised the risks to the mother. The best way to offset puerperal fever was to prevent its occurrence, but for many years so little was known about it that it was impossible to evade. As McCalman has noted, puerperal fever was a dread visited upon the arena of childbirth that caused death to the mother and ruin

136 Ibid.
137 Appendix One.
138 J. McCalman, *Sex and Suffering: Women's Health and a Women's Hospital*, p.30.
139 Ibid., pp.30-34.
140 Ibid., pp.32-34.

to the livelihood of the medical practitioner:

> It came in epidemics; it was obviously contagious; it struck down perfectly healthy lying-in mothers who had not necessarily had long and exhausting labours and birth injuries.[141]

Pioneers in the isolation of causal factors of puerperal infection identified the need for asepsis and the isolation of parturient women from hospital borne infections, including those contracted from the hand of doctors and medical students who conducted post mortems and examined labouring or parturient women.[142] In the latter part of the nineteenth century, control of puerperal infection was based upon avoidance and thus scrupulous attention to asepsis.

In 1893, Wilton Love acknowledged the importance of thorough attention to cleanliness in the lying-in setting, even more necessary, he felt, than in private practice. Advancing Semmelweiss as a leader in the field of obstetric asepsis, Love confirmed his commitment to the use of antiseptics, porros. sublimate 1:2000 prior to vaginal examination and a warm sublimate lotion 1:4000 as a vaginal irrigation before the birth.[143] McCalman observes about the attitude of the medical profession in the management of infections in lying-in institutions, that:

> …if the patients could be kept physically isolated when infected, if basic cleanliness and good care were practised, and if sickly, diseased and undesirable patients could be kept out, then infection might be kept as bay.[144]

Puerperal infection, then, was a complication that was linked to places where women in varying states of health congregated to give birth and where it was imperative that birth attendants maintained a good state of hygiene. Tew

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141 Ibid., p.32.
142 Ibid., pp.33-34.
143 W. Love, "Records of the Lady Bowen Hospital, Brisbane", *AMG* p.147.
144 J. McCalman, *Sex and Suffering: Women's Health and a Women's Hospital*, p.43.

points out that in the history of puerperal infection, poorer women were least likely to be afflicted even though their social class rendered them at high risk of maternal mortality.[145] Tew argues that while the social conditions inherent within impoverished communities increased the chance of women in those communities contracting puerperal sepsis, they were offset by the fewer contacts that these women had with medical practitioners.

Puerperal mania

Puerperal mania was a different matter. This condition was linked to pre-existing infection in the mother that was manifest in a variety of clinical symptoms and diagnoses. The symptoms were those of intense and acute infection that might be diagnosed as peritonitis or pyaemia. The treatment was largely ineffective and the prognosis was consequently poor. The pre-existing infection often included venereal disease and in the days leading up to death women suffered a multitude of afflictions consistent with acute infection. The condition was so resistant to treatment, that every means was used to try to bring about a resolution, including the application of leeches. Sometimes, the infection was made worse by the treatment of vaginal syringing that carried the chance of introducing bacteria to a normally sterile uterus.

Once again, Love provides an anecdote and one that illustrates both the acuteness of the disease and its poignant aftermath. Love recalls that:

> August 26, 1881, Sent for at 12.15 a.m. to see M.M., confined last week; found the matron had been obliged to go for the police, while the assistant was sent for me. All the patients had left their beds, and were huddled together in a state of panic. I found M.M. divested of all clothing, swinging Mrs. Kelly's baby by the leg. She, M.M. was in a state of acute puerperal

145 M. Tew, Safer Childbirth? A Critical History of Maternity Care, *2nd edition*, pp.282-283.

> mania. I took the infant from her and held her till the police arrived. She was very violent, and temporarily letting her go for a moment, she seized a kerosene lamp and threw it at me. Fortunately she did not set fire to any combustible material. On the constables' arrival I requested them to hold her, and sent for Dr. Bell, who kindly and promptly came to my assistance. I was informed that the maniac had broken several windows, and had attempted to cut the throat of Bridget W. with a piece of glass. I accompanied her to the Reception House.[146]

Clearly, there was little that could be done for this unfortunate woman. The pharmaceutical preparations used in the treatment of puerperal infection at the close of the nineteenth century were numerous, but few would seem to have been of help to someone with advanced infection and psychological derangement. These preparations included some whose appropriateness might be challenged. Injections into the bladder, uterine curette in the presence of continued fever, laparotomy and venesection, are active procedures whose benefits are not immediately apparent.

Abnormal labour

Abnormal labour is said to occur when there is delay or inhibition in the passage of the foetus through the birth canal. Taking the average length of the active stage of labour as that point at which the woman's cervix is three centimetres or more dilated, current medical opinion asserts that twelve hours is the maximum time it should take the cervix to reach its full ten centimetres dilation.[147] Based on this maxim, prolonged labour is said to have occurred if the labour lasts longer than eighteen hours in total. Abnormal uterine activity describes conditions in which the contractions are either over active and incoordinate or under active and infrequent.[148]

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146 W. Love, "Records of the Lady Bowen Hospital, Brisbane", *AMG* pp.146-147.
147 L. R. Leader, M. J. Bennett, F. Wong, *Handbook of Obstetrics and Gynaecology*, p.214
148 Ibid., pp.210-213.

Hyperactivity is associated commonly with malposition while hypoactivity may result from multiple pregnancies, malpresentations or cephalo-pelvic disproportion. For example, disproportion between the mother's pelvis and the baby's head may occur because the pelvic is wrongly shaped or too small, or it may be that the head of the baby is too large or presenting in an unusual attitude.[149] Sometimes the foetus is simply too big to pass through the pelvis or it may be positioned in such a way that it is impossible to negotiate the birth canal as in the case of a baby lying across the uterus rather than being longitudinal to it.

Abnormal labour occurred quite frequently as a complication of childbirth during the nineteenth and early twentieth century and was often beyond the treatment skills or even the diagnostic abilities of midwives. The causes of delay in the completion of labour may rest with the mother or the foetus or both. The most common reasons for abnormal labour are identified as, "abnormal uterine activity"[150] and "cephalo-pelvic disproportion",[151] both of which conditions are associated with increased morbidity or death of the mother or the foetus.[152] During the study period, inhibited labour that was caused by an obstruction in its course was not always described in these terms. Sometimes abnormal labour was concealed within the description of "exhaustion" as in the cases of Sarah Bridges of Toowoomba in 1868 [153] and Emmistine Trueman of Tiaro in 1874.[154] On these occasions it is likely that exhaustion accompanied the protracted and complicated course of the

149 Ibid.
150 Ibid., pp.210-214
151 Ibid., pp.207-210
152 Ibid., p.206.
153 QSA, Justice Department, JUS/N19 68/105.
154 QSA, Justice Department, JUS/N42 74/321.

childbirth and therefore became the official and perhaps most obvious cause of death.

In 1891, the medical practitioner, Swift, from Adelaide, explained the difficulties associated with an abnormal labour in which the foetus lies with its back towards the mother's and where it is wedged and unable to descend into the lower part of the birth canal. Swift defined this circumstance, a persistent occipito posterior position, as one in which, "…the occiput remains in the sacral hollow and will not rotate, [155] and he went on to lament the difficulties associated with this condition:

> If I were asked the question: what class of cases give you the greatest amount of trouble? I would answer without a moment's hesitation occipito posterior presentations, for these reasons, viz., the presentation is by no means a rare one; the labours are always tedious; and in a great majority of cases forceps have to be applied.[156]

Swift's explanation of the treatment usually employed for labours inhibited by this problem suggests that without the correct diagnosis and the use of instruments the birth outcome might well be compromised:

> When called to a confinement I generally suspect an occipito posterior presentation if I find the os high up and far back and dilating very slowly, even though the pains have been strong and forcing for some hours… Barnes [a leading obstetrician) says these labours are always tedious, and in the majority of cases in which he has been called upon to use the forceps the delay has been due to this position.[157]

In the shared midwifery experiences of medical practitioners published in medical journals in the late nineteenth century, conditions that led to prolonged labour were discussed as specific causes such as ovarian tumour, or impacted shoulder.

While instrumental intervention was considered a boon to the medical practitioner in achieving improved childbirth outcomes, even the

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155 H. Swift, "Midwifery Experiences", *AMG*, (April, 1892), p.184.
156 Ibid., p.182.
157 Ibid.

most experienced obstetricians were not beyond being tested in the normal course of childbirth as Alfred Lendon, Physician and Acting Obstetric Physician to the Adelaide Hospital, demonstrated in 1892 when he said:

> I am obliged to confess that I have a difficulty in deciding always as to whether a head presentation be an occipito posterior or occipito anterior, but I have learnt to suspect it to be the former in a case where there is no obstruction in the passages, and where the os is well dilated, and yet the head makes no progress in descent; and I feel assured of it when after applying I find that they slip off the head.[158]

The method that Lendon used to confirm his diagnosis may seem extreme but perhaps demonstrates the limitations that existed in knowledge of childbirth amongst all its attendants. The application of forceps to retrieve the foetus from the birth canal was a procedure available in Australia only to medical practitioners and one increasingly employed by them during the late nineteenth century. McCalman has said of forceps and the conditions that underpinned their use:

> Contracted pelvis and the consequent difficulties in delivering a baby consumed more intellectual energy in nineteenth-century obstetrics than any other topic. It had underwritten the man-midwife's entry into the birthing chamber, for it had been the Chamberlens' invention of the obstetrical forceps which gave men a specialty with which to stake their claim against traditional female midwifery.[159]

Forceps enabled the birth to be completed in a shorter time than might otherwise be possible and their popularity grew amongst the medical profession. It was clear to medical practitioners and especially those whose focus was midwifery practice, that forceps gave them the chance to deliver a baby alive who might otherwise be stillborn or brain damaged.

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158 A. Lendon, "Midwifery Experiences: The Treatment of Occipito Posterior Presentations", *AMG*, (April, 1892), p.182.
159 J. McCalman, *Sex and Suffering: Women's Health and a Women's Hospital*, p.22.

In 1892, Hamilton used forceps in one hundred and eighty six confinements out of one thousand consecutive cases. In justifying his use of forceps, he pointed out that he applied them primarily for his own convenience because:

> …in a country practice the forceps are perhaps more frequently used than in towns, for "…expediency", when you find yourself 20 or 30 miles away from home and are bound to remain with the case till it is over.[160]

Without hint of contrition, he goes on to explain his second most usual indication for using forceps:

> …In the rural districts, especially amongst the Germans, the womenfolk do a great deal of manual work, and the consequent muscular development and rigidity can only be overcome by chloroform and forceps.[161]

Allwork of Riverton was also a convert, using forceps in eighty-four of four hundred consecutive cases. Allwork gave no reason for his preference for forceps other than to say that:

> …the results of such cases in my practice have been so satisfactory that I am strongly impressed with the advantages to be gained by not unnecessarily delaying their use, particularly in multiparous women.[162]

In 1893, Love quotes a forceps rate at the Lady Bowen Hospital for the period 1885 to 1893 as one in every twenty-two confinements and maintains that their use prevents women from becoming exhausted. [163] The diary of Ophelia Powell, written in 1857 and quoted by Huff provides a rare opinion from a woman who experienced the application of forceps. It is Ophelia's

160 J. Hamilton, "Midwifery Experiences", *AMG* p.183.
161 Ibid.
162 F. Allwork, "Midwifery Experiences", *AMG,* (April, 1892, p.187.
163 W. Love, "Records of the Lady Bowen Hospital, Brisbane", *AMG* p.146.

first child and she is relieved to hear to sound of the medical man's carriage outside the door:

> …Oh how thankful I felt when I heard his wheels stop at our door – After 12 hours of extreme pain and suffering, and Mr. Gillett's judicious use of instruments at 25 minutes after four o'clock on Tuesday morning Sept–8–1857 Mr. G. announced the birth of a perfect little boy.[164]

Ophelia clearly acknowledges the medical man as an expert in a process that has caused her great pain and is thankful for the way in which he has managed her childbirth. Although she is the one who has withstood the "extreme pain and suffering" she relinquishes the control of the birth to "Mr. G" who informs her that she has given birth.

While judicious use of forceps saved lives, there was a danger that over-enthusiasm might lead to abuse. In 1889, Myer of the Women's Hospital, Melbourne, advised caution in the use of forceps saying that they were all too frequently applied in both the first and second stages of labour with detrimental consequences to the mother. Infection, lacerations to the perineum and gynaecological complications were all associated with the misuse of forceps.[165] In 1892, Swift gave a graphic example of the misuse of forceps when he recalled:

> The patient told me afterwards, her account being corroborated by the nurse, that in her last confinement the doctor used the instruments and pulled the patient, nurse, and bed across the room until he was stopped by the wall.[166]

The physical and psychological consequences of such extreme force being used to apply traction to the foetus are unimaginable. In the same year, the medical practitioner Monsell, reinforced both the concept that labour carries with it a certain degree of risk and that its outcome might be

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164 C. A. Huff, "Chronicles of Confinements: Reactions to Childbirth in British Women's Diaries", p.65.
165 J. McCalman, *Sex and Suffering: Women's Health and a Women's Hospital*, p.119.
166 H. Swift, "Midwifery Experiences", *AMG*, (April 1892), p.183.

affected adversely by the quality of the birth attendant when he recalled that:

> I was called on one occasion to see a primiparae who was in labour for several hours with very severe pains. She was attended by a foreign doctor who wanted to "put on" the forceps... When I examined, the head appeared to be below the brim, coming down with but receding after every pain. Now when I examined, the feeling that was imparted to my finger rather puzzled me, so I examined again, and after some time, to my great surprise, I found the os so high up that it was almost out of reach of the examining finger, and dilated only to about the diameter of a sixpenny piece, and nearly as thin as a piece of paper. I had her conveyed to hospital, and with the administration of chloral and bromide, and hot vaginal douches, the os dilated and labour terminated naturally in about eight hours. Now had the forceps been put on in that first instance I shudder to think of what the consequences might have been.[167]

It is apparent from Monsell's description, that the task of estimating the degree of dilatation of the cervix that acts as an indication of the stage of labour is not an easy one. Here, two men who practise as doctors were initially mistaken in their findings and it was only after some time and perhaps the greater expertise of one of them, that an accurate assessment was made. The "foreign doctor" is not admonished as an incompetent practitioner for his poor skills either in misdiagnosing or in attempting to instigate the wrong treatment.

Despite the negative connotations associated with the use of forceps, on occasions they were the only means by which the foetus could be extracted and then only after destructive procedures had been applied. In these situations, it might be necessary to reduce the size of the foetus by cutting into its skull or removing it in pieces from the uterus.[168] These were clearly procedures well outside the capabilities of a midwife in the home and yet were sometimes essential if the mother's life, at least, was

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167 F. Monsell, "Midwifery Experiences", *AMG,* (April, 1892), p.184.
168 J. McCalman, *Sex and Suffering: Women's Health and a Women's Hospital*, p.22.

to be saved. These treatments were a source of concern to many medical practitioners as Chenhall acknowledges, but there was often little choice:

> Conditions demanding craniotomy are important, because one constantly feels the moral obligation of saving both lives. Yet it always seems to me permissible when the child is dead, when marked cerebral deformity or hydrocephalus exists, or where pyrexia indicates infection of the parturient canal from careless handling.[169]

According to Chenhall, a way of avoiding the procedure might be to apply forceps and weighty traction to extract the foetus, but that was likely to cause unnecessary trauma to the mother. Chenhall argues that, in such circumstances, there was no real choice but to resort to destructive measures because:

> No warrant exists for dragging a dead child through the parturient canal with great force when craniotomy or embryulcia will render delivery easier. On two occasions, where we believed the child was dead and the patient's condition desperate, I perforated, applied the cephalotribe, and delivered and saved both mothers. One could not have seriously considered the advantages of pubiotomy or Caesarean section in such cases. Generally, I believe it expedient to allow natural expulsion to occur wherever practicable after reduction of an abnormal presenting part.[170]

The ramifications of abnormal labour that this passage describes represent the most drastic of measures and are not lightened by the language. The way in which this short passage is presented serves almost to detach the reader from the reality of the situation and supports the claim that, to some members of the medical profession, childbirth was merely a mechanism that occurred within an inanimate and systematised device. Chenhall reinforces this conceptualisation when he asserts that forceps are not always the best

169 W. T. Chenhall, "Some Meeting Points of the Obstetrician and Surgeon", *AMG*, (Jan. 27, 1912), p.84.
170 Ibid., p.81.

choice and that caesarean section is sometimes the better option. He observes that:

> Attempted delivery of a living child *per vias naturales* is unscientific where unnatural proportions between the passenger and passage are found, and Caesarean section alone offers hope for saving both lives.[171]

While Chenhall advocated caesarean section as the optimum treatment option, not all his colleagues were so inclined. Cautioning that it is imperative to make the correct diagnosis at the outset and that harm may result from selecting the wrong treatment option, Chenhall explains that where disproportion exists, he prefers the option of caesarean section because, in his experience:

> Undue force is far too frequently applied at the expense of mother or child when precise study of existing conditions would have revealed a contracted pelvis, an impacted shoulder, or some equally potent cause of dystocia.[172]

Consistent with the experiences of Hamilton and Monsell, Chenhall's comments suggest that not all medical practitioners were competent and not all lives were enhanced or assisted by their interventions. There was plainly a difference between the levels of knowledge and experience medical practitioners might bring to the birthing scene. By 1892, when Hamilton and Monsell recorded their particular encounters with other practitioners, medical practitioners had seemingly benefited from a three-year course of specialist training in medicine. With all the opportunity that afforded them for advanced knowledge of the subject, maternity practice continued to perplex and confuse.

For those women whose childbirths were associated with forceps, the application of these instruments was often combined with an anaesthetic

171 Ibid., p.81.
172 Ibid.

such as chloroform. In the late nineteenth century, a combination of chloroform and forceps was used to treat obstructed labour or delay in the birth of the foetus.[173] The use of forceps without some form of anaesthesia was unthinkable given the severe damage that forceps might wrought especially in situations where their employment was injudicious. McCalman cites a range of injuries that were the consequence of forceps application and which marred the woman's future life.[174] Opium, an older preparation than chloroform, was cited in the labours of Sally Drinker Downing in North America in 1795.[175] Its use in Australia seems to have been predominantly in the treatment of pain caused by gynaecological conditions or as a sedative.[176]

The diversity in the ways in which childbirth presented itself and to which midwives were exposed during the course of their work was sometimes quite beyond the scope of their knowledge. That diversity frequently included complexities that were impossible to treat without the techniques that were available only to medical men. Medical evidence in the late nineteenth and early twentieth century continually reinforced the notion that doctors held superior skills and knowledge to that of midwives. At the same time, the unpredictable nature of childbirth that the medical profession acknowledged in their own discourse was not included in their assessments of the work of midwives. Indeed, in their appraisal of midwives, the medical profession saw fallibility as a profound deficit. In contrast, when it came to

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173 J. McCalman, *Sex and Suffering: Women's Health and a Women's Hospital*, pp.119-120.
174 Ibid., pp. 21-26, 119-120.
175 J. W. Leavitt, *Brought to Bed: Childbearing in America 1750 to 1950*, p.39.
176 J. McCalman, *Sex and Suffering: Women's Health and a Women's Hospital*, pp.28-29, 44-45.

reflecting on their own work, fallibility became the fault of the "patient" or of the circumstances in which the "patient" gave birth. The midwife's position was shifting and unstable. She was the principal practitioner in childbirth, but she worked alone without the support of others of her kind, relying for the most part on the goodwill of the community. That goodwill was generally forthcoming and although community reminiscences of the practices of individual midwives tend to be complimentary, some might argue that the community had no other option.

Current obstetric thought interprets many of the conditions that this chapter has discussed as "obstetric emergencies". In the language of the twenty-first century, from a text whose first edition was published in Britain in 1917, an emergency is defined as:

> …a situation or occurrence of a serious and often dangerous nature, developing suddenly and unexpectedly, and demanding immediate attention.[177]

Amongst the conditions that constitute an emergency in current obstetric practice are, hypertensive disorders, haemorrhages and post-partum collapse. The treatment of these conditions is specific to the cause and includes cessation of labour by means of caesarean section, urgent replacement of blood loss and reversal of clinical shock through intravenous therapy.[178] For conditions in which labour progresses slowly, or not at all, as a result of inefficient uterine contractions or cephalo pelvic disproportion, the treatment is active management by use of a uterine muscle stimulant or assisted "delivery" of the foetus.[179] In the twenty-first century, the condition

177 S. Campbell, C. Lees (eds), *Obstetrics by Ten Teachers 17th edition*, (London: Arnold, 2000), p.303.
178 Ibid., pp.303-308.
179 Ibid., pp.120-121.

of cephalo-pelvic disproportion often requires extraction of the foetus through caesarean section.

With present day treatments relying so heavily upon obstetric interventions to offset or remedy clinical complications, there is little doubt that lay midwives in the nineteenth and early twentieth century were severely disadvantaged from the outset. Uneducated in the physical processes of childbirth and ignorant of the ways of resolving complex situations, they were devoid of the means of preventing or treating impediments to childbirth. Their perceived deficiencies led to claims against them by, arguably, their most hostile audience. But could medical practitioners really offer anything better than that which was available from the lay midwife? In retrospect it seems that perhaps they could not. This chapter has shown that the treatments offered by medical practitioners were notably unscientific and their use of technology dependent upon the administration of chloroform, the application of forceps and the occasional use of drugs whose effects are now questionable.

With the benefit of hindsight, Tew draws on her detailed statistical analysis of childbirth trends in the twentieth century to argue that the medical profession contributed very little to childbirth in terms of improved mortality rates. Tew is emphatic in defending her findings, contending that:

> It is impossible to find evidence that medical care raised the safety of birth for mother or child before 1935. It is impossible to find evidence which supports the claim that improvements in the education and technical efficiency of doctors or midwives, or indeed in other elements of maternity care, were responsible for the major and sustained improvement after 1936 in the survival of mothers in childbirth. It is just as difficult to show that these were the factors responsible for the markedly improved survival of postnatal infants after 1900 and of neonatal infants and fetuses after 1939.[180]

180 M. Tew, Safer Childbirth? A Critical History of Maternity Care, *2nd edition*, p.311.

But this advice was not apparent in the period under review. With this in mind, the following chapter concentrates in some detail on the work of lay midwives and the criticisms levelled against them by members of the medical profession. At that time, medical practitioners brought to childbirth ways of thinking and interpreting that were different from that of midwives. It was an "expertise" that saw childbirth as an illness for which the medical practitioner needed solutions based on scientific principles and in which he was assisted by technological advances.

Conclusion

As this chapter has shown, by the early twentieth century the medical profession was already a formidable presence in childbirth and medical ascendancy over midwifery practice was rapidly becoming a reality. The medical profession had emerged as an organised body with a monopoly over its own training and practice. Its members were predominantly men drawn from the middle class whose wealth and social status distinguished them from the women of the working class, the majority of whom represented on the one hand, their "patients" and on the other and to a lesser extent, their competitors. Unlike the midwife cluster whose knowledge of childbirth was largely dependent upon practical response to the event, the medical profession of the late nineteenth century comprised self-assured men who were not only literate, but were also educated and trained within a specialised discipline. These men had been taught the art and the science of medicine and they brought their skills to the practice of midwifery.

The inherently unpredictable and potentially problematic nature of childbirth supported the medical profession's campaign against lay midwives. In emphasising the inadequacies of midwives' knowledge and promoting their own perceived greater expertise, the campaigners called for the creation of a trained midwifery nurse to replace the unqualified midwife. The medical profession was a strong proponent of childbirth reform and focused on the deficits of the untrained midwife and held those instances where maternal or infant deaths occurred in association with attendance by lay midwives to be the normal state of affairs. While this was undeniably not the case, a view supported in parliamentary debates that took place during the early twentieth century,[181] the medical profession was successful in its pursuit of a significant restructuring of midwifery practice. Importantly and as argued earlier, the imperatives driving this agenda were compatible with broader social objectives being pursued by the governments of the day.

The following chapter identifies the principal claims made by some members of the medical profession against lay midwives. The claims are assessed in the light of coronial and magisterial evidence related to deaths in childbirth that occurred between 1864 and 1912. The accounts conform, where possible, to the complications of childbirth that have been dealt with in this chapter, but in the place of the medical practitioner, the work of the lay midwife is highlighted. The chapter will show that, in comparison with the specialist medical practitioner who professed to have the means to

181 ORDLCA Vol. CVIII, 1912, pp.531-533. See also, ORDLCA, during the Third Session of the Twenty-Second Parliament, 13 George V, Vol. CXL, 1922, pp.1763-1765, 1854-1870.

make a difference to childbirth outcome, the midwife, when severely tested, was often found to be lacking. Lack of education, lack of skill, lack of foresight and lack of insight all contributed to the deaths of women and their infants and gave credence to the claims against midwives.

CHAPTER FOUR

IGNORANCE OR NEGLECT?
CLAIMS AGAINST MIDWIVES: QUEENSLAND 1859-1912

> …if positive proof were required, how many heartrending cases could we not all relate, where loss of health, and even life, has resulted from the fatal treatment of some uneducated, drunken, or dirty midwife.[1]

The thesis thus far has identified the origins of the role of the midwife and has traced the development of that role as it evolved in New South Wales and Queensland. It has demonstrated the ways in which the lay midwife went about the work of childbirth assistant and has addressed, in comparative terms, the ascendency of the expert practitioner role adopted by the medical profession. The previous chapter established the medical profession as a progressive and stalwart body in the arena of childbirth in Britain and Australia. The chapter illustrated the ways in which the medical profession conceptualised childbirth and the options available to it in the ”management” of childbirth as a medical “condition”. The different approaches to childbirth, the disparate functions that midwives and medical practitioners performed, and the ascendancy of medicine, deemed the restructuring of midwifery practice inevitable. It was an inevitability assisted by the lack of an organisational structure to support midwives in Australia and to guide their occupational development.

While the midwife was the traditional attendant in childbirth, both women and midwives came to rely increasingly on the medical

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1 W. B. Nisbet, “The Education of Midwives”, *AMG*, (June, 1891), p.270.

practitioner. This reliance was expressed by women who, when provided the opportunity, opted for painless childbirth, and by midwives who, when caught in clinical situations that were beyond their abilities, called for medical aid. Medical practitioners were thus able both to increase and reinforce their impact on childbirth. Some medical practitioners used their influence to deride midwives for poor work practices, while others lost no opportunity to draw attention to deficits that they attributed to midwives' inferior knowledge base. This censure was not directed against all midwives and not endorsed by all members of the medical profession. Yet, some midwives were inept and it was their practices that fuelled condemnation of the midwifery role.

At the same time, the complexities of childbirth brought midwives and medical practitioners into close contact and allowed each the opportunity to observe the practice of the other. Although lay midwives held a powerful attraction for women of the working class, they were impotent against the greater prestige and authority of the medical fraternity who were beginning to dominate the childbirth arena. When medical practitioners were called to assist at a confinement that had become complicated, they were ideally placed to comment on events that had preceded their arrival and to apportion blame with whomever they felt responsible.

The status held by the medical practitioner as birth specialist was strengthened by, or perhaps gave strength to, the role of the medical practitioner in the courtroom. Medical practitioners appeared as expert witnesses and medical examiners. Police called on medical practitioners

to give evidence related to the circumstances of unexpected death and to conduct post mortem examinations. In assisting coroners and magistrates to assess the clinical facts that confronted them, medical practitioners were involuntarily afforded the means through which they might find out more about what went on in the birth-rooms of the working class. The medical practitioner was, therefore, in a prime position to pass judgements on the practice of lay midwives and to suggest ways in which midwifery practice might be improved.

The value of medical opinion was no less apparent in the political arena where policy makers sought solutions to the growing problem of population decline and infant mortality. Articles in medical journals in the late nineteenth century contain frequent negative references to the work of untrained midwives and it is clear from submissions to the New South Wales Royal Commission that medical practitioners held a firm platform as advisers to the Inquiry.[2] Formal criticisms against midwives came, for the most part, from a small number of medical practitioners who took active measures to make their case known. Graham, in New South Wales,[3] and Nesbit in Queensland,[4] were two of the most vigorous campaigners for the regulation of midwives.

This chapter considers some of the claims made by medical practitioners against midwives and evaluates the substance of those claims on the basis of evidence provided to coronial and magisterial investigations into maternal and infant deaths. The chapter demonstrates

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2 W. B. Nisbet, "The Education of Midwives", *AMG*, (June, 1891), pp.269-271. See also, RCDBR, Vols. I & II.
3 Anon. "A Meeting of the Medical Profession: Midwifery Nurses' Bill", *AMG*, (November 21, 1898), pp.480-485.
4 W. B. Nisbet" The Education of Midwives", *AMG*, (June, 1891), pp.269-271.

that, far from being indisputable, the contention that lay midwives were the primary perpetrators of deaths in childbirth remains a matter for conjecture. For while the attendance provided by the lay midwife was not devoid of shortfalls, neither was it inherently or unanimously perilous. And while it is clear from the testimonies that there was a need to standardise and formalise the midwife role, the variable nature of childbirth, compounded by the lack of organised medical assistance to support complex childbirth, were significant influences in childbirth outcomes.

The call for changes to midwifery practice

It was in June 1891 that Nisbet, a medical practitioner from Townsville, made an emotive appeal for changes to the work of midwives in Queensland. Nisbet called for the abolition of what he termed, "the indiscriminate practice of midwifery by untrained nurses" and for provision to be made, "for educating suitable women to become certificated midwives".[5] Using figures contained in a paper by Aveling and delivered before the British Gynaecological Society, Nisbet quoted a maternal mortality rate in Britain of 1:200 in women attended by an untrained midwife compared with 1:729 attended by midwives who had received training. Relating these figures to Queensland, Nisbet showed that maternal mortality in 1888 and 1889 was 1:201 and 1:241 respectively.[6]

5 Ibid., p.271.
6 Ibid., p.270.

Based on these figures, Nisbet posed the rhetorical question:

> …if positive proof were required, how many heartrending cases could we not all relate, where loss of health, and even life, has resulted from the fatal treatment of some uneducated, drunken, or dirty midwife.[7]

Nisbet's claim was not a new one in terms of correlating the midwife or the nurse with ignorance, alcohol and lack of hygiene.

In a portrayal of nursing progress over a fifty-year period between 1838 and 1888 published in the *Nursing Record* in 1888, the picture of a large, unkempt, and rough-looking woman, wearing a mop-cap and a domestic apron, is posed against the image of a slim young woman of refined appearance, whose hair is neatly contained within a trim and close-fitting bonnet. In the background of the picture of the first woman rests a bottle over which lies an umbrella, or "gamp" as was its slang term. The background of the second woman contains a cross.[8] The association between the first woman portrayed and the character of "Sarah Gamp" whom Dickens created in his fictional work, *Martin Chuzzlewit,*[9] is an analogy that has become easily recognised in nursing and midwifery discourse.[10]

In his work, Dickens portrays the nurse as an uncouth and bulbous woman whose rough exterior does little to soften her insensitive nature.

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7 Ibid.
8 C. Davies, "Introduction: The Contemporary Challenge in Nursing History", In C. Davies (ed) *Rewriting Nursing History*, (London: Croom Helm, 1980).
9 C. Dickens, *Martin Chuzzlewit*, (London: Penguin Books, 1986), pp.373-390.
10 C. Davies, "Introduction: The Contemporary Challenge in Nursing History". See also, K. Williams, "From Sarah Gamp to Florence Nightingale: A Critical Study of Hospital Nursing Systems from 1840 to 1897", In C. Davies, (ed), *Rewriting Nursing History*, (London: Croom Helm, 1980), pp.41-75.

The uncomplimentary picture that Dickens paints is summarised in this passage:

> The face of Mrs. Gamp – the nose in particular – was somewhat red and swollen, and it was difficult to enjoy her society without becoming conscious of a smell of spirits. Like most persons who have attained to great eminence in their profession, she took to hers very kindly; insomuch that, setting aside her natural predilections as a woman, she went to a lying-in or a laying-out with equal zest and relish.[11]

The implications of this description are clear. This character is a woman who is in high demand as accoucheur and mortician and whose inclination towards alcohol is a part of her everyday life. This portrayal, taken out of context as it has been and applied to a diverse assortment of women who are purported to represent one social body, that of midwife, has acted to both identify the role of the midwife and to damage its plausibility.[12]

The "Sarah Gamp" image was consistent with Nisbet's interpretation of the midwife role and he was in no doubt that maternal mortality was "due to ignorant midwives" whom he described variously as "uneducated, drunken, or dirty".[13] Nibset's claim that a proportion of women who acted as midwives consumed alcohol to the detriment of the women they attended cannot be dismissed, and there is coronial and magisterial testimony to support it. While the true incidence of inebriation as a factor in negligent midwifery practice is impossible to determine, its presence was enough to reinforce criticism of midwives. It seems that consumption of alcohol by women was not especially remarkable. Constance Ellis in her memoirs recollected with some

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11 C. Dickens, *Martin Chuzzlewit*, p.378.
12 A. Summers, "'For I Have Ever So Much More Faith in her Ability as a Nurse': The Eclipse of the Community Midwife in South Australia 1836–1942", pp.183-187.
13 W. B. Nisbet, "The Education of Midwives", *AMG*, (June, 1891), p.270.

wryness that the nurse who assisted her in the birth of her first child failed to arrive the following morning as arranged because she and her husband had consumed a bottle of brandy given to her by Constance the day before.[14]

Nisbet further claimed that the majority of midwives were ignorant of the processes of childbirth and as a consequence women experienced long-term gynaecological conditions or even death. Nisbet maintained that, those women whose labours were mismanaged by midwives were likely to become exhausted during the confinement, to be slow to recover after childbirth, and perhaps be plagued with backache for the rest of their lives. In support of his views, Nisbet explained that:

> …it is not only the actual loss of life which might be prevented. Think of the hundreds of women who, through ill-health following a mis-directed confinement, are rendered miserable and useless as workers and wives. What brings the crowds of chronic sufferers as out-patients to the Gynaecological department of a hospital in any large town?[15]

Nisbet called on the state to help the medical profession rid Queensland of the dread of the lay midwife. He argued that, if women were to persist in continually seeking out the services of the midwife in preference to the medical practitioner, then it was the responsibility of the state to ensure that midwives were trained to an acceptable standard.[16]

Nisbet was not alone in his denigration of the lay midwife. In 1893, Love, Honorary Physician to the Lady Bowen Hospital in Brisbane, linked midwives to maternal and infant mortality, saying they were, “self-taught

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14 C. Ellis, I *Seek Adventure: An Autobiographical Account of Pioneering Experiences in Outback Queensland from 1889 to 1904*, (Sydney: Alternative Publishing Cooperative, 1981) pp.37–39.
15 W. B. Nisbet, “The Education of Midwives”, *AMG*, (June, 1891), p.270.
16 Ibid., p.271.

and correspondingly ignorant".[17] In 1898, at a meeting of the medical profession in New South Wales, it was asserted that midwives were "ignorant and unskilled" although it was conceded that this statement did not apply to all midwives.[18] In 1909, Victorian midwives were referred to as an "inferior grade" of practitioner.[19]

The purported ignorance and lack of skill associated with lay midwives was parallelled by the claim that untrained midwives acted as a vehicle for infection. Here, the medical profession argued that midwives would benefit from a compulsory period of training in a lying-in hospital where they could be taught the need for surgical cleanliness. The 1904 Royal Commission made much of the benefits of hospital births in the fight against puerperal infection.[20] The Report differentiated between being "clean in the ordinary sense" yet "surgically unclean" in terms of childbirth, arguing that the lay midwife was a liability because she had not been trained to understand the distinction between these states of hygiene. The Report further proposed that such knowledge might only be gained from "a course of training in a properly equipped Maternity Hospital".[21] However, in making their claims against lay midwives, neither medical practitioners nor politicians attempted to define the term "midwife" or to acknowledge the lack of uniformity in the midwife role.

Dawley, in her exploration of the origins of nurse-midwifery in the United States argues that in the United States, the aspersions cast on

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17 W. Love, "Records of the Lady Bowen Hospital, Brisbane", *AMG,* (May, 1893), p.145.
18 Anon, "A Meeting of the Medical Profession, Midwifery Nurses' Bill", *AMG*, (Nov. 21 1898), p.487.
19 Anon, "The Registration of Midwives", *Intercolonial Medical Journal*, (November 20 1909), p.273.
20 RCDBR Vol II, pp. 31-32.
21 Ibid., p. 32.

midwives both validated attempts by the medical profession to extend the new medical specialty of obstetrics and assisted public health nurses in their efforts to adopt midwifery practice as a branch of nursing.[22] The result was a campaign to discredit midwives, whom it branded as "ignorant, dirty and dangerous" and to eliminate the independence that was characteristic of their practice.[23] The objective shared by nurse leaders who supported the campaign was the amalgamation of nursing with midwifery and the creation of the nurse-midwife.[24]

The United States shared both the high rate of infant mortality and the tendency to attribute this to midwives. Indeed, Dawley[25] and Borst[26] concur that infant mortality in the United States was considerably higher than in any other western country and that the blame for this situation was placed firmly with midwives. Dawley shows that between 1900 and 1930 maternal mortality rates in the United States were disproportionately high compared with thirteen European industrialised countries.[27] The rates were almost twice as high as those in England and Wales and over three times higher than those in the Netherlands.[28] To quantify this data, the United States had a maternal mortality rate of between sixty seven and eighty five per ten thousand lives births compared with between forty four and forty eight per ten thousand in

22 Ibid.
23 Ibid.
24 Ibid., 91.
25 Ibid., pp.86-87.
26 C. Borst, "Teaching Obstetrics at Home: Medical Schools and Home Delivery Services in the First Half of the Twentieth Century", *Bulletin of the History of Medicine*, (72. 2, 1998), p.224.
27 Ibid., p.86.
28 Ibid., pp.86-87.

England and Wales and twenty three to thirty three per ten thousand in the Netherlands.

A similar pattern emerged with neonatal death rates. During the period 1900 to 1910, a comparison between neonatal mortality in the United States and that of twenty-one European countries revealed the United States rates to be significantly higher.[29] The high rates of childbirth-associated deaths were blamed on midwives, European immigrants and African Americans who comprised the majority of practising midwives even though this claim was inconsistent with the low rates in the Netherlands where midwives managed the majority of births.[30] Loudon, too, found a direct link between a significant *decline* in maternal mortality in Britain between the years 1650 to 1850 and the practice of lay midwives.[31] The increase in the numbers of lay midwives was associated with a corresponding enhancement in their skills, but Loudon makes a distinction between these lay midwives and the relatives and friends who acted as midwives, arguing that the lay midwife was infinitely better.[32]

In Queensland, an important factor in the indiscriminate criticism of lay midwives is that no distinction was made between the lay midwife who routinely attended women in childbirth and those who acted as midwives only in the absence of an alternative. Coronial and magisterial documents indicate that even among lay midwives there was no clear image of what constituted a midwife and no continuity in the way in

29 Ibid., p.87
30 Ibid.
31 I. Loudon, *Death in Childbirth: An International Study of Maternal Care and Maternal Mortality* 1800 – 1950, p.161.
32 Ibid., pp.161-162.

which they described themselves. For example, in 1871, Margaret O'Connor, the woman who acted as midwife to Julia Casey, referred to herself as being, "in the habit of attending friends in their confinements as nurse."[33] In 1877, Mary Ann Williams, who acted as midwife to Sybella Klump and had done so in the previous four confinements, stated that, "I go out to nurse."[34] In 1895, Norah Talty stated that she had, "acted as nurse at the birth."[35]

The lack of differentiation between women who habitually attended as midwives and those who did not may help to explain the dichotomous portrayal of lay midwives that emerged in Chapter Two. Even though in some communities in Queensland the lay midwife was remembered with respect and affection,[36] coronial and magisterial Inquiries contain evidence to the contrary. While the numbers of instances where lay midwives were implicated in the deaths of women through incompetence is difficult to gauge, the data amplifies the inconsistent and ad hoc nature of the midwife role in Queensland, and clarifies the motivation of the medical profession and the state in becoming involved in the business of childbirth. The accounts show how childbirth and midwifery practice, occurring as they did in the privacy of the home, were beyond formal gaze and might easily be seen as the reason for unexplained maternal and infant deaths.

33 QSA, JUS/N131 71/178/1871
34 JUS/N54 77/231/1877
35 QSA, JUS/N234201/1895
36 W. Selby, "Motherhood in Labor's Queensland 1915–1957", pp.93-105.

The extent of the problem in Queensland 1859-1912

Maternal deaths

It is difficult to obtain accurate figures in relation to maternal mortality. Maternal deaths were grouped within the category of Developmental Diseases, Adults, Class IV, Order 2, which described paramenia, childbirth and "others".[37] These deaths were recorded as a proportion of 10,000 estimated mean population. During the study period, the average number of deaths of women in or associated with childbirth appears to have been between thirty-five and fifty-five each year.[38] Mean population figures and related births and deaths are contained in Appendix Four. In 1884, childbirth was ranked twenty-seventh on a list of common causes of death amongst the total white population of Queensland. The number of maternal deaths for that year was fifty-six and the average age was between twenty-five and thirty years.[39]

In comparison with the overall population, the most common cause of death, dysentery, accounted for nine hundred and six deaths, the second most common cause was phthisis with five hundred and seventy-two deaths reported, and typhoid fever was third, with five hundred and forty-two deaths.[40] In the years between 1880 and 1890, three hundred and ninety maternal deaths were recorded.[41] When expressed as a

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37 Queensland Legislative Assembly, *Votes and Proceedings*, 1871-1872, p. 427
38 Ibid., p.472. See also, *SCQ for the year 1884, 25th Annual Report*. See also, *SCQ for the year 1890* And, *SCQ for the year 1920*, Part VIII, Vital Statistics Table No. XVII.
39 *SCQ for the year 1884*, 25th Annual Report, Appendix, Table Nos. XI, XIII, pp.13, 17.
40 Ibid., p.13.
41 Ibid., p.XXXII, See also, *SCQ*, *for the year 1890*, p.XXVII.

proportion of the total deaths per 1,000 the rate averages a little over eight percent per year over a ten-year period.[42]

Evidence submitted to the New South Wales Royal Commission in 1903 in relation to the ratio of maternal deaths in Queensland during the period 1870 to 1902 demonstrates an average of 2.98 deaths per one hundred total female deaths.[43] Expressed as a ratio of maternal deaths per one thousand births, an average of 4.41 deaths is recorded during this thirty-two year period. The most common causes of maternal deaths were divided into seven categories, including abortions and miscarriages, which were represented as one category. While the majority of deaths fell within the category of "indefinitely defined", the next most common causes of maternal death were abortions and miscarriages, puerperal convulsions, and placenta praevia respectively.[44]

This study has located ninety-one maternal deaths and five hundred and seventy-two infants deaths that were the subject of coronial or magisterial Inquiry during the period 1859-1912.[45] Details of maternal and infant deaths appear in Appendices Five and Six respectively. In relative terms, 545,101 births took place in Queensland during that period.[46] Taking into account that a proportion of these births would have been multiple, and acknowledging discrepancies in registering births and deaths, it is only possible to offer an approximation of the number of births in comparison with deaths that were formally investigated.

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42 *SCQ for the year 1884*, p.XXXII. See also, *SCQ for the year 1890*, p.XXVII.
43 RCDBR, Vol. I, Evidence of Statisticians, p.32 (para. 6244).
44 Ibid., p.32 (para. 6245).
45 QSA, Justice Department, Index to Inquests 1859-1886, 1887-1897, 1897-1914.
46 *SCO*, *for the year 1920,* Part VIII, Vital Statistics), Table No. XVII.

Infant deaths

This study is primarily concerned with the transition of midwifery practice from untrained to qualified and while the death of the unborn or newly born baby is an adjunct to that transition, such deaths are not a central focus. The data on investigated neonatal deaths does, however, offer a sound indication of the problems facing the state in terms of deaths of infants and of the incidence of infanticide. The deaths of infants located during the study period are listed in Appendix Six and expressed in numerical form in Appendix Seven. Other information accrued includes the geographical location of the death, the date of the Inquiry or death, the cause of death and the archival location number of the Inquest.

The data has been included in full in the appendices in order to provide an indication of the extent of the problem facing those concerned with infant mortality. However, deaths that were clearly not linked to childbirth have been eliminated from the discussion. These deaths amount to eighty-six deaths that were attributed to various diagnoses[47] and sixty-three deaths caused by gastro-enteritis. The category "Other" describes fifty-one deaths where the cause is not sufficiently explicit to be inserted elsewhere.[48] Convulsion was another clinical condition that resulted in the deaths of fifty-four infants.[49]

Deaths occurring at or soon after birth

The twenty-four deaths that occurred during childbirth suggest either that the care during birth was questionable, or that a complication

47 Appendix Seven.
48 Ibid.
49 Ibid.

had occurred that was untreatable by the birth attendant.[50] These circumstances include those where the mother may have been alone during childbirth. On two occasions, the body of the infant was subsequently discovered in a river. The final entry on page 432 of the list of *Justice Department Infant Inquests 1859-1886* indicates that the body of an unknown newly-born female infant who "died in delivery" was found in the Brisbane River, while the fourteenth entry on page 440 shows that the body of an unknown male was found in the Mary River after dying from "improper tying of naval cord".[51]

It is possible that the bodies of babies who died either inadvertently or by design, during or shortly after birth, might be disposed of anonymously rather than the birth and subsequent death being reported to the district registrar as the law required.[52] This is particularly relevant to the unmarried or unsupported mother. To dispose of the body in this manner might relieve the unmarried mother of the responsibility of making an admission that she found embarrassing in a social environment where illegitimacy was a stigma.

Deaths resulting from prematurity

Prematurity was a prominent cause of death associated with childbirth or the weeks following birth and one in which, it could be argued, deaths might have been avoidable in certain circumstances. Archival data records fifty-seven deaths due to prematurity in the study period.[53] The Royal Commission Report identified prematurity as the

50 Ibid.
51 Ibid.
52 *The Registration of Births Deaths and Marriages Act of 1855,* (Vic. 19, No. 34).
53 Appendix Seven.

primary cause of death in newborns.[54] J. Hughes, Register-General for Queensland, informed the Commission that premature births were the second most common cause of infant deaths.[55] The other causes were primarily enteritis followed by "convulsions, diarrhoea, whooping cough, pneumonia, bronchitis and dentition".[56] These findings are borne out by archival data contained in Appendix Six.

Deaths attributed to stillbirth

The total number of stillbirths that occurred during the study period was twenty-three.[57] Details of these deaths appear in Appendix Eight. A number of the deaths due to stillbirth carried the comment, "appeared to be stillborn" or "supposed to be stillborn" appended to these records.[58] What this suggests is the possibility that those deaths were in some way contrived and that the status of "stillborn" was attributed only in the absence of evidence to the contrary. Therefore, although the midwife was not implicated directly in the deaths of stillborn infants, the midwifery role was still open to question. Of the twenty-three stillbirths, it appears that six were babies who had been abandoned after birth and whose bodies were discovered some time later, either buried or disposed of in a river.[59] In these instances, where the circumstances of birth could not be accurately ascertained, the domestic location of childbirth was a significant hindrance. The obstacle posed by births that took place in the home extended to infants who

54 RCDBR, Vol I, pp.38-40.
55 Ibid., p.33.
56 Ibid.
57 Appendix Seven.
58 Appendix Eight.
59 Ibid.

were reported to have been stillborn. It was impossible to know whether the stillbirth might have been avoided by judicious treatment on the part of the birth attendant or whether the stillbirth masked infanticide.

Stillbirths also posed a challenge to medical practitioners whether they practised in the institutional or domestic environment. In the twenty-nine year period, 1864 to 1893, the Lady Bowen Hospital recorded one hundred and fifty two stillborn infants out of an adjusted total of 2 946.[60] Forty-four of these infants died before the mother left the hospital. Similarly, in a seven-year period between 1883 and 1890, of the one thousand consecutive "cases" that the medical practitioner, Hamilton, dealt with in his Adelaide practice, eighteen were stillborn.[61] The New South Wales Royal Commission linked stillbirths with lay midwifery practice, and made the recommendation that the compulsory registration of births should be enforced more strongly in order to, "call attention to any midwife in whose practice stillbirths were unduly frequent".[62]

Deaths from unknown causes

Forty-nine deaths were recorded as "unknown" and these were often bodies of unidentified infants whose actual cause of death was equally mysterious. For example, of the sixteen deaths recorded on page 432, Appendix Six, each was anonymous and all were suspicious, with eight bodies found in the Brisbane River.[63] There is the likelihood that some, if not all of these deaths were linked either to infanticide,

60 W. Love, "Records of the Lady Bowen Hospital, Brisbane", *AMG,* (May, 1893), p.145.
61 J. Hamilton, "Midwifery Experiences", *AMG*, (April, 1892) p.183.
62 RCDBR, Vol. I*,* p.33.
63 Appendix Six.

illegitimacy, or both. The difficulty in determining the exact cause of death is reflected in the ninth entry on page 449, Appendix Six, where the death of an unknown child in South Brisbane was recorded as, "Probably drowning. If drowning probably a case of murder".[64] In the absence of sufficient information to enable accurate categorisation and thus to judge whether the death was likely to subscribe to neonatal classification or to be outside the scope of the study, it has been included in the overall number of "infants".

Deaths due to drowning

Drowning was a major contributor to deaths in infancy and was the cause noted in thirty-nine of the cases recorded.[65] While some incidences of drowning were attributed to accident, others were clearly not. In the same way, the finding of "murder" was returned in fifteen of the 572 deaths, but it is probable that the figure is not a true representation.[66] The numbers of deaths of unknown infants and the location at which their bodies were discovered suggest that infanticide was a problem of considerable magnitude. The abandoning of unwanted infants into rivers was a frequent occurrence both in Brisbane and other parts of Queensland. Its significance to this study rests in trying to arrive at a "true" assessment of the problem that confronted those who were keen to preserve infant life. The abhorrent nature of this particular event is apparent from the details disclosed at an inquest held in Brisbane on the 13 October 1875.[67]

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64 Ibid.
65 Ibid.
66 Ibid.
67 QSA, Justice Department JUS/N46 75/395/1875.

The Inquiry was informed that, three days before the hearing, on Sunday 10th October 1875, the body of a female infant had been found by a couple in a boat. The couple, brother and sister, had noticed a bag in the mud on the banks of the river at South Brisbane. The bag was tied at one end with a white stocking and at the other end a baby's foot was protruding. Inside the first bag was a flour bag that contained the body of a partially clothed infant who had a white stocking tied tightly round its neck. William Hobbs, the medical practitioner called in by police to perform the post mortem examination, stated that the baby had been born alive but that she had died soon after birth as a result of suffocation and strangulation.

Illegitimacy as a factor in stillbirth, drowning, and unknown causes

The rates of illegitimacy in Queensland during the latter years of the nineteenth century caused the government some concern. In the period 1895 to 1904 there was a 2.0 percent increase in the numbers of babies born to unmarried women and a consequent rise from 4.93 per cent in 1895 to 6.9 per cent in 1904.[68] Although this figure was exceeded in New South Wales, with a rate of 7.12 per cent, the rate of illegitimacy in Queensland was high in comparison with other Australian states and with New Zealand. In Queensland, seven children in one hundred were illegitimate.[69] In real terms, this meant that approximately eight hundred babies were born each year to unmarried women. In 1904, that figure reached nine hundred and seventy one.[70] It was this

68 ORDLCA, Vol. XCVI, 1905, p.1657.
69 Ibid., p.1656.
70 Ibid., p.1661.

increase that worried the Queensland government, who were anxious to reverse this trend.

The connection between the lay midwife and illegitimacy and infanticide was a tenuous one that originated from the presence of the midwife in the birth-room and the custom whereby some midwives opened up their homes as lying-in facilities.[71] It was a link that extended to stillborn infants, a group whose causes of death were difficult to determine with accuracy. A concern of government was the extent to which lay midwives might contribute to and conceal infant mortality. First, they might cause the death of an infant through ignorance resulting in mismanagement of childbirth. Second, they might assist the mother to conceal the birth of an illegitimate infant or make the claim that such an infant was stillborn. Allen argues that, in New South Wales, infanticide was a criminal act in which untrained midwives were implicated strongly during the early 1900s.[72]

Drawing on evidence submitted to the New South Wales Royal Commission, Allen cites an allegiance between a lay midwife and an undertaker that brought about the demise and burial of numbers of infants who had reportedly been stillborn when, in fact, they had been starved to death in fruit boxes housed in the cellar of the midwife's home.[73] Women, who were unable or unwilling to care for their newborn infants, paid the midwife to see them through their confinements and to place their infants in the care of a baby-minder. Instead, the midwife

71 Ibid., pp.1652-1663.
72 J. Allen, "Octavius Beale Reconsidered: Infanticide, Babyfarming and Abortion in NSW 1880-1939", pp.112-116.
73 Ibid., pp.114-115.

murdered the infant and disposed of its body under the guise of a stillbirth.

Cases brought before the coroner or magistrate 1859-1912.

The accounts that are featured here and in the following chapter provide an example of some of the births that occurred at this time. They have been selected for their vividness in presenting the occasion of childbirth. Three criteria governed their inclusion. First, they needed to show the circumstances in which women gave birth. Second, they were to enable identification of the birth attendant or attendants and the role they played in childbirth. Third, they had to demonstrate the types of problems that had arisen to cause deaths investigated at Inquest. The organisation of this data conforms to the medical conditions discussed in the previous chapter and its purpose is to test the claims that midwives were ignorant menaces against the official records of the period. Appendices Nine and Ten detail the names of the deceased, the dates and locations of death and the official causes of death.

It must be emphasied that, while the accounts offer valuable insight into the circumstances in which women gave birth and the types of situations women experienced, these births are not held as being true of *all* birth experiences. However, the statements presented to the coroner or magistrate, obtained as they were under oath, include depositions of family and friends of the deceased; of the birth attendant; and of the medical practitioner who had been called in before or soon after the death had occurred. These coronial and magisterial testimonials highlight the

perils and sufferings of women and their babies and, through those experiences, capture the essence of childbirth for working class women.

The data supports the argument that there was a *needless* loss of maternal and infant life and that the factors that impinged upon those deaths were complex and were likely to require a variety of means to address the problem. The data in relation to infants reveal examples of overt murder such as death by strangulation or drowning; deaths in which murder is plausible but not proved such as those instances when bodies of infants were found in rivers, or when asphyxia occurred as a result of being overlain by their mothers; and deaths that were directly attributed to childbirth including stillbirths and neglectful treatment, both of which causes carry with them the possibility that death occurred in suspicious circumstances.[74]

The cases that appeared before a coroner or a magistrate were those where the death had been determined by a senior member of the police force as being worthy of closer inspection.[75] It was a requirement of *The Registration of Births Deaths and Marriages Act of 1855*, and *The Amended Registration Act of 1867,* that the district registrar should be notified of every birth and death in his district within sixty days for a birth and thirty days for a death.[76] A relative of the deceased, or a police officer or coroner, might initiate that notification. The coronial and magisterial testimonials indicate that when a death occurred it was customary for the next of kin to notify the police who would then determine whether a

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74 Appendix Six.
75 *The Registration of Births Deaths and Marriages Act of 1855* (Vic.19, No.34).
76*The Registration of Births Deaths and Marriages Act of 1855*, *The Amended Registration Act of 1867,* (31 Vic. No. 7).

coronial inquiry was necessary.[77] An Act of Council that originated on 1st November 1825 initially governed the coroners.[78] In 1866, the Inquests of Death Act abolished coroner's juries and empowered Justices of the Peace to hold inquests into deaths.

The first coroners appointed in Queensland were William Armstrong in Drayton, Henry Challinor in Ipswich, and Kearsey Cannan in Brisbane.[79] Cannan acted as public vaccinator and, from 1st October 1850, as surgeon to the Brisbane Gaol.[80] In 1864, Challinor was listed as a member of the Queensland Medical Board, the president of which was Cannan.[81] At the end of the Inquiry, the Coroner completed a Certificate of Particulars in which the findings of the Inquiry were conveyed. Those cases where death was attributed to negligence on the part of a person were referred to the Attorney General and the Commissioner of Police.[82] The details of the maternal deaths that are discussed in this chapter appear in Appendix Nine. There are ten in total and they cover the period 1864 to 1911.[83]

Of the maternal deaths that appeared before the coroner during the study period, four identified antepartum haemorrhage as a primary cause. The first account deals with the role of the lay midwife and the second, the Certificated Ladies' Nurse.

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77 QSA, Justice Department, JUS/N234 235/1895.
78 *Coroner's Act of Council*, (6 Geo. IV, No. 20, 1 November 1825).
79 *Statistics of Queensland for December, 1859*, (QSA, Blue Book, 1859-1860), p.28.
80 Ibid., pp. 28-33.
81 *Pugh's Queensland Almanac, Directory, and Law Calender for 1864*, (Brisbane: Theophilus P. Pugh, 1864), p. 49.
82 QSA, Justice Department, JUS/N31 71/178.
83 Appendix Nine.

Antepartum haemorrhage

Sarah Ann Short, Moggill, October 1877[84]

Sarah Ann lived at Mogill and had arranged for her mother-in-law to care for her during her confinement. Although her mother-in-law, Ann, was a nurse neither she nor Sarah Ann had anticipated the problems that would ensue. When Sarah Ann began to bleed profusely before the birth of her baby, her mother-in-law sent for Rose Stanley, a local woman whom they engaged as midwife. The evidence of William Short, farmer, and husband to Sarah Ann, is a graphic introduction to the events that befell Sarah:

> I recall Tuesday the 30th day of October. On the evening of that day I was sitting in the doorway with the deceased, talking. This was about half after 7 pm. She said I must go to bed and you had better call grandmother, who came into our bedroom. I was in the room with my deceased wife. I noticed she was suffering from violent haemorrhage. I assisted in putting her into bed. I left her in charge of my mother… Afterwards I went into the bedroom to see how my wife was. My mother had given her a cup of tea. She appeared better. I asked her if the haemorrhage had stopped. She answered 'Yes'. I thought she looked very easy tempered. She fell off to sleep. At about a quarter after 10 pm my mother went into see if the deceased was all right. Everything appeared so. I went to bed. I had only been asleep about a quarter of an hour when my wife …and said "You will have to get up Short". I got up. She then called for my mother. She went in. My mother then came out and said to go for Mrs. Stanley. I did so. Mrs. Stanley came and after seeing my wife told me I had better go for a doctor. I went to catch a horse to go for a doctor but before I could get the horse ready Mrs. Stanley called for me to come quickly. I answered I had not got the horse harnessed. Mrs. Stanley replied, "It is no use now. Let the horse go". I did so, returned to the house and found my wife about dying. I knelt down near her. She drew her breath about twice and expired.

The statement made by William Short's mother, Ann, indicates that although Sarah had started bleeding around 7 pm that evening, no one had realised the seriousness of her condition. In fact, it is likely that she

84 QSA, Justice Department, JUS/N54 77/238/1877.

had already lost a considerable amount of blood by the time the midwife was alerted about five hours after the bleeding was first noticed:

> …Between 11 and 12 o'clock in the night of the 30th my daughter-in-law Sarah Ann Short was taken ill. I sent for Mrs. Stanley who was living close by to come and see her – she came immediately. My daughter-in-law was near her confinement. Mrs. Stanley was engaged as midwife. The deceased was suffering great pain in her bowels, not the pain of labor (sic). I gave her a little brandy to sip - but the pain never ceased as far as I could judge. A few minutes before she died she said Grandmother take care of my children and died immediately afterwards. She was only poorly about an hour, not more.

The testimony of Mrs. Stanley, the midwife, emphasises the severity of Sarah's condition and the powerlessness of her attendants to rectify it:

> Mr. Short came to my house – he said –Mrs. Stanley my wife is sick I want you to come down immediately. I went and on seeing the deceased Sarah Ann Short I thought she would not live being near her confinement and flooding having happened very violently. I took the pillows from her head to give her relief and prevent as much as possible the flooding. I asked her if the pains she was suffering were labor (sic) pains – she said No. I placed cloths dipped in vinegar around the lower part of her body. I remained with her until she died which occurred about three quarters of an hour after I first came to her.

Mrs. Stanley does not explain the purpose of the treatment she rendered to Sarah Ann, but its acceptance by the Coroner suggests that it was considered appropriate. The medical practitioner who examined the body of Sarah Ann opted not to perform a post-mortem and based his decision on the evidence of Ann Short and Rose Stanley. His opinion was that Sarah Ann died from, "loss of blood during the early stage of labor" (sic). This judgement reinforces the acceptance that a proportion of women and unborn babies would die from complications of childbirth. The account highlights the vulnerability of women as both mothers and midwives suddenly confronted with life-threatening situations that they were unable to remedy.

A consequence of a complication such as antepartum haemorrhage was death and there was little anyone could do to avert that process. In this case, the medical practitioner did not offer the suggestion that a medical presence might have made a difference. It is clear from the midwife's testimony that she had limited understanding of the mechanisms that were in action to cause the profuse bleeding. It might have been an irreversible situation where the bleeding was beyond the scope of domestic treatment. Nevertheless, the actions of Rose Stanley and Ann Short were such that it is unlikely that any other outcome would have been possible. The language used by Mrs. Stanley in describing the degree of bleeding suffered by Sarah Ann imbues a sense of inevitability that death would be the outcome of such profuse blood loss.

Muriel "May" Fraser, Nambour, November 1911[85]

Even midwives who had received formal recognised training were not above reproach. When Nurse Louisa Laidlam, a Certified Ladies' Nurse, accepted Muriel 'May' Fraser into her lying-in home in Nambour in November 1911, she could not have known that she would be faced with a clinical condition that she had not previously encountered. May was eighteen years old and she died on 21st November 1911. The circumstances of May's death were complicated by rivalry between the midwife and the doctor who May had consulted earlier in her pregnancy. The testimony of May's mother, Ann, unfolds a story that begins in the weeks preceding May's death:

> I am the wife of William Alexander Fraser – and my home is at Mullumbimby, NSW. I am the mother of deceased – Muriel May Fraser. – My daughter – deceased – and I arrived in Nambour on 16th September

85 QSA, Justice Department, JUS482 540/1911.

> (this year). My daughter was a single girl. My daughter got into trouble in N.S.W. and I brought her to Nambour, to stay until her confinement was over – which I expected to take place in the last week in November.

The language used by Ann Fraser in describing the circumstances of May's pregnancy and her action in removing her daughter from her local environment are consistent with the social stigma attached to illegitimacy. Ann was clearly supportive of her daughter who she described as a "strong healthy girl" of eighteen years. Ann Fraser engaged Dr. Penny to oversee her daughter's care and employed Nurse Laidlam to attend the confinement. Ann goes on to describe a blood loss suffered by May while she was staying at the lying-in home:

> On the night of the 15th November the hemorrhage (sic) commenced and ceased next day – except a slight show. We kept her in bed on the 16th November. She seemed alright (sic) until the night of the 20th inst. At about 7 o'clock on the night of the 20th inst. She complained of a pain. She was in bed at this time. Nurse Laidlam attended to her. Her bowels were moved twice from 7 to about 9 o'clock. Some time after 9 the nurse examined her, and said it had made a start.
>
> There was slight hemorrhage (sic) through the night – but deceased said the pains were only slight. A little before 7 on the morning of the 21st my daughter rose up in bed and looked for the time, and said – "We'll soon be hearing the whistle". She seemed well and cheerful then. A little after this nurse Laidlam asked me to go for Doctor Penny. I went and saw Doctor Penny - and asked him "Will you come down to May at nurse Laidlam's". The Doctor replied "I refuse to work with Nurse Laidlam for reasons of my own." "If her life is in danger I would come." I then left.
>
> When Ann Fraser arrived back at the lying-in hospital, Nurse Laidlam was on the veranda. The nurse asked if the doctor was on his way, and when told of his response, asked Ann Fraser to return to the doctor with the message that she thought Muriel would die. Dr. Penny arrived soon after and sent for a second practitioner, Doctor Malaher, but he was not available. Soon after, Muriel died.

From this statement it appears that Ann Fraser had little understanding of what was happening to her daughter and that she put her trust in the nurse. The testimony of Nurse Laidlam confirms Ann Fraser's account and includes the information that the medical practitioner, Dr. Penny, had

treated May following the antepartum haemorrhage she had experienced. Nurse Laidlam explained that:

> … On Thursday 2nd Nov. I got a letter from Mrs. Barlier – Mrs. Fraser's sister-in-law. When I got the letter I was nursing Mrs. McCallum at Kurelpa. The letter said that May had had a hemorrhage (sic) and Doctor Penny had prescribed for her, and advised them to get May a bed at the Bungalow. The bungalow is Dr. Malaher's private hospital. The letter said further – that there was no bed available at the bungalow – and Nurse Taylor – in charge – did not attend cases out. There was no bed available at Nurse Adam's. The letter asked me to call and see Mrs. Fraser.
>
> I replied to the letter, saying that I thought it hardly fair to ask me to come all the way from Kurelpa, where I was attending a patient only two days confined – to have a talk with them. I had no reply to that letter.
>
> I came to Nambour on the 11th Nov. Mrs. Barber met me in the street when I got out of the coach, and told me that May was not over her trouble, and asked me to go up and see them – which I did at once. I saw Mrs. Fraser – who told me about the hemorrhage (sic).
>
> I asked Mrs. Fraser had she made any arrangements for confinement. She said – we might take her down to your place. I said "alright' – but did Doctor Penny say anything when he knew I was to nurse the case – as they said they considered him engaged professionally. Mrs. Fraser said No he had said nothing- I said rather than have any disagreement between Doctor and nurse I would forfeit the case. It was undecided at that time whether the deceased should remain in the house or be moved to my place. During the week we arranged for both May and her mother to stay with me in my house. May came to my place on the 14th Nov. and the mother came on the 17th. On Monday 13th Nov. Mrs. Fraser said Doctor Penny had refused to attend the case, but said he would come if the patient's life was in danger.
>
> On The night of Wednesday 15th November the deceased had a slight hemorrhage (sic). I attended to her. Twice on Thursday morning early I attended to her but the hemorrhage (sic) was only slight. I kept the patient in bed until her end came.

Nurse Laidlam appears to have been in something of a predicament. She had been told that the medical practitioner would attend only if May's life was in danger, but when that point was reached, it was too late to treat her. The haemorrhage that had started on the 15th November continued intermittently and the nurse explained that on the night of 20th November

she remained with May all night because the haemorrhage had worsened.

When Nurse Laidlam eventually called in the medical practitioner, it was because she had noticed a change in May's colour that she recognised as a significant sign, although she does not enlarge upon this point. By the time the medical practitioner arrived, it was clearly too late to save May and it transpired that her baby had died some weeks before. Nurse Laidlam provided a detailed account of the measures Doctor Penny employed in his efforts to resuscitate May:

> Some time after the Doctor came and examined her. He asked had I given her any brandy. I said no but I had some already mixed. He asked me what strength it was and I said about half and half. He threw that lot out, and took some neat brandy out of the bottle, and injected some under each breast. The Doctor then took off his coat and washed his hands and after working at the deceased some time got me to alter the patient's position on the bed. Then he asked if I thought Dr. Malaher would come. I said I would send and ask. I asked Mrs. Fraser to go for Dr. Malaher. After that I went back to the bedside. Soon after I heard a step and went outside and saw Mrs. Ferguson who said Dr. Malaher was out of town. I told Dr. Penny this message.
>
> Shortly after this the patient died. In my opinion she died from hemorrhage (sic). When she complained of a pain in the chest I thought it might result from internal hemorrhage (sic). She did not suffer much from hemorrhage (sic) while she was at my place. I did not send for the doctor sooner because Mrs. Fraser told me he would not come unless her life was in danger and I did not consider that her life was in danger until after I had sent for the Doctor the first time.
>
> If a Doctor had been engaged for the case I would have warned him on Monday night to be in readiness. Early on Tuesday morning I made up my mind that it was a case of placenta praevia. I have not had a case of placenta praevia before. I have never had any dealings with Dr. Penny before. Dr. Malaher is unfriendly to me. I do not think Dr. Malaher would have come if I had sent for him.

The statement that May had not suffered a haemorrhage while in the care of Nurse Laidlam would seem to be untrue by the nurse's own admission. It is possible that Nurse Laidlam did not recognise May's condition as a haemorrhage until the morning of May's death.

However, the testimony of Ann Fraser indicates that even when the nurse did arrive at the correct diagnosis, she did not call in medical aid at that time. Ann Fraser stated that:

> At about 2.30 on the morning of the 21st Nurse Laidlam said to me that she thought it was a case of placenta praevia. She did not then mention the Doctor.

It is unclear whether the reluctance on the part of the nurse to call in the medical practitioner was based upon erroneous judgement or disinclination to ask assistance of someone who had made it clear that he would not attend unless the situation was life threatening. The evidence suggests that the fault lay with the nurse in not recognising the urgency of the condition. She indicated that she had not come across a case of placenta praevia in the past. She may well have been inadequately versed in the complications of the condition and, for that reason, may have felt powerless to call in the medical practitioner against his implicit instructions without obvious cause to do so.

For his part, the medical practitioner was emphatic regarding his expectations of the midwife and the course of action that he would have taken had he been summoned at an earlier time, stating that:

> I think I ought to have been sent for sooner as placenta praevia is a most dangerous condition, and this should be detected by a fully qualified nurse at an early stage of labour. It would be the duty of a nurse to get medical assistance as soon as she detected this. If a nurse detected placenta praevia at eleven o'clock at night – it would be a grave error not to send for medical aid at once. …Had I been informed on the previous evening that it was a case of placenta praevia I would have gone immediately…I don't say that if I had been sent for sooner I could have saved the girl's life, but there would have been a chance – an equal chance.

The verdict was that death was caused by "exhaustion through haemorrhage". It is worthy of note that the midwife was a Certificated

Ladies' Nurse and as such, might be expected to have received sufficient instruction in the care of women during childbirth to enable her to recognise what was happening. Indeed, the medical practitioner expressed surprise at what he considered to be a lack of ability on the part of a midwife who was "qualified" to act as midwife.

The treatment initiated by the medical practitioner of injecting brandy, while questionable as a restorative was used by Hamilton in 1892 with seeming success.[86] Hamilton had been called to treat a woman who was bleeding profusely as a result of placenta praevia. He recalled that although "the patient was "cold, fainting, pulseless, and gasping for breath", she responded to brandy and ergot that he administered "freely".[87] Hamilton does not indicate the mode of administration, but the woman made a "good recovery". An additional treatment that he employed but which failed to stem the flow of blood was "plugging" of the woman's vagina. As McCalman points out, in her discussion of maternity care in Victoria in the 1920s, medical practitioners were often called in to emergency situations by desperate relatives or friends of women, without any preparation for what they were likely to encounter.[88]

In May Fraser's case, it seems that she may have had a chance of survival had the condition been recognised at the outset and medical assistance called at that time. Another option in 1911 would have been removal to hospital and treatment by caesarean section. Although

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86 J. Hamilton, "Midwifery Experiences", *AMG*, (April, 1892) p.184.
87 Ibid.
88 J. McCalman, *Sex and Suffering: Women's Health and a Women's Hospital,* pp. 160-161.

caesarean section was not without risk, it was a valid treatment option. In 1912, Chenhall was advocating the use of caesarean section in appropriate situations arguing that mortality was not overly high and directly proportional to the seriousness of the clinical condition.[89] Even had the midwife been more able and the medical practitioner summoned before the May Fraser's condition deteriorated, distance may have been an obstacle.

There were, in 1911, only four major hospitals that were specifically designed to admit women during childbirth. These hospitals were the Lady Bowen in Brisbane that had opened in 1864; the Rockhampton Women's Hospital founded in 1893; the Lady Musgrave Hospital in Maryborough that was established in 1904; and the Lady Chelmsford Hospital, Bundaberg, effective since 1907.[90] In relation to Nambour where May Fraser was living, Brisbane or Maryborough were approximately equidistant, but transportation was likely to have been difficult and lengthy. Selby has noted that in the years preceding 1922, there were smaller maternity hospitals located across Queensland owned by midwives or medical practitioners, some of which employed other staff.[91] According to Strachan, in 1920, hospitals in Queensland were small and independent of each other.[92] It is debatable whether

89 W. T. Chenhall, "Some Meeting Points of the Obstetrician and Surgeon", *AMG*, (Jan. 27, 1912), p.82.
90 QSA, *Correspondence Records and Reports Re: Hospitals, Hospital Boards and Ambulances, Correspondence Records and Reports Re: Hospitals, Hospital Boards and Ambulances*, PRV 8705, PRV 8708, PRV 8713, PRV 8716, PRV 8722, PRV 8699.
91 W. Selby, "Motherhood in Labor's Queensland 1915–1957", pp. 87-111.
92 G. Strachan, *Labour of Love: The History of the Nurses' Association in Queensland 1860-1950*, (N.S.W: Allen and Unwin.1996), pp.92-93.

such premises would have had the facilities to deal with severe antepartum haemorrhage that was the result of placenta praevia.

Postpartum haemorrhage

Inquiries into maternal deaths during the study period included twelve that were attributed to bleeding that occurred after the birth of the baby. Both instances of postpartum haemorrhage that are featured in this chapter took place in the early years of the twentieth century. The first involved a man midwife in Sapphire and the second a woman who worked as a nurse for three medical practitioners in Townsville.

Edith Sullivan, Sapphire, June 1907[93]

In 1907, the man midwife, George D'Costa St. Omer, a resident of Sapphire, was called in to treat Edith Sullivan. Mr. St. Omer was a miner with what he termed, "knowledge of forensic midwifery". It was for his skill as a midwife that he was called to the home of William Sullivan at about 11.30 on the night of the 7th June 1907. From the account of the events that surrounded the birth of Edith Sullivan's child, it is apparent that this man-midwife employed surgical instruments and a pharmacological preparation in his attempts to extract the placenta and control the haemorrhage that was taking place.

Edith Sullivan had given birth to a baby boy at around 6.30 that evening. She had asked her neighbour, Catherine Cooney, a housekeeper, to stay with her during her confinement. Mrs. Cooney was not a midwife and her attendance seems to have been based on her relationship with Edith Sullivan as a woman and a neighbour. By

93 QSA, Justice Department, JUS/376 317/1907.

9.30 that evening the placenta had delivered and Mrs. Cooney suggested to William Sullivan that he send for Mr. St. Omer. Mr. St. Omer responded immediately to William Sullivan's request saying that he need not worry because he would "see the thing all right". When Mr. St. Omer arrived at the Sullivan's house at 11.25 at night he found Edith in a collapsed state. Mr. St. Omer said that after he had examined Edith Sullivan he, "…found there was not the slightest hope of recovery." At this time, Edith Sullivan had no palpable pulse, the placenta was pale and the umbilical cord was untied. In evidence, he said:

> After I examined the deceased I tried to do the best according to my knowledge but failed. I tried three times to extract the placenta in a gentle manner knowing the deceased was too weak to bear any further strain on her anemic system, though stimulant was given every five minutes. I told Sullivan it was useless to send for a Doctor (sic) as his wife would be dead before he arrived. It was four and a half hours after the event before I was called in by Sullivan.

It was clear that Edith Sullivan's condition was rapidly deteriorating and a local midwife was called in at about one thirty the following morning. The midwife, Mary Anne McLaren, observed that:

> When I arrived I found the afterbirth had not come away and I took it from her. The deceased was on the bed at this time. After I took the afterbirth from the deceased I contracted the womb by working with my hand on the stomach. This was by an outward application by massage but I had to follow the afterbirth as it was grown to the right side. I took the afterbirth all away but one small piece but she was too weak to stand any further exertion and I thought I could get it at another time. I had very little hope at the time as the deceased was pulseless at the time.

The circumstances in which Edith Sullivan died suggest that, with the correct treatment at the proper time, her life would have been saved. Instead, she was left, literally to bleed to death, through the ignorance of Catherine Cooney, the woman whom Edith had asked to attend her.

In defence of her inaction, Catherine claims a lack of knowledge that reflects women's informal approach to childbirth and their tendency to treat it as an event outside their control. Catherine thus absolves herself of blame with the observation that:

> I believe it was the loss of blood that made the deceased weak. I cannot account for the blood coming away from the deceased. I was called in as a neighbour and I did my best. I do not propose to understand midwifery nor did I propose to understand it to either Mr. Sullivan or the deceased.

The two midwives who attended after the birth seemed to possess some knowledge of the cause of Edith Sullivan's exsanguination and the treatment options that might counter it. In this case there is some implied recognition of the distinction between lay and skilled midwives. Furthermore, the sequence of events suggests that there was no expectation that either a skilled midwife or a medical practitioner need oversee the childbirth process. Yet, events such as these supported criticism of the lay midwife, which, by implication, was extended to all who assumed a midwife role.

The relationship of the two midwives, St. Omer and McLaren, suggests a more equitable status than that which existed between midwives and medical practitioners. Yet, St. Omer demonstrates a willingness to employ instruments and medication that is out of keeping with the records of women midwives. The limited accounts of the practice of man midwives in Queensland as opposed to physician-accoucheurs renders realistic appraisal impossible, but they clearly were employed and their practice seems to have been more closely aligned to that of medical practitioners than to the work of women midwives.

Mabel Glenwright, Townsville, June, 1910[94]

The second example of the calamitous effects of untreated postpartum haemorrhage took place in Townsville in 1910. In this case, the woman, Mabel Glenwright, gave birth at home attended by a neighbour who had warned Mabel that she "would not know what to do when the child was born". By the time the nurse arrived, the baby had been born. The nurse was unable to remove the placenta and she sent for a medical practitioner, but he was unable to attend. Two hours elapsed before an ambulance was called, by which time Mabel Glenwright "had become drowsy and wanted to sleep." The ambulance attended within minutes, but Mabel died on the way to the hospital.

In the evidence presented to the court, it appeared that Mabel Glenwright was twenty-nine years old and pregnant with her second child. She had been attended by a doctor for the first confinement and on this occasion had booked the services of a Doctor Woodburn Stevens. Working under the direction of Woodburn Stevens was Angelina Symons, an unqualified nurse. When Mabel Glenwright gave birth to a baby boy at about ten o'clock on the morning of the 23rd of June, the nurse was not in attendance. A neighbour, Annie Schinkel recalled that:

> …the deceased sang out between 6.30 and 7. o'clock on that morning for me to go over to her. I went and her mother-in-law Mrs. Glenwright and George Glenwright her husband were there. The deceased's mother-in-law asked me to stop with her daughter-in-law. She said she was nervous and would not like to stay there. She then went away. I told the deceased that I would stay with her. The husband just left to go to work as I came in. The reason the deceased sent for me was that she was about to be confined. She asked me would I stay with her. I said, "yes" but I said I would not know what to do when the child was born. It was

94 QSA, Justice Department, JUS/N450 386/1910.

> then she told me to send for Mrs. Bowden until Nurse Symons would arrive. She was not suffering much pain when I went in but she was a little ill. Before the deceased's husband came I asked him to send for a Doctor. That was between 6.30 and 7 o'clock. The child was born about 9.30 and in the meantime the deceased seemed to have a good time…

Annie Schinkel seems to have been concerned and called in another neighbour, Mary Ann Thomas. When Mary Ann arrived Annie Schinkel told her that, "the baby would soon be born". In evidence, Mary Ann Thomas said:

> I gave assistance to the deceased in her confinement. I took the cord from round the baby's neck and legs. I rolled the baby up in a towel and left it lying there. I did not interfere with the mother in any way. Mrs. Bowden arrived shortly afterwards. She cut the cord and tied it. She did not attempt to remove the afterbirth but otherwise she assisted in every way she could, as far as I know.

Mabel Glenwright had also sent her young son to summon Mary Bowden who went immediately to the house. Mary Bowden stated that while she was used to attending in confinement cases, she was not a "certificated nurse" and she usually worked as an assistant to doctors. When she arrived, the baby had been born and Annie Schinkel and Mary Ann Thomas were with Mabel. Mary Bowden explained that:

> They were standing by near the bed waiting for someone to come. The deceased was lying on her back in the middle of the bed and the child was rolled in a towel just by the mother. I said "Where is the nurse" and they said they had sent for her. I moved the baby away and moved the mother on a dry position near the side of the bed. I asked the deceased if she had seen a Doctor and she said No. I asked her if she wanted to send for a Doctor. She said "No there is no Doctor needed".

Soon after, Angelina Symons, the nurse who had been booked to attend Mabel Glenwright, arrived at the house. According to Mary Bowden:

> The trouble after the birth of the child was the afterbirth. Nurse Symons tried every means to get the afterbirth away. She did not succeed in doing so. I have been present and seen the Doctor take the afterbirth away. Nurse Symons, so far as I know, did all she could. The nurse removed some clots of blood but she could not get the afterbirth. I saw what came away but did not examine it. Nurse Symons asked for a

> Doctor but we could not get one at the time. Mrs. Thomas came and said that Dr. Huxtable was telephoned for. The Doctor said he could not come in less than 20 minutes as he was very busy. The second time he ordered the deceased to be taken to the hospital. I have had considerable experience and I saw that the deceased was not then in a fit state to go to the hospital. Mrs. Johnson rung up for the ambulance. Nurse Symons sent the little boy Glenwright to ring up for the ambulance. The ambulance arrived within a few minutes. That was between 12 and 1 o'clock. Nurse Symons was there about two and a half hours before the ambulance arrived.

The disinclination to call upon a medical practitioner and the subsequent absence of a medical practitioner able or willing to respond to the calls for assistance that were eventually made are clearly factors in the death of Mabel Glenwright. However, the considerable delay between the time the medical practitioner was first called and the arrival of the ambulance, two and a half hours, was probably the element that most contributed to outcome. It is difficult to know why there was such a delay, although this is explained in part by Nurse Symons who said:

> There was some trouble about the afterbirth and when I failed to take it away Mrs. Thomas went to ring up a Doctor. When Mrs. Thomas came back she told me that Dr. Huxable could come in half hours time. I said that's no good. Get some Doctor to come at once. That was about 10.30 shortly after I arrived. I failed to remove the afterbirth and then saw that a medical man was necessary. Mrs. Thomas went again about 11 o'clock to ring up a Doctor. She said that Dr. Huxable said to remove her to the hospital

When the ambulance did arrive, the ambulance superintendent refused to take Mabel Glenwright to hospital without the authority of a medical practitioner. By the time the ambulance superintendent had made the necessary telephone call and had received the instruction to remove Mabel to hospital, she was in a moribund condition. Mary Bowden confirmed that:

> Just before she [Mabel] left she appeared very drowsy and wanted sleep. We know that that was a sign that all was not well.

By her own admission, Nurse Symons failed to remove the placenta and the uterus was therefore unable to contract as it should. However, as the nurse pointed out:

> During my experience I have never seen a similar case. I think if the Doctor had been there when the child was born there would have been a different result.

The nurse went on to say that she normally attended women in labour in conjunction with three doctors. One of those doctors was James Forrest, who conducted a postmortem on Mabel Glenwright. Forrest pronounced the cause of death to be postpartum haemorrhage. He added that:

> She was a generally delicate woman but her organs were sound. Most probably had she had a Doctor there she would have been alive now. The afterbirth was there at the postmortem and the nurse did nothing to cause any wrong. I know Mrs. Symons and she is a very capable woman in such cases. During the holding of the postmortem I noticed not the slightest sign of any injury. Cases are very common of this kind. The child is born very easily but the afterbirth adheres. Death was not due to any ill-treatment.

This vindication of the nurse is quite unusual as far as the testimonies of medical practitioners are concerned. Indeed, this is the only such case discovered in the sources accessed. Whether this conciliatory tone stemmed from a true regard of the nurse's abilities and the difficulties of the situation in which she was placed, or whether it was due to her affiliation with a group of medical practitioners, is impossible to judge. However, this nurse received a far more understanding hearing than the majority of lay midwives, especially those who worked outside the protection of the medical profession.

Puerperal convulsions

The diagnosis of puerperal convulsions was made in relation to six deaths during the study period. The following account, that relates to the death of Anne Taylor in 1864, highlights the limited options available to women in Queensland in the 1860s both in terms of birth attendants and treatments. This example demonstrates that any woman suffering from puerperal convulsions posed a challenge to medical practitioners and an impossible hurdle to the woman who was "called in".

Anne Taylor, Fetton, December 1864[95]

In 1864, Anne Taylor was pregnant for the second time. Her first pregnancy had ended in miscarriage. Anne was married to James Taylor, a shepherd employed at Fetton Station where they occupied a hut. Anne and James were recent immigrants to Queensland from Ireland and after some travelling within the state they had settled in the Drayton district. James suggested that they arrange, "…to have a woman to assist her in her confinement" but Anne declined saying that she would wait until the time came. Anne's labour began on the morning of Wednesday, 21st December. James left to tend the sheep and when he returned in the afternoon the pains had worsened. By 10 p.m. Anne had become restless and James offered to fetch a local woman, Mrs. Clarke who lived nearby, but Anne declined saying, "Stop with me and don't leave." It seems that soon after, Anne began to suffer convulsions.

At daybreak, James sent his neighbour, a fellow shepherd, to the Station superintendent who lived one and half miles away. He asked him

95 QSA, Justice Department, JUS/N9 65/31/1864.

to tell the superintendent that his wife was, "…in a dangerous state." Later in the morning, the master of the Station called to James to tell him that he had sent for "the doctor and a woman". The woman arrived at about noon and the doctor between two and three o'clock. The woman stated that during her attendance at the confinement, Anne had delivered a stillborn child. The woman does not provide details of the role she actually performed. It seems, however, that her skills in the birth room were limited, for although she tied the umbilical cord she left the placenta in place. As chapter Three has demonstrated, by the 1890s, it was customary for medical practitioners to remove the placenta as soon after birth as practicable in order to reduce the incidence of haemorrhage.[96] It is not clear whether a lay midwife in the 1860s would have actively sought to remove the placenta, and although Teale has accused midwives of bringing about "rupture of the uterus" through their attempts to remove the placenta, she does not substantiate these claims with detailed information and her claims therefore difficult to assess.[97]

Nevertheless, in Anne Taylor's case, when the medical practitioner arrived, he set to work immediately to restore Anne's failing health, but soon realised that his efforts would be unsuccessful. In his statement, he recollected that:

> I removed the placenta and opened a vein but the blood would not flow as the circulation had almost ceased. I also used some strong stimulants but to no effect. I then left the hut and told her husband and some other people in the hut that I could do no more as the woman was dying.

The medical practitioner demonstrated a more advanced knowledge of the process of childbirth than the woman attendant, and he had access to

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96 J. Hamilton, "Midwifery Experiences", *AMG*, (April, 1892) p.183.
97 R. Teale, (ed) *Colonial Eve: Sources on Women in Australia 1788–1912*, p.122.

pharmaceutical preparations that might have enhanced his attempts to revive Anne. Although he does not explain his intentions in opening the vein, as Leavitt has observed, bloodletting was a commonly employed treatment by medical practitioners for a diverse range of childbirth afflictions from haemorrhage and inflammation.[98] Even though the medical profession did not require its members to be proficient in midwifery practice until 1886[99] the medical practitioner who attended Anne Taylor in 1864 exuded confidence in his approach to the life-threatening situation with which he was confronted. His somewhat callous disengagement of the circumstances in which he found himself may be seen as a product of his social and professional status in that he identified the parameters within which he was prepared to operate without regard to the way in which his actions might impact upon those concerned.

As this study has so far demonstrated, realistically, there were three options available to childbearing women in Queensland in the 1860s. First, she might engage the services of a lay midwife. Second, she might leave things to chance and hope that someone would assist her when the time came. Third, she might nominate a medical practitioner to oversee her confinement. The first and third options were dependent upon such a person being resident in the local area. As Chapter Two has shown, on some occasions, women were unable to avail themselves of help during childbirth because they lived too far from either a midwife or a medical practitioner. Whatever option Anne Taylor, and other women

98 J. W. Leavitt, *Brought to Bed: Childbearing in America 1750 to 1950,* pp.43-44.
99 *The Medical Act, 1886*, (49 & 50 Vict. c.48).

whose pregnancies were associated with convulsions, took, the outcome was unlikely to be favourable. In the nineteenth century, there were conditions that arose during pregnancy, childbirth, or the puerperium, that women could not survive regardless of their attendants at birth. However, while puerperal convulsions represented an obstacle that was difficult to overcome, the circumstances of prolonged labour resulting in maternal and foetal exhaustion were clinical conditions that, while testing the parameters of midwifery practice by midwives, were relatively easily treatable by the medical practitioner.

Prolonged labour and exhaustion

The following two accounts relate to childbirth that was protracted and which led to the finding that the mother had died of exhaustion. The causes of prolonged labour might rest with the inability of the uterus to perform the function of contracting and relaxing in order to assist the baby's passage through the birth canal. Conversely, unduly long childbirth might occur as a result of disproportion deriving from the mother, the foetus, or both.[100]

Sarah Bridges, Dalby, May 1868[101]

Sarah Bridges was thirty-six years of age and had eight children. She had been married for thirteen years to William, a labourer with the railway at Dalby. At about ten o'clock on the night of Tuesday, 6th May 1868, Sarah went into labour. William sent for Mrs. Raffy whom, he said, "has been in the habit of going to women when in labor" (sic). The labour seemed to be proceeding well at first but at about four in the

100 L.R. Leader, M.J. Bennett, F. Wong (eds), *Handbook of Obstetrics and Gynaecology, 4th edition*, pp.210-214.
101 QSA, Justice Department, JUS/N19 68/105/1868.

morning Sarah was unable to move her legs and the pains of labour disappeared. William gave her beef tea and brandy to nourish her and continued this treatment, with the inclusion of hot fomentations, throughout the next day. The labour pains returned at about six o'clock in the evening but they were very slight and by the early hours of Thursday morning the pains had ceased all together. Two hours later Sarah died. The evidence of the woman called in, Mrs. Raffy, was short and consistent with that of William Bridges, except that she admitted that she "felt alarmed". Neither mentioned the possibility of seeking help from anyone else.

At the time of her death, Sarah had been in labour for approximately thirty hours. With no indication of malposition or disproportion between the pelvis and the foetus, it seems that the birth proceeded well until uterine inertia reduced Sarah's ability to complete the process. Following the post mortem examination the medical practitioner, Edwin Roberts, stated that:

> I found a child almost born in a natural position so that it might with great ease have been delivered by medical assistance. In my opinion the woman's life could have been saved had she had medical assistance in time.

This comment, if accurate, suggests that the loss of life was due directly to a knowledge deficit on the part of the woman acting as midwife. The woman, Mrs. Raffy, if she had indeed been used to attending women in childbirth had either not come across such a circumstance as that which hindered Sarah, or had failed to identify and act upon it. As Sarah lived in Dalby, it is feasible that had Mrs. Raffy sought medical aid, such aid would have been forthcoming and the outcome might have been quite

different. In relative terms, of the five hundred and eighty four women treated at the Lady Bowen Hospital, Brisbane, during its first ten years, 1864 to 1874, eight births were assisted with forceps.[102] Over the next two decades, the use of forceps increased from one in seventy-three, to one in thirty and then in 1893, one in twenty-two. Sarah's childbirth occurred in 1868 and as Rich has pointed out, obstetric forceps were available to medical practitioners from 1773.[103] There seems no reason to doubt that medial assistance might well have saved the life of Sarah and her unborn infant.

Mary Ann Pattison, Samford, April 1880[104]

Twelve years separated the deaths of Sarah Bridges and Mary Ann Pattison, but the pattern of events that Mary Ann experienced was in many ways similar to that of Sarah. Mary Ann Pattison was twenty-five years old, the wife of a farm labourer and lived in Samford. Childbirth was not a new event for Mary Ann: she had four living children. Mary Ann went to her father's house at Cedar Creek to have the baby and when she went into labour on the 2nd April 1880, her mother, Mary Dane and a neighbour, Mary Denning who described herself as a nurse, attended her. Mary's labour was not consistent with the previous experiences of her carers and the transition from normal to abnormal childbirth went unrecognised. For two days Mary Ann experienced some discomfort that, her attendants agreed, was not typical of the pains of childbirth. When

102 W. Love, "Records of the Lady Bowen Hospital, Brisbane", *AMG,* (May, 1893), p.146.
103 A. Rich, *Of Woman Born: Motherhood as Experience and Institution*, p.145.
104 QSA, Justice Department, JUS/N68 80/82/1880.

she died on 4th April 1880 after being in labour for two days, her attendants expressed surprise and attributed her death to a natural consequence of childbirth that, only one conceded, might have been averted had medical assistance been obtained.

Bergin, the Justice of the Peace who conducted the Inquiry into the circumstances of Mary Ann's death took testimonies from all who were present at the time of the birth. Mary Denning attested that:

> She was up and down in her bed but never got her right pains. I was attending to her with her mother Mrs. Dane. She was ill for about two days when she died. We did not think she was so near dying.

Mary Denning's comments suggest that she perceived the birth attendant and family powerless to intervene in the process of labour. It was inevitable that nature would take its course, whatever direction the course should take. The only people with the means to modify the natural progression of labour were medical practitioners. They alone had access to instruments that could facilitate childbirth that, on some occasions and in certain circumstances might change childbirth. In many situations it is unlikely that the outcome would have been different.[105] At the same time, this event took place in the home amongst family and friends whose testimonies defend the adequacy of lay midwife role provided by the nurses Mary Dane and Mary Denning. While John Dane, Mary Ann's father said that:

> It is hard for me to say if a Doctor was here whether her life could be saved or not

And her husband, William Pattison affirmed that:

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105 QSA Justice Department, Index to Inquests 1859-1886: Justice Department, Index to Inquests 1887-1897: Justice Department, Index to Inquests 1898-1914.

> I have no blame to any person for the cause of her death.

Mary Dane went further, stating that:

> Mary Denning attended with me as nurses to her. I don't think a Doctor could have saved her. I have no blame to William Pattison for not bringing in a Doctor. I believe he would have done so if he was told.

The unwillingness to engage a medical practitioner may have originated from failure to appreciate the full circumstances of Mary Ann's labour, or from reluctance on the part of women to be attended by a man. Christina Tews, a midwife who worked at Mount Gemmel, attended Caroline Neal in 1885 and put the case that women were generally unprepared to seek out the services of a medical practitioner. In outlining her experience in relation to the death of Caroline Neal that was recorded as caused by "Exhaustion from childbirth" in unsuspicious circumstances, Christina Tew articulated women's attitudes towards childbirth that are implied within much of the coronial and magisterial evidence. Christina testified that:

> I was here about two hours before the baby was born. The deceased had a difficult confinement. The very same that she had on the occasion that I attended to her previously. She was fairly exhausted after it, very weak, no pain whatever, and quite cheerful. There was no false presentation, everything was as natural as could be. I have attended several women at their confinements. No woman ever died that I attended before. About ten minutes before she died she was talking to me. I never expected she would die. I had given her a dose of Castor Oil about an hour before and she said, "I think the oil will work me shortly and I will be all right." There was nothing in her case up to a few minutes before her death not of the common, nothing that a woman could not attend to. I saw no necessity for sending for a doctor, many women object to a doctor. I am quite satisfied she did not wish for a doctor. The deceased attended many people herself and understood a lot about confinements.[106]

In the case of Mary Ann Pattison, there is insufficient detail in the evidence to indicate exactly what caused her death, and while the official verdict that she, "Died in her confinement" contributes little to the overall

106 QSA, JUS/N118, 85/236/1885.

picture, it does perhaps reaffirm the concern held by medical practitioners that births in the home many questions were left unanswered and people outside the immediate birth venue were left largely uninformed.

Although the exact causes of the prolonged labours are not known, in the absence of disproportion or malpresentation, as Chapter Three has shown, the most probable option available to a medical practitioner would have been the use of chloroform to the mother and extraction of the foetus with forceps.[107] These techniques lay outside the bounds of lay midwifery and, in 1880, six years prior to the Medical Act that required a certain proficiency in midwifery,[108] the average medical practitioner might have been tested by the need to initiate treatment. In 1893, Wilton Love pointed out that the improvements in maternal mortality rates that had occurred from 1864 to February 1893 were attributable to three factors. The first was improved transport facilities that enabled birthing women to be conveyed to hospital more quickly. The second was greater knowledge of asepsis and the use of antiseptics. The third was, as Love put it:

> The more frequent use of artificial aids to delivery, e.g., forceps, women not being allowed to exhaust themselves before instrumental aid is offered…[109]

By Love's reasoning, the death of Sarah Bridges in 1868 might have been inevitable. Living in Dalby and without the facilities that medical practitioners alone had available to them and specifically theoretical knowledge and clinical technology, it is difficult to imagine a different

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107 J. McCalman, *Sex and Suffering: Women's Health and a Women's Hospital* pp.119-120. See also, L. R. Leader, M. J. Bennett, F. Wong, (eds), *Handbook of Obstetrics and Gynaecology, 4th edition,* pp.210-214.
108 *The Medical Act, 1886*, (49 & 50 Vict. c.48).
109 W. Love, "Records of the Lady Bowen Hospital, Brisbane", *AMG,* (May, 1893), p.146.

outcome. In relation to the death of Ann Pattison, although she died in 1880, her residency at Samford precluded the services of anyone other than a local midwife with perhaps the opportunity of calling in a medical practitioner. The crucial element in both these instances is that the midwife was out of her depth and had no contingency arrangements in place.

While the possibility existed that the actions of midwives might alter the course of events or the birth outcome in some situations, puerperal infection was one complication of childbirth that was generally beyond the scope of treatment until the 1930s.[110] Puerperal fever was a notifiable disease in Queensland and in 1912 out of 2,258 recorded infectious cases, puerperal fever accounted for eleven, one of which occurred in the Brisbane metropolitan area.[111] This classification made no distinction between "fever" and "mania".

Puerperal fever

The cases presented here has been selected in order to explicate the condition of puerperal fever, but it also raises the issue of midwives practising whilst under the influence of alcohol.

Annie Lonergan, MacKay, December 1881[112]

During the afternoon of Wednesday, 14th December 1881, Annie Lonergan of MacKay began her labour. Her husband James, a carpenter, went for Mrs. Wheeler, a nurse who had been engaged to attend Annie. Mrs. Wheeler was busy with another confinement and said she was

110 M. Tew, *Safer Childbirth? A Critical History of Maternity Care, 2nd edition*, pp.284-285.
111 Anon. "Health of Queensland, Abstract of the Annual Report of the Commission of Public Health to 30th June, 1911", *AMG*, (March 16, 1912), p.280.
112 QSA, Justice Department, JUS/N79 81/350.

unable to recommend anyone else in her place and would call upon Annie when she was free. When Mrs. Wheeler arrived soon after one o'clock in the morning of Thursday, 15th December she was just in time to assist Annie whose baby was born within fifteen minutes of the midwife's arrival.

James Lonergan stated that, "…Mrs. Wheeler smelt of liquor after she had assisted my wife. I asked her to have a drink and she took it. I cannot say that Mrs. Wheeler was drunk". Mrs. Wheeler left the house soon after, saying that she would be back within the hour. She did not return until seven-thirty that morning and stayed about half an hour. According to James Lonergan, Annie was unhappy with the care she had received from Mrs. Wheeler. James remembered that after Mrs. Wheeler left his wife asked him to:

> …get some woman to do the washing as Mrs. Wheeler had neglected to do it. My wife then told me that she (Mrs. Wheeler) had only just then washed the child and bound herself which should have been done immediately after the birth of the child. I then went for a Mrs. Williamson to come to attend to my wife. She came and found that the afterbirth had not been attended to.

Annie complained to a friend who visited her later that morning that Mrs. Wheeler had left her without attention until almost eight o'clock that morning. She said she felt hungry and weak and had had nothing to eat. The friend, Annie Stewart, recalled that Annie had told her that, "Mrs. Wheeler had left her and had not attended to her till about 8 o'clock that morning…[and]…that she thought Mrs. Wheeler had been drinking." Another friend, Mary O'Droyen, supported this claim and said that when she called to see Annie on Thursday morning Annie complained to her that she had not received proper attention from Mrs. Wheeler.

The woman called in to do the washing, Mrs. Williamson, was critical of the care Mrs. Wheeler provided Annie Lonergan and it was she who "…cleaned up the place and destroyed the afterbirth which was then in the bed-chamber". Mrs. Williamson made the comment that, "I think she, Mrs. Wheeler, had had some liquor but she was not intoxicated on the Saturday morning". When Mary O'Droyen returned to see Annie again on Saturday morning she, "found her in a excited state…[and]…she complained again of Mrs. Wheeler not being there to see her". Mary Droyen went on to say that Mrs. Wheeler arrived while she was there and attended to Annie Lonergan.

On Sunday morning Mrs. Wheeler called in on Annie and helped her out of bed and into a chair. She then prepared beef tea for Annie and left. That evening, Annie complained of feeling worse than she had previously. Mrs. Wheeler returned that evening and James recalls that:

> Mrs. Wheeler came and my wife again told her that she had neglected her and accused her of being the cause of her breasts being bad which Mrs. Wheeler denied. Mrs. Wheeler said she did not want the case for the sake of the paltry few pounds you had better get somebody else. I asked my wife to have patience and Mrs. Wheeler would see to her.
>
> Mrs. Wheeler assured my wife that she was perfectly safe and had no milk fever. She left the same evening and I sent for my wife's sister to attend to her (my wife) for the night. On Monday morning I called in Doctor Byrne and my wife has been under his care since.

William Byrne, the medical practitioner, found Annie to be suffering "from the excitement consequent upon puerperal fever". Annie made a number of complaints to the doctor against Mrs. Wheeler, accusing her of being neglectful toward her. It seems the ministrations of the medical practitioner were ineffective in preventing Annie's death and she died on

Wednesday, 21st December. The medical practitioner had this to say at the Inquest:

> I am of the opinion that owing to the ignorant and neglectful treatment she received at the hands of Mrs. Wheeler puerperal fever ensued. I did not see Mrs. Wheeler and I forbid her coming to the house as my patient was so excited by her (Mrs. Wheeler's) neglect and I feared all consequences.

Despite the comments of the medical practitioner, the coroner did not identify Mrs. Wheeler's practice as negligent and no person was accused of contributing to her death. Annie Lonergan's death introduces another claim that was levelled against midwives: that midwives were wont to practice while under the influence of alcohol. While the incidences of alcohol consumption by midwives may have been infrequent, their very occurrence and implied connection with malpractice was enough to provide support for generalising this perception. In this case, the medical practitioner who gave evidence at the Inquest went so far as to accuse the midwife of "ignorant and neglectful treatment" and to allege that this negligence contributed to the woman's death.

The medical profession had much to gain by defaming the lay midwife and its criticisms were not entirely unfounded. The primary source accounts that appear in this chapter highlight deficits in midwifery practice that provided the medical profession with the grounds to denigrate the lay midwife role. At the same time, it might be argued that the shortfalls in childbirth practices that are apparent in retrospective appraisal of the testimonies of witnesses were merely a product of the time. As the case studies have indicated, childbirth was acknowledged to be a hazardous process and there was an acceptance that little could be done to change its natural course.

Moreover, while the medical profession was keen to promote itself as the optimum choice in childbirth and especially in complex childbirth, this and the previous chapters have shown that, in many instances, medical treatments were punitive and doubtful contributors to a successful outcome. For example, in the case of antepartum haemorrhage, the pharmaceutical preparations available at the time were unlikely to achieve cessation of blood loss and without rapid transfer to hospital and immediate surgical intervention, the life of woman and child would be compromised and frequently lost. In the same way, midwifery practice in the home environment was never going to be able to address the situation of severe antepartum haemorrhage. The only prospect of averting inevitable death was assessment at an early state and removal to hospital. In the words of obstetricians Campbell and Lees, in relation to antepartum haemorrhage in the year 2000, "final resolution is only achieved through emptying the uterus.[113] That was clearly not an option open to the midwife.

However, there were occasions when a skilled midwife might have made a difference to the birth and it was those instances upon which medical practitioners dwelt. For example, while postpartum haemorrhage does not carry with it quite the same inevitability of outcome that has been attributed to antepartum haemorrhage,[114] in situations of postpartum haemorrhage during the study period the midwife might have been able to affect the outcome had intervention occurred at an early stage. In the case of Edith Sullivan, both midwives initiated the right treatment by

113 S. Campbell, C. Lees (eds), *Obstetrics by Ten Teachers, 17th edition*, .p.307.
114 Ibid., p.308.

present day standards,[115] but each was called in too late for their treatment to be effective. It is apparent from the evidence that had a medical practitioner been called in at that late stage when the woman was already in a collapsed state, the outcome would have been the same.

Here there is evidence of an acknowledged distinction between the two midwives and the birth attendant who, by her own admission, was not competent to assist in childbirth and was unaware of the danger in which her charge was placed. Her ignorance of the processes of childbirth was the major factor in the death of Edith Sullivan. It was women such as the birth attendant, Catherine Cooney, who provided the medical profession with just cause for complaint and with support for their contention that the midwife was a menace. The lack of distinction between a midwife who regularly attended women and those who acted as midwife on an impromptu basis, or under the direction of a medical practitioner, compounded the blurring of the midwife role and contributed to a generalised condemnation of midwifery practice.

Yet, in the two cases of prolonged labour that eventuated in the deaths of the women concerned, midwives with some experience were clearly implicated. In both cases, this complication of labour was outside both the knowledge base of the midwife and the parameters of normal midwifery practice by midwives. Indeed, the option open to the midwives was to call in medical aid and for instrumental intervention to be employed. However, their capacity to respond well to the situation was inhibited by insufficient knowledge of childbirth and its eventualities and

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115 V. R. Bennett, L. K.. Brown, (eds) *Myles Textbook for Midwives, 12th edition*, (Edinburgh: Churchill Livingstone, 1993), pp.462-472.

probably by infrequent attendance at childbirth. These “midwives” were often quite out of their depth in circumstances where a birth extended beyond their experiential knowledge.

Conclusion

This chapter has identified the claims made by members of the medical profession and has presented evidence related to those claims. The chapter has shown that childbirth in the home was assisted by a variety of people, mostly women, whose involvement was an unremarkable part of their lives, even when their participation in childbirth ended in death. And while it has been conceded that some untrained midwives appeared at times incompetent and unskilled, it has also been suggested that there were, at times, mitigating circumstances that impacted upon the ability of the untrained midwife to achieve a more satisfactory birth outcome. A contributing factor was a lack of organisational structure that could support a form of unified or standardised practice. The result was that the lay midwife was an easy and arguably, justifiable target for both accusation and change. Although the literature has shown that sustained improvement in maternal and

CHAPTER FIVE

POPULATION DECLINE AND THE ISSUE OF NEGLIGENCE QUEENSLAND 1859-1912

> I am sorry to say that in a country which is clamouring for population we have been guilty of a culpable amount of indifference in regard to the health and mortality of our young children.[1]

The previous chapter illustrated the risks associated with childbirth in nineteenth century Queensland and highlighted the ignorance and incompetence on the part of birth attendants as major contributors to poor birth outcome. While the chapter suggested that questionable midwifery practice might lead to loss of life, the focus was on ignorance rather than outright neglect. This chapter extends those concepts to examine incidences where culpable negligence was perceived to be the principal cause of death and argues that it was the potential for concealing deaths in childbirth that drew the attention of the state to childbirth at a time when infant life had become the focus of social and economic policy.

The chapter employs testimonies derived from twelve Inquests into maternal and neonatal deaths that amplify the ways in which neglect might occur during childbirth and the difficulty presented to authorities in obtaining an accurate record of what had occurred. As in the previous chapter, the cases have been selected as representative of the culture of childbirth and for their ability to reveal the perceived problems that non-institutional childbirth presented to the medical profession and the state. Details of these cases are listed in Appendix Ten. Seven cases relate to mothers and three to infants.

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1 ORDLCA, Vol. XCVI,1905, p.1652.

The chapter demonstrates that there was a strong association between neglect in childbirth, whether from ignorance or design, and loss of maternal and infant life. Neglect might occur as a result of failure to make adequate provision for childbirth, as in the case of women who did not arrange for attendance at birth, or in situations where unmarried women gave birth alone. Neglect might derive from incompetency on the part of birth attendants, or maltreatment of a pregnant woman by her husband. A degree of negligence might also be construed into circumstances in which a medical practitioner was called to attend a woman but did not do so. The cases included within this chapter therefore deal with incidents of neglect of one type or another. Among the cases excluded are those that either offered no new evidence or related to issues peripheral to the study focus. For example, three cases of unmarried women birthing alone were initially included in full, but were later subjected to radical modification in order to limit intangent material. Such restrictions were necessary both to keep the volume of material manageable and to assist the flow of the narration.

An important aspect of neglect in childbirth is that it came to be of concern to the state at a time when the lives of infants were increasingly becoming a valued asset. Australian states became aware that their populations were declining while those of their close Asian neighbours were increasing at a rapid pace. In 1903, The Royal Commission on the Decline of the Birth-Rate and on the Mortality of Infants in New South Wales heard that population decline had occurred in New Zealand,

Britain, North America and the countries of Europe.[2] Australian states became convinced that national security was threatened by Australia's proximity to Asian countries whose populations were considerably greater than their own. State governments responded to this perceived peril by devising ways of increasing natural population growth. While immigration continued to boost population throughout the study period, infant life was valued more highly as it represented an innate asset and one that might be replicated through the promotion of large families.

The attention of the state thus turned to childbirth and to the work of midwives. And while Australian states channelled their energies into investigating factors identified as causing population decline, including contraception, abortion, infanticide and illegitimacy, their response to this decline, in terms of families, was to initiate policies that would reduce family self-determination and replace it with state intervention.[3] As Tiffin points out, the late nineteenth and early twentieth centuries was a time when, "…the welfare of children was seen as crucial to national strength, imperial greatness and internal stability".[4] Docker argues that it was during this period that Australia underwent a major ideological appraisal that underpinned its subsequent national development.[5] Already unnerved by the economic depressions of the 1880s and 1890s in which the potential power of the labour movement became manifest,[6] Australia

2 RCDBR, Vol. I. pp.5-6.
3 S. Tiffin, "In Pursuit of Reluctant Parents: Desertion and Non-support Legislation in Australia and the United States 1890-1920", In Sydney Labour History Group, *What Rough Beast? The State and Social Order in Australian History*, p.131.
4 Ibid.
5 J. Docker, "Can the Centre Hold? Conceptions of the State 1890-1925", In Sydney Labour History Group, *What Rough Beast? The State and Social Order in Australian History*, pp.56-88.
6 Ibid., p.57.

suffered a further philosophical onslaught when, in 1905, Japan triumphed in a war against Russia that forced the world to acknowledge the military strength Japan had achieved under the Meiji.[7] The response of Australian states to challenges from both inside and outside Australia was to increase state intervention in the social lives of its citizens and in the relationships between individuals and groups.[8]

The Asian threat and the importance of White Australia

The origins of Australian governments' preoccupation with population growth have been attributed to a perceived threat to its national security.[9] This perception came about in part as a response to British action and also as a result of internal strife involving Chinese immigrants to Australia. In 1870, Britain withdrew the last of it garrisons from Australia, leaving the country without the military support it had previously depended upon. Almost twenty years later, in 1889, a British report criticised Australia for the inadequacies of its national defence. But while Australia's national security was found to be lacking, Australian volunteer troops fought alongside Britain in wars in which it did not have to be involved. In the 1860s, Australian troops were pitched on behalf of Britain against the New Zealand Maori; in 1885, Australians supported a British squad in Sudan; between 1899 and 1902, Australians fought against the Dutch in South Africa, and in 1900, Australia once again assisted Britain to suppress a rebellion in China.[10]

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7 R.H.P. Mason, J.G. Caiger, *A History of Japan*, (Tokyo: Charles E. Tuttle, 1972), pp.219-225
8 Sydney Labour History Group, *What Rough Beast? The State and Social Order in Australian History*, pp.9-12.
9 S. Macintyre, *A Concise History of Australia*, pp.140-141.
10 Ibid.

Australia's participation in wars outside Australia served to enhance Australian awareness of its vulnerability as a British colony lying within the Asia Pacific region. Macintyre argues that by the early twentieth century, Australia identified Japan as a potential external threat that was exacerbated by an Anglo-Japanese Treaty in 1902 that enabled Britain to decrease its naval presence in the Pacific.[11] At the same time, Chinese immigrants within Australia had been the butt of hostility that derived from fears that the Chinese offered employers the prospect of cheap labour that would ultimately threaten wage thresholds.[12]

By the 1900s, Australian governments were attempting to devise ways of offsetting the ostensible threat from Asia. While immigration from Britain and Europe was a means by which Australian governments boosted their population from the mid-nineteenth century onwards,[13] childbirth was considered to be the optimum means of population expansion.[14] As Birrell points out in his exploration of the factors that led to Federation, by 1901, restrictive immigration rules were supported across all spectrums of class on the basis that only the indigenous white population could achieve the social ideals that Australia aspired.[15] Birrell asserts that, by 1914, the concept of a white Australia became a "national creed" imbued with egalitarian ideals and, some would argue, a contrived patriotism that fell short of claiming a distinctive Australian history, but which promoted the notion that the white minority were making a stand

11 Ibid.
12 Ibid., pp.142-143.
13 Ibid., pp.113-114.
14 ORDLCA, Vol. XCVI, 1905, p.1652.
15 B. Birrell, *Federation: The Secret Story*, (Sydney: Duffy & Snellgrove, 2001), pp.290-291.

against, what one writer described as, “the multicoloured millions of Asia”.[16]

In 1904, the New South Wales Royal Commission made explicit what it considered to be the vulnerability of Australian nationhood to the threat of more populous and alien nations, arguing that:

> From time to time in recent years public men, seeing in the establishment of the Australian Commonwealth the first step in the construction of a great nation, and anticipating therefrom a rapid increase of national prosperity and progress, have referred hopefully to the day when Australia with her teeming millions will hold a commanding place among the peoples of the world. The patriotic ardour inspired by this hopeful anticipation is, however, destined to be cooled in the contemplation of the fact that, while Russia and Japan, prospective rivals of Australia for supremacy in the Western Pacific, are already seeking outlets beyond their own borders for the energies of their ever-growing people, it will be forty-six and a half years before Australia, with her three and three-quarter millions of inhabitants, and dependent alone on her natural increase (if this even be maintained at its present rate), will have doubled her population: 113 years before she will have twenty millions of people; and 168 years before her numbers will have reached the present population of Japan.[17]

Thus, the defence of Australian interests rested with population growth and within this broad debate maternal and infant life became valued commodities and the focus of state intervention. However, childbirth was shrouded by a veil of concealment that was, in part, due to its location in the domestic arena and also to its strong affiliation with women birth attendants. Just as the medical profession had long been critical of the role of midwives, so now the state turned its attention to this specific issue. Its stimulus was a decline in birth rates in Australia and throughout the western world.[18]

In 1905, the Home Secretary expressed the dilemma faced by the government when he introduced the second reading of the Infant

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16 Ibid.,p.292.
17 RCDBR, Vol. I, p. 52, (174).
18 Ibid., pp.5-7.

Life Protection Bill to the Queensland parliament. In his address, the Home Secretary voiced some of the concerns faced by parliament in its quest to reverse the downward trend in birth rates and to improve the prospects for infant life that were impinging upon Queensland's national development:

> In a young country like Queensland, and, in fact, Australia generally, it goes without saying that we cannot build up the country without population, and there are special circumstances in connection with the country which should make us particularly anxious to see the population increasing. Taking into account our proximity to the densely populated countries of Asia, and the fact that we have a large area of unoccupied country, unless we realise our position and make some effort to settle a European population in the country, it will inevitably be occupied by some race of coloured aliens. Realising that, we can only come to one conclusion, and that, is – that it is necessary to conserve what population we have. We must look carefully after our assets.[19]

In pursuing its goal of addressing the perceived threat of invasion from more densely populated countries and in caring for the assets of state, the Queensland parliament followed the examples of New South Wales, Victoria and South Australia in committing itself to devising a means of offsetting deaths in infancy.[20]

As the previous chapter has shown, a proportion of infant deaths were viewed with suspicion and bodies of babies were not infrequently abandoned without parental claim. Stillbirths might easily mask infanticide as the true cause of death, or equally, might be the fault of an unskilled birth attendant. Compounding the difficulty of getting to the truth of the matter was the high incidence of illegitimacy that predisposed unmarried women to resort to infanticide or to pass their

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19 ORDLCA, Vol. XCVI, 1905, p.1652.
20 Ibid., pp. 1652-1653.

babies to “baby farms”. The Infant Life Protection Act of 1905 was designed to address these problems, but it was not enough to abate the considerable loss of life in infancy.

Declining birth rates 1859-1912

The comparison between births and deaths in Queensland during the study period that appears in Appendix Four indicates that while the birth rate increased throughout the period and always exceeded the death rate, the government was right to be concerned about the numbers of babies being born. In the fifty-three year period under review, there was a marked decline in the number of births in relation to the mean population.[21] For example, in 1860, when the mean population of Queensland was estimated to be 25 788, the number of births to every ten thousand of the population was just under forty-eight births or four births per thousand population.[22]

By 1870 the population of Queensland had grown to 112 732 and yet there was still only a four percent birth rate.[23] From 1870, there was a slow but steady decline in birth rates in relation to the total population, so that, by 1890, a population of 414 716 was reproducing at the rate of thirty-seven per ten thousand, or less than four percent. The decline in population continued, dropping to just under thirty births in ten thousand in 1897 with only a slight recovery in 1900 before dropping again by 1912 to a recorded average of 29.70 births in an estimated total mean population of 631 577 in 1912. In other words, in the fifty-three year period between

21 *SSQ*, *for the year 1920 Complied from Official Records in the Registrar-General’s Office,* Part VIII, Table No. XVII).
22 Appendix Four.
23 Ibid.

1859 and 1912, the population had increased from 25 788 to 631 577, but the birth rate had dropped from four in one thousand to three in one thousand.[24]

Illegitimacy as a factor in negligence

The Queensland government was in something of a quandary. The population of the state was not increasing through birth rates as fast as it might and, to make matters worse, there was a marked loss of infant life through illegitimacy, the rates of which were increasing. The debates that underpinned the passing of the Infant Life Protection Act in Queensland illuminate the limited options open to unmarried women. A popular choice for those who became pregnant was to move from their own communities and travel to largely populated areas such as Brisbane, Rockhampton and Maryborough where they could be admitted to a lying-in hospital.

The anonymity that towns offered helped unmarried mothers "to hide their shame" and, at the same time, enabled them to "receive proper medical treatment". The Hon. Vincent Lesina of Clermont highlighted the fate of many illegitimate infants in the following oration:

> A woman comes down to the city from the country districts, and is confined with a child born out of wedlock, and wants to place that child and go back to her people. She secures a person who takes the child in, and pays a certain amount for the keep of the child. If it is placed in the care of a motherly woman, in whose breast the milk of human kindness is not altogether dried up, and the mother pays her fees regularly, the probabilities are that the child will become a healthy and vigorous member of the community. If the mother is more or less careless of the fate of the child, and the person to whose hands it is delivered is careless, the sooner it is got rid of the better, and there are many methods adopted for starving a child, ill-feeding it, or over-feeding it, or "killing it with kindness" down to killing it with sheer brutal murder. All these methods are tried, children are overfed and underfed, killed with kindness, or through ignorance, with malice aforethought,

24 Ibid.

> drowned, or choked, or got rid of by some method by the person who is anxious to get rid of them.[25]

The graphic scenario provided by Hawthorn is borne out in coronial and magisterial Inquiries whereby illegitimate infants were disadvantaged prior to birth and during their delivery through the ignorance and fear of their mothers and the absence of social acceptance or support.

Mary Walsh, Brisbane, November 1866[26]

In November 1866, Mary Walsh gave birth to a baby unaided outside the Brisbane Hospital. It was only when a police constable noticed bloodstains on the pavement where she had been sitting that Mary was taken to the Brisbane Lying-in Hospital. The child lived until the following morning. Its death was attributed to the mode of its birth, with the Death Certificate recording that:

> Newborn infant (male) born of the body of Mary Walsh – single woman, died at lying in Hospital, Brisbane, 16th November 1866, fracture of the skull accidentally occasioned through sudden delivery of the mother in the erect posture.

In his evidence, Joseph Bancroft, medical officer of the lying-in hospital explains the circumstances in which he encountered Mary:

> On reaching the Hospital I saw the woman now present, Mary Walsh and a newly born male child. The woman had been put to bed and the child was downstairs. I examined the woman first – She had recently been delivered of the child – the afterbirth had not been removed – I removed it at once. About ten inches of the navel string was still remaining – so part of the navel string protruded beyond the parts - it was retained in the womb. The navel string had not been cut it was ruptured. The woman was in a nice natural condition for giving birth to a child. I asked her how the child was born. She said the child had dropped from her whilst she was standing near the General Hospital in George Street – that she had previously asked to be admitted there but that she had been told that she could not be taken in there.

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25 Ibid., p.1657.
26 QSA, Justice Department, JUS/N14 66/210/1866.

Jane Glass, Fortitude Valley, Brisbane[27]

In 1870, Jane Glass, who lived in Fortitude Valley, Brisbane, complained to a neighbour that she had been, "nearly dead all night with her bowels". When the neighbour, Mrs.Doherty, called to see Jane she noticed bloodstains on the doorstep and she began to think that her suspicion about Jane "being in the family way was correct". Eventually, Jane admitted that she had given birth to a baby and that she had placed its body in a box in her room. Mrs. Doherty attested that she returned to the house to find Jane sitting on the bed with Mrs. Murray, a neighbour. Her statement continues:

> I then said to Jane Glass from the marks I saw there had something taken place she had not explained to me and told her I would send for a policeman to take her into custody and a Doctor if she would not explain the matter fully. She then said she would drown herself, but afterward admitted that she had had a baby which she had put into her box which she had in the same room. Mrs. Murray then opened the box and on getting near the bottom of the box I found something which I said was too light to be a baby but on opening the bundle which was the skirt of an old dress I found a baby rolled up which I put down upon the floor. Dr. Mullen was sent for and returned to the house in company with Sergeant Blake.

The post mortem finding was that:

> The baby appeared to have come to its full time and of a fair average size. The umbilical cord was cut at a distance of about sixteen inches of the body. There was no ligature placed upon the cord before it was severed. The cord appeared to have been severed with a sharp instrument.

The verdict of the magistrate, Henry Buckley, was that the baby died as the consequence of improper treatment after birth, but that no person should be held to be responsible for its death.

While official findings into such deaths exhibited leniency on occasions, there were other instances when the mother was held

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27 QSA, Justice Department, JUS/N2 69/138/1870.

responsible for the neglect that had occurred and the death that had followed.

Mary Ann Brophy, Mackay, 1875[28]

In 1875, in Mackay, Mary Ann Brophy tried to conceal the birth of her illegitimate child by hiding its body under the mattress of her bed. Julia Wheeler, a nurse, recalls that:

> …I saw the girl Mary Ann Brophy lying on the bed. I asked Mary Ann what is the matter my girl. She was not conscious. I then looked on the floor and saw a quantity of blood marks and also on her hands and on her nightdress. I remarked to Mrs. Brown, "There has been a birth her". Mrs. Brown then said, "Nonsense, that cannot be." I then asked Mrs. Brown to make a search and we set to and discovered a bundle under the bed. I examined this bundle and some blood stains, also further proof that there had been a birth in the room. I ……to Mrs. Brown, "Where is the child?' Mrs. Brown said, "I don't know." I then asked her to search some boxes that were in the room. We did so together and found nothing at that time. I came back to the bedroom by myself and Mrs. Brown was present and searched again. First I looked under the mattress at the foot of the bed and found nothing there. I then searched at the head of the bed under the mattress and found the dead body of a female child. It was wrapped up in an old cloth. The cloth was blood stained. I then said to Mrs. Brown we must have the doctor and that the police should also be informed.

The findings of the Inquest were that the baby had died as a result of "neglect during confinement", but in this instance, the mother was accused of causing the neglect and the case was referred to the Attorney General. Although the midwife was not necessarily involved in misrepresenting childbirth outcomes, those instances in which negligence occurred attracted attention from police, medical practitioners, coroners and magistrates. The result was that midwives tended to be implicated because they were integral to childbirth culture, their practice did not conform to an identifiable structure and they were beyond the monitoring capabilities of those who sought to initiate change.

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28 QSA, Justice Department, JUS/N46 75/327/1875.

While infant deaths associated with illegitimacy might present as examples of accidental or unintentional neglect, there were occasions when negligence was identified by the coroner or magistrate as a preventable cause of loss of infant life. The following seven cases highlight negligence as a definitive finding that might be levelled at any person in attendance during childbirth. These cases are listed in Appendix Ten and they feature negligence in which the woman, the husband, or the midwife stood accused. The accounts show that needless loss of life occurred through negligence that was compounded by the absence of skilled midwives; the distances between townships; and a shortage of lying-in facilities, particularly in rural areas.

The circumstance of negligence was defined by the medical profession and laid, for the most part, against lay midwives as proof of the need for regulation. When the claim of negligence was made against lay midwives it damaged the reputation of midwives in general even though the negligent midwife was a construct rather than a proven entity. The cases show that, while reform was indeed necessary, the medical profession and the state channelled the direction of that reform, but they were the accusers. Midwives were said to be the perpetrators of a crime and were therefore powerless, not only for reasons of class and gender, but because they constituted the accused. Thus, the medical profession absolved itself of responsibility for deaths in childbirth and the state deflected attention away from concomitant issues such as poverty and poor standards of public health.

The negligent midwife

When the New South Wales Royal Commission identified negligence as a factor in loss of infant life, it laid the blame primarily with midwives, arguing that:

> …a number of lives are lost to the State by the children being killed in the process of birth, either wilfully, or through the negligence or ignorance of the midwife in attendance.[29]

However, this contention is not supported either in the parliamentary debates that underpinned the Health Act Amendment Act of 1911[30] or those that underwrote the Maternity Act of 1922.[31] Instead, deaths in childbirth were blamed upon other factors such as lack of lying-in accommodation, a shortage of medical practitioners and trained nurses and distances between townships, with lay midwives receiving support from politicians for their willingness to attend women in their time of need.[32] This willingness was attributed to an excess of maternal instinct and a neighbourly outlook that prompted women to take on the midwife role.[33]

In 1922, one parliamentarian, Mr. Moore, member for Aubigny, acknowledged that the unpredictable timing of childbirth prevented some people from accessing lying-in hospitals and, when that happened, women had:

> …to take the next best thing. That is, they have to seek the assistance of people who, though not properly qualified, are able to alleviate suffering to a tremendous degree.[34]

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29 RCDBR, Vol. I, p. 33, (120).
30 ORDLCA, Vol. CVIII, 1912, pp.532–533, 725-734.
31 ORDLCA, Col. CXL, 1922, pp.1763-1876.
32 ORDLCA, Vol. CVIII, 1912, pp.708, 734.
33 Ibid., p.734.
34 ORDLCA, Vol. CXL, 1922, p.1856.

Moore went on to vindicate the work of lay midwives and in so doing reinforced much of what has been written about these women by members of their communities, arguing that:

> In some of these places it is not possible to secure a medical man or a registered nurse in time, and we should give the women I have referred to an opportunity to do the best they can.[35]

The following accounts go some way to explaining the different representation of midwives. In highlighting negligence as a contributing factor in loss of life, the cases demonstrate that childbirth was, in some instances, associated with carelessness, ignorance, errors of judgement and omissions in practice. The cases support the need for uniformity of midwifery practice and for some form of intervention to prevent unnecessary loss of life.

The first three studies investigate alleged neglectful practices in which the midwife was implicated. The first two instances relate to the work of women midwives, while the final example involves a male midwife as the principal attendant and a female midwife who works alongside him, at least, at first.

Catherine Last, North Brisbane, December 1861[36]

On the 17th December 1861, an Inquisition was convened in North Brisbane under the direction of the coroner, Kearsey Cannan, to investigate the death of Catherine Last. Catherine Last had died the day before and now twelve men had congregated to determine the cause of her death. Catherine lived in Edward Street, Brisbane and had engaged a nurse, Margaret Mooney of Charlotte Street, to attend her. Mrs. Mooney

35 Ibid.
36 QSA, Justice Department, JUS/N3 61/96/1861.

agreed to stay for a week or a fortnight. According to the evidence of Catherine's husband, Fredrick, a dentist, he wanted to employ a surgeon, but Mrs. Mooney told him that she was capable of doing everything that was necessary. Mrs. Mooney testifies quite differently, saying that she was reluctant to take responsibility for Catherine because Catherine was in a weak state.

The baby, a boy, was born without any recorded difficulty but Catherine had suffered a cough and shortage of breath for the duration of the pregnancy and her condition became worse after giving birth. She became progressively more exhausted as the days went by and died a week after her confinement. The nurse who acted as midwife explained her treatment of Catherine's condition:

> During her illness I gave her some Castor Oil and some pepper, caraway seeds, treacle and about a cup or two of brandy. I gave her it before she was confined and only once after.

Catherine's illness became progressively worse until, on the Sunday following the baby's birth, she asked for a doctor to attend her. Fredrick Last confirmed that Catherine was:

> In a state of great exhaustion. She said she was not comfortable in the bed and wished to get up for a little… On Sunday night about eight o'clock my wife said I am getting very bad, just as I was on Friday, go for a doctor quick.

When Robert Hancock, the medical practitioner, visited Catherine Last he was perturbed that "there was no nurse present to gain any particulars from". Catherine told him that all she needed was something "to ease her cough as it was almost suffocating". Hancock found Catherine to be, "…in a state of very great exhaustion and violent coughing." He does not outline his treatment of Catherine but says that

the following day she seemed better. However, the improvement was short-term and, as Robert Hancock explained, “She got gradually weaker and weaker till she became delirious and died.”

Mrs. Mooney was recalled a second time to expand on evidence she had given in relation to the medication. She denied giving anything of harm to Catherine, but was unable to produce the bottle in which the medicine was contained, saying that she had thrown the bottle out and it had broken amongst some empty shells. The medication became something of an issue at the Inquest. A bottle of medicine was produced and it was suggested that if that medication had been given to Catherine, it would have worsened her cough.

Margaret Mooney’s treatment of Catherine extended to criticism of the actual care she rendered. Martha Stewart, Catherine’s neighbour, declared that:

> Mrs. Mooney neglected the deceased very much allowing her to comb her own hair and wash her face. I tasted the medicine Mrs. Mooney was giving to the deceased and that now produced is the same…Mr. Last found the bottle. I cleaned it. There was a label on it a red one which I washed off.

The verdict of the coroner was that Catherine Last:

> …died after her confinement from neglect and injudicious treatment and not calling medical aid in due time.

This finding is interesting in that the medical practitioner had attended Catherine the day before she died and had thought that Catherine’s condition was beginning to improve. In addition, Catherine clearly had suffered the respiratory symptom throughout her pregnancy. In those circumstances, it is difficult to see how Margaret Mooney’s treatment of Catherine subsequent to the birth would have made a difference. The

issue of Catherine being given inappropriate medication might have been significant, but it is difficult to assess the damage this might have caused during the course of one week. Although the coroner found that neglect had occurred, he did not attribute blame to any one person or persons. While the evidence implied doubt over the ability of the nurse, Margaret Mooney, she was not the person who might be expected to initiate medical assistance. That, it might be conjectured, should have been the responsibility of Fredrick Last.

Julia Casey, Townsville, November, 1871[37]

The emphasis on medical aid being called in at a judicious point in the care of mother and child is demonstrated in a number of coronial and magisterial testimonies. In Townsville in November 1871, the death of a mother and her child prompted the claim that the midwife was remiss in her treatment of the deceased. An issue that exists in this case is one that is not commonly noted and relates to the right of a midwife to administer a drug to enhance labour. In this instance the medical practitioner contests the midwife's use of the drug and there is some support for the claim that the midwife exhibited negligence.

John Casey recalled that at about 11.30, on the evening of 26th of November 1871, his wife was "taken ill". John does not expand on this term, but it seems that his wife was exhibiting signs and symptoms of childbirth. John asked the next-door neighbour, Mrs. McGhee, to stay with his wife while he fetched Margaret O'Connor, a local woman who

37 QSA, Justice Department, JUS/N3 61/96/1871.

was, in her words, "in the habit of attending friends in their confinement as a nurse." John Casey recollected:

> I wanted to fetch the Doctor but my wife said no, a woman would be sufficient for the night. It was then I fetched Mrs. O'Connor. We got back to the house about a quarter to twelve o'clock. I then engaged Mrs. O'Connor as nurse. She said she understood what was the matter with my wife. I asked her to come and confine my wife. I did not mention any fee I would give her. Mrs. O'Connor remained till about half past one the next morning. She came at about twelve o'clock.
>
> I called in Dr. Clayworth. He arrived about half past seven or eight o'clock. I was up the whole time from the time my wife was first taken ill till she died. When the Doctor came Mrs. O'Connor left directly. Mrs. Molloy and Mrs. McGee were there with the Doctor. I was not prevented by any person from going for the Doctor but my wife. Mrs. O'Connor went to sleep in her chair and did not get up till the labour pains had mostly gone off my wife.
>
> I consider neglect was shown. Mrs. O'Conner gave my wife drugs to fetch on the labour pains again. I think some of the drug is left in the house. I might find it. When Mrs. O'Connor awoke, I think she used all the means in her power to revive my wife, and bring her too. I could not say there was any wilful neglect. Every time I saw the nurse she told me my wife would be right in two hours up to the last time I saw her. She then told me my wife would be right in the course of the day.
>
> I think it was about an hour after the Doctor arrived that my wife died. The Doctor said to me my wife was dying and that she should have been confined at three o'clock.

John Casey's statement suggests that he had faith in the ability and judgement of the nurse, and had frequently sought confirmation from the nurse that his wife was in a satisfactory condition, which had been affirmed. It was not until the doctor arrived later that morning that Julia's condition was accurately appraised.

Unfortunately, it seems that Margaret O'Connor did not possess the necessary skills to assist Julia. She did not realise that the childbirth process had begun. Her action in attempting to enhance the contractions of childbirth and her inaction in seeking medical advice prompted the claim by John Casey that the nurse had been neglectful in her treatment

of his wife. Indeed, there is no indication that the nurse made any form of physical examination of Julia or based her treatment on clinical judgement. In her own words:

> I was called in to Mr. Casey's house about one o'clock on Monday the 29th instant to attend upon his wife. On arriving there I found his wife sitting on the floor. Casey asked me to go to his wife as she wished to see me. I asked her if she was ill. She said she was not ill but that she saw symptoms that she thought she would be ill soon. She did not exactly know what was the matter with her as she did not expect to be confined for a month, but she had symptoms, that she would like to have some one with her. I am in the habit of attending friends in their confinements as nurse. She did not at all during the night appear to be a woman expecting her confinement as far as my previous experience goes. She told me she had had the changes on her and that was the reason she sent for me. She said I ought to sleep and if she felt bad she would call me. I attended till the Doctor arrived. It was about 10 o'clock. I was not engaged to attend her. I gave her brandy and water, coffee and tea; and port wine…

The role played by this nurse is one of support person rather than that of a specialist who is responsible for Julia's safe birthing. The notion that the nurse or midwife will stay with the woman overnight to see her through the event suggests an informality that is not apparent in dealings between women and medical practitioners. There is a sense that childbirth is the business of women and anyone other than a woman is an outsider to the group.

The medical practitioner who attended Julia Casey was Charles Clayworth. His testimony is authoritative and uncompromising:

> I arrived at Mrs. Casey's house about fifteen minutes past ten in the morning. I went as I had received a message from Mr. Casey to attend his wife. On arrival I found Mrs. Casey sick in bed and Mrs. O'Connor attending her. I spoke to the nurse first. I asked her how the patient was progressing. She said she would be all right in about half an hour. I turned round to the patient and found her in a dying state. I told Mrs. O'Connor she would be dead in half an hour. The patient spoke to me. I inquired of Mrs. O'Connor how long the patient had been so cold and weak. She said she did not know, she had not felt her. I immediately gave the patient a restorative in the hope of increasing her strength, but it was of no avail. I applied instruments, as I found the patient was in labour, with the hope of delivering the child at once. The patient …and died under the application of the instruments. I believe the patient died of debility. Had I been called

> in at an earlier period as when the woman was first taken ill, the probability is I could have save her life. I am qualified under the Queensland Medical Board.

The claim made by Clayworth that he might have been able to save the life of Julia has repercussions for the role played by the midwife in this case. While the midwife did not actively prevent any of those present from summoning the doctor, her assurances that the presence of a doctor was unnecessary impacted upon others. This is supported by the testimony of Mary Molloy who arrived at the house of Julia Casey at about 9 pm on 27th November and remained there until Julia Casey died. Mrs. Molloy remembered that Julia was "…scarcely able to speak." She said:

> I asked her if she would wish to have the Doctor she said Yes. I told Mrs. O'Connor that both Casey and Mrs. Casey wished to have the Doctor. She said you may go if you like but there is no occasion for it. Mrs. O'Connor did not try to prevent me getting the Doctor. I saw Mrs. O'Connor give the patient some drink. I do not know what it was; it was out of a cup. I did not see her mix any powder to give her.

The powder referred to becomes the subject of interest and the medical practitioner is recalled and asked to identify the substance. He confirmed that the powder is ergot, a medicine used to assist labour which, he insists, "…is a dangerous drug to administer by other than a medical man: it ought to be given at particular stages."

It may be that Julia Casey might have survived her ordeal had the midwife been more capable. The midwife lacked skill and judgement and her evidence is free of any sense of guilt or remorse or understanding that her limitations may have contributed to the death of mother and child. The early reliance placed upon the midwife by both Julia and John Casey, while misguided in retrospect, was in keeping with childbirth and motherhood as a domestic event unsuited to strangers. Ultimately, the

lack of formal instruction in midwifery left Mrs. O'Connor dependent upon her "previous experience" which, in this instance, was not sufficient to prevent the death of the mother and her infant.

The dependence birth attendants placed upon their previous experiential knowledge of women giving birth is a recurring characteristic in cases that came before the coroner. Their trust in what they had previously known obscured the inability of these women to distinguish between normal and abnormal childbirth and frequently prevented recourse to medical assistance until it was too late. An attitude prevailed that death in childbirth was an accepted risk and very much a matter of chance and neither woman nor midwife had to power to redirect the course of events.

The third account relates to the role of the male midwife. While only two instances of midwifery practice by men other than those qualified as medical practitioners have come to light, there is evidence to suggest that some men worked outside the parameters of legal practice. As Chapter Three has shown, the Medical Acts required medical practitioners to fulfil certain conditions in order to practice. However, while the Medical Act of 1858 was designed to exclude practice by non-registered medical practitioners, by 1867 there were still men taking on the role of medical practitioner on a full time basis without interference from authorities.[38]

38 *Queensland Parliamentary Debates, Second Series, 31 Victoria, 1867, Vol. V, Comprising the Period from the Sixth day of August to the Seventh day of November, 1867*, (Brisbane: James C. Beal, Government Printer, 1867), pp.149-155.

Emmiline Trueman, Tiaro, November 1871[39]

When William Bailey undertook the maternity care of Emmiline Trueman in Tiaro in November 1871, he did so on the basis of previous experience as a midwife.[40] However, the evidence suggests that he may have deliberately misrepresented himself as a medical practitioner, for he is referred to as both as Mr. Bailey and Dr. Bailey. In his statement, William Bailey introduces himself as "a planter residing on the Mary River near Tiaro", and he goes on to state that:

> I have been in the habit for many years of attending in midwifery cases when required. I produce an Indenture showing that I was a pupil for five years with a medical man. I also produce a certificate certifying that during those five years I attended upwards of one hundred and fifty cases of midwifery cases.

Bailey furnished the court with other documentation, including an item from a hospital in Brazil where he claimed to have performed surgical operations.

William Bailey was employed as accoucheur to Emmiline Trueman for the birth of her first child. Emmiline was twenty-nine years of age and had been married for eleven months. Maria Ridgway, a women with many years experience as a midwife, was engaged to act as assistant to William Bailey. Also present at the confinement and during the eight preceding days was Emmiline's sister, Caroline Biddles, who claimed experience of several cases of childbirth where the birth of the child had been assisted by the use of instruments. On the afternoon of Monday, the 9th of November 1874, Emmiline complained of "being unwell".

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39 QSA, Justice Department, JUS/N42 74/321/1871.
40 Ibid.

William Bailey and Maria Ridgway were called and they each arrived during the evening.

Over the next few days, Emmiline complained of pain that was regular but weak. It was acknowledged that she was in labour, but there was dispute between William Bailey and Maria Ridgway regarding the management of the confinement. One week from the time she first experienced labour pains, Emmiline was delivered of a stillborn child and she died within an hour of the infant's birth. The coronial inquiry concluded that she died as a result of "exhaustion from prolonged labour", but the verdict does not reflect the role played by William Bailey in his management of Emmiline. The evidence of the Police Surgeon, John Power, casts William Bailey as an unqualified midwife, who exceeded the scope of his practice and, in so doing, inadvertently contributed to the death of Emmiline Trueman and her child.

Mrs. Trueman's choice in obtaining the services of William Bailey is not explained, but he was presumed by the family of Emmiline to be a man of knowledge in matters of midwifery and was given overall supervision and management of Emmiline's childbirth. In fact, William Bailey was a man-midwife of doubtful ability. He failed to recognise the complications that arose and was thus unable to select the optimum treatment for Emmiline.

In contrast, the evidence of Maria Ridgway demonstrates that she had in her years as a lay midwife acquired sufficient understanding of the process of childbirth to identify the presence of abnormality, but lacked the credibility to convince others. Her past experience as a midwife did

not accord the prestige enjoyed by William Bailey who, when Maria Ridgway challenged his treatment of Emmiline, received the unequivocal support of Emmiline's husband and sister and remained firmly ensconced in his position as a childbirth expert. Maria Ridgway recalled that in the early hours of Tuesday morning Emmiline was experiencing pains that were "slight but regular" which indicated to Mrs. Ridgway that Emmiline was in "slow labour".

During the night, Emmiline's pains increased a little and they were still present the following morning. Later in the day there was a small leakage of odourless amniotic fluid. Maria Ridgway explained that:

> Soon after Mrs. Trueman asked me if I thought she would be very long. I said I did not know, and asked her to allow me to try if I could feel the baby making any progress. With her permission I tried and felt the baby, as I thought about the size of a half a crown, of its head. I told Mrs. Trueman that I distinctly felt the child's head and that it had hair on – I could only just feel the child with the tip of my finger. I am quite sure it was the child's head I felt and the hair – the womb was open and allowed me to feel the child's head. I oiled my finger, and worked around the womb. I made a similar examination about seven o'clock in the evening and I though the womb was a little more open and the child was further down.

By the following morning, Thursday, Emmiline's pains had increased in strength and frequency. Maria Ridgway described them as "very strong bearing down pains" although, in her opinion, the pains were not strong enough to bring about the birth of the baby. She later noticed that the baby was lower down in the pelvis than it had been asked Emmiline's sister, Caroline, whether she should deliver Emmiline or send for a doctor. Caroline told her that she should do nothing because Mr. Bailey was present in the house and he would not approve of her acting as accoucheur to Emmiline.

Maria Ridgway then remonstrated with Mr. Bailey, suggesting that the baby should be delivered. She was aware that the pains experienced by Emmiline had begun to reduce in intensity, but Mr. Bailey could not be persuaded to intervene. Maria Ridgway contested Mr. Bailey's management of Emmiline, saying:

> Mr. Bailey come at once, the baby is about coming into the world". He said "not it" "not it" and sat up on the sofa. I went back to Mrs. Trueman's room and remained there as near as I can think for about a quarter of an hour, or twenty minutes, and then went for Mr. Bailey, took him by the shoulder and shook him. I said "Mr. Bailey why do you not come. Mrs. Trueman's pains seem to be getting weaker. Mr. Bailey sat upright on the sofa, and spoke to me three times. I then returned to Mrs. Trueman's room and examined her again – found that the baby had gone back about from two to three inches. I thought the head leaned a little to one side. I went the third time to Mr. Bailey and said to him "Mr. Bailey why do you not come. Mrs. Trueman's pains are getting weaker and weaker and the child is not as near the birth as when at first I called you". He jumped up at once and fell over me into the room when I said to him "I think the child's head is leaning a little to one side". Mr. Bailey then tried and said "No it is all right the child's head is out of the womb and there is now only the difficulty of the shoulders". The pains continuing weaker Mr. Bailey gave deceased some medicine and the pains seemed to revive again. The medicine given was a liquid one of a dark colour. Mr. Bailey remained in the room till about four o'clock at which time he rolled his sleeves up and said "There is a change about to take place". After some time no change having taken place Mr. Bailey got up and walked out of the room.

It is likely that the medicine Maria Ridgway described was a preparation designed to make the uterus contract strongly to assist the expulsion of the foetus. Mr. Bailey acknowledged that he had given Emmiline "two doses of ergot" and "when the pains seemed at all harassing, I administered small doses of tincture of opium". The use of these preparations was popular with "physician-accoucheurs" during the nineteenth century. Ergot was used to stimulate uterine contractions and tincture of opium, or laudanum is it was also called, was employed in cases of protracted labour where its effect as a relaxant both eased the

pain of labour and facilitated dilatation of the cervix and thus the passage of the foetus.[41]

It is apparent from her statement that Maria Ridgway did her best to convince Mr. Bailey and Emmiline's family that the labour was not progressing as it should and that the baby ought to be delivered. On Friday morning Mrs. Ridgway again examined Emmiline and found that there was no change in the position or decent of the baby. She stated that:

> It was exactly in the same position as at between one and two in the morning (this was about seven in the morning). I then said to Mrs. Biddles "Why is Mr. Bailey deceiving you. He rolled his sleeves up as though the child was coming into the world and it has not moved at all – Mrs. Biddles. I don't pretend to know much, but from what experience I have had I am sure that child will never come by natural force, and I am sure she ought to have been delivered. I am quite sure there is danger". I am almost sure she said in reply "Well Mr. Bailey ought to know.

Maria Ridgway continued to plead for medical intervention but her arguments were disregarded. It seems that one of the two doses of ergot that Mr. Bailey conceded he had given Emmiline might have been administered on Friday night when Maria Ridgway found Emmiline in extreme pain. She said that she "…found her on her knees in strong agony...[and that]…those were the strongest bearing-down pains I ever witnessed a woman suffer." According to Mr. Bailey, he administered ergot, "…without effect". Mrs. Ridgway remained with Emmiline until the early hours of Saturday morning. During this time, Emmiline seems to have had a premonition of her impending death and she told Mrs. Ridgway "…that she thought that the baby and she would soon go."

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41 Merck & Company, *Merck's 1899 Manual of the Materia Medica,* pp.141-142,

On Sunday morning, William Bailey sent Mr. Trueman to Maryborough for a doctor with a note that requested, in the event of the doctor being unable to attend, the loan of short forceps and a catheter. The doctor, Joseph Little, sent the instruments and Mr. Bailey subsequently used them on Emmiline, but was unsuccessful in his attempts to deliver the baby. At midnight on Sunday, Joseph Little received a second note from William Bailey requesting his presence at the confinement and when he arrived between six or seven o'clock on Monday morning, he found Emmiline to be "completely prostrated". With the use of forceps, he delivered her of a stillborn child and Emmiline died soon after.

Joseph Little supported the evidence of Maria Ridgway and stated that, in his judgement, "…the second stage of labour had been unusually prolonged...[and] … Mrs. Trueman's pelvis was unusually small, and that was the cause of all the difficulty." He went on to say:

> From the evidence I have heard today I believe medical assistance should have been sought on Thursday and then there was a fair probability of saving her life. From the fact that medical assistance was not sought on that day, she was not skilfully treated as it was impossible to treat the case at all without instruments and they should be used by a skilful duly qualified man.

John Power, in his position as Surgeon to the Police at Maryborough, supported this opinion. After listening to the evidence that had been submitted he concluded that:

> …Mr. Bailey displayed want of skill in not calling in medical assistance earlier than he did. I consider that from Mr. Bailey's' own evidence even supposing that the second stage of labor (sic) did not take place till Saturday, as he states, delivery ought not to have been delayed and medical assistance should have been immediately sent for; and the fact of Mr. Bailey not having sent for such assistance shows neglect or ignorance of the urgency of the case. The fact of Mr. Bailey being in the house from the 9th to the 16th ultimo in attendance without asking further advice was in itself proof of either ignorance or negligence.

> The fact of the deceased pelvis being so small was a reason why delivery could not have been accomplished without Instrumental (sic) assistance: and the operation should have been performed by a skilful practitioner. I do not think an unqualified man the proper person to use Instruments.

As a result of the evidence of the two medical practitioners, the coroner forwarded details of the case to the Attorney General in Brisbane with a view to taking legal proceedings against William Bailey. However, if William Bailey had been a qualified medical practitioner, that option would not have been available. In the words of Joseph Little in vindication of his loan of obstetric instruments to William Bailey:

> I remember being asked by one of the Magistrates here if it was a case for a Magisterial Inquiry as the Police wanted to know. I said it was not a case for Magisterial Inquiry. My reason for saying so was that (which I at the time stated) Mr. Bailey was a duly qualified medical man and although erring on judgment had a right to act on his opinion in the matter…

It seems then, that while a lay person acting as a midwife could be prosecuted for his or her actions, a medical practitioner who makes a judgement that is erroneous may be excused for that judgement and its consequences simply because he is authorised to practice under the Medical Act.[42]

Midwives were in a less favourable position. They were neither able to avail themselves of professional protection, nor to provide their patients with the more complex treatments available to medical men. Maria Ridgeway had skills as a midwife that William Bailey did not possess. Yet, had she been engaged as midwife, she would not have been able to obtain and employ obstetric instruments in the way that Bailey had. His credential for acquiring these instruments was that he

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42 *Medical Act [1858],* (21 & 22 Vict. c. 90). See also, *Medical Act of 1867*, (31 Vic.No.33, Section 13).

was a male practitioner in the birth room and therefore taken to be qualified.

The cases explored thus far have illuminated incidences where neglect was considered a direct factor in death. Even when the link between the midwife, negligence and death was tenuous, the presence of a midwife at the birth or in the days following was often enough to incite the complaint. For example, Catherine Last had been ill prior to the birth of her baby. The birth itself seems to have been uneventful. When she became ill following the birth, exhibiting similar symptoms to those she had displayed prior to the birth, the omission on the part of the midwife to report the case to a medical practitioner was perceived by him to be a failure that constituted neglect. The onus of responsibility in this case, as far as the medical practitioner was concerned, lay not with either the woman or her husband, but with the midwife who had been engaged as a monthly nurse.

However, when William Bailey is mistaken as a medical practitioner colleague, his repeated errors of judgement, even though they eventuated in the death of mother and child, are shrouded beneath the medical role. This raises the question of whether medical errors were given less attention or even deliberately ignored by members of the medical profession. There is support for this possibility from Wilton Love of the Lady Bowen Hospital who, in 1893, used the following example to indicate the progress that had been made in obstetric

medicine. The extract refers to a medical practitioner in the "early days" of the hospital's history:

> 6 am – Called to see Mrs. B. with funis and right hand presenting; turned and brought the child so as the head only remained, and as the child was dead, left it to the care of the matron so as to keep an appointment at the 17-mile Rocks. Another surgeon had to be called in to complete delivery some hours after.[43]

Practices such as this are unlikely to be any more a reflection of medical practice as a whole than the cases of negligence that were attributed to midwives. There is no doubt that medical malpractice did occur. However, the evidence presented above suggests that, while errors on the part of midwives were deemed characteristic of the work of *all* midwives, mistakes made by medical practitioners were accepted as being either a reasonable oversight or the exception to the rule.

Negligence and the medical practitioner

It is worthy of note that there was nothing in the archival material to suggest that the work of the medical practitioner was scrutinised in relation to deaths in childbirth. Two Inquests identify situations in which a medical practitioner was called but did not attend either at all or until it was too late to alter the outcome. The first case relates to the death of Mabel Glenwright that appears in Chapter Four.[44] The medical practitioner was called on two occasions to lend assistance when the midwife was unable to remove the placenta following the birth of Mabel's child. In the first instance he stated he was too busy and at the second call he ordered that Mabel should be removed to hospital by ambulance. By that time, over two and a half hours had elapsed since the birth and

43 W. Love, "Records of the Lady Bowen Hospital, Brisbane", *AMG,* (May, 1893), p.147.
44 QSA, Justice Department, JUS/N450 386/1910.

Mabel was almost moribund. At the Inquest the medical practitioner was not questioned regarding his non-attendance nor was any criticism directed at him.

Sybella Klumpp, Eight Mile Plains, 19th October 1877[45]

In a second case, that of Sybella Klumpp whose fifth child was born on Thursday, 6th September 1877, the "nurse" in attendance asked Sybella's husband, Fredrick, to get the opinion of the chemist in relation to "a cold" that Sybella was suffering. The chemist advised Fredrick to call upon a medical practitioner and Fredrick did so. Prentice, the medical practitioner did not go out to see Sybella, but instead made out a prescription saying, according to Fredrick, "he could rely upon my account of her health". On Friday, the nurse, Mary Ann Williams, saw Sybella and noted that medicine prescribed, but she did not consider that Sybella was any better. When Mary Ann Williams called on Sybella on Sunday, she once again asked Fredrick to call in the medical practitioner.

In his evidence, the medical practitioner said he had arrived at the Klumpp residence at about six thirty on Monday morning, 10th September and that:

> I found the woman affected by puerperal mania and upon inquiry was told that she had barely slept since her confinement five or six days before, I apprehended little danger to her life if she could be made to sleep. I prescribed for her for the purpose of bringing on sleep which is always very difficult. From information I received from the nurse the medicine did not put her to sleep. She took about half of the medicine. The husband called the same afternoon and wished me to go out again but I considered that there was no need, I could only have repeated the same… Sleep was the only thing that could have saved her. Could the deceased have been put to sleep the second or third night of the attack it is probable that the attack of mania would not have occurred.

45 QSA, Justice Department JUS/N54 77/231.

> On the next morning, Tuesday, I went out at about half past seven and I then found that puerperal convulsions had set it in and when these follow on mania the result is always fatal.

At the Inquest, Prentice made a point of exonerating the nurse and the family members who were present during the confinement and in the days that followed. He attached a certification to this effect for the "private information of the Attorney General" and not, Prentice assured the court, to cast blame on others.

Negligence and alcohol

Honora Smith, Blackall, September 1889[46]

The situation was quite different in the case of Mary Dunn who was the "monthly nurse and midwife" engaged to attend Honora Smith of Skeleton Creek, Blackall, in September 1889. Mary Dunn's evidence contained inconsistencies that caused her account to be closely examined by the magistrate. The midwife, Mary Dunn, maintained that she was in close attendance upon Honora Smith throughout the night, yet aspects of her statements suggested a degree of neglect that contributed directly to the death of Honora.

Mary Dunn began her evidence by depicting circumstances in which her charge was disturbed in the early hours of the morning in the mistaken belief that her labour had started. The midwife claimed that no such condition existed and that she did what she could to settle Honora. Five hours later, the midwife was surprised to discover that Honora had

46 QSA, Justice Department, JUS/N169 436/1889.

died during the night. Mary Dunn began this portrayal in the following way:

> The deceased was quite well last evening up to eleven o'clock when she went to bed. She called me about one o'clock. She was walking about the room. She said she thought she was beginning to be ill – I said, "Go to bed my dear go to bed". She went to bed. I helped her in and covered her up. She did not complain of any pain. She moaned a little I said, "What are you fretting for it will be hours and hours before your child is born. I put her head on the pillow and she went to sleep soon after. She was dozing. I sat on the side of the children's bed on the opposite side of the room. I remained with her all night. I did not go to sleep. She never moved hand or foot and I was glad to see her sleeping so peacefully.
>
> At six o'clock I went to make her a cup of tea. I made three cups and took one to her. When I touched her shoulder I found her dead. She had not moved from the position I put her in at one o'clock. Word was immediately sent to the Police barracks reporting the death. I gave her no medicine yesterday of any sort except Castor Oil. Deceased was very jolly last evening up to eleven o'clock when she went to bed. She sang two songs at the dining table. I went to bed at eleven o'clock – we was (sic) all jolly together. She and the rest of us were drinking beer.

It is only at this point that Mary Dunn offers the information that she and Honora had been drinking alcohol in the company of others. She goes on to state that:

> I have laid her out this afternoon. There was (sic) no marks of violence on her body in any way. There are appearances on the body now of the confinement having commenced. The womb has opened. The water broke just about half past one o'clock this morning but there was no pain at all. There is no appearance of the child at all.

Mary Dunn's incidental comment in relation to the rupture of the fluid sac surrounding the foetus constitutes a worrying ignorance in relation to the processes of birth. Her apparent lack of understanding is reinforced by her next comment, which implies that in the absence of pain or delivery of the foetus the rupture of the membranes holds no significance. While she clearly is unable to assess rupture of the

membranes as an indication that labour had commenced, she further implicates herself as incompetent when she continues:

> Blood has been coming from the womb for days. It is still coming. She informed me some days ago she was hurt internally.

Suddenly, the whole set of circumstances is changed. The picture that emerges is one of neglect caused by ignorance. The labouring woman, dependent on Mary Dunn as midwife, is left alone to die while the midwife sleeps on. Mary Dunn's final comment in her initial statement may provide a clue to how she was able to ignore her charge and fail in her duty. Her concluding remark was:

> I had no liquor at all last evening no beer nor spirits. I did not take any for fear she might be taken ill during the night.

It seems that the magistrate was concerned with the accuracy of Mary Dunn's evidence and its implications concerning the discharge of her duty to Honora. Mary Dunn was required to give further evidence. Before she did so, the magistrate informed her that:

> The witness is here cautioned by the Bench that she is not compelled to answer any question that may be put to her that may tend to incriminate her in any way, there being a certain amount of suspicion attached to her that the deceased's death is owing to her neglect of her duties as a midwife.

Mary Dunn continued:

> When I was called at about one o'clock by deceased she did not appear to be in pain. I do not know when she was moaning for…I made an internal examination but the child was too far off to be felt by me. I could only get my two fingers in the womb when I tried again – I do not know if the water broke before or after the examination by me. I never saw the waters. I do not know if I swore at Skeleton Creek on the twenty-seventh instant before the Police Magistrate that the water broke at half past one o'clock. I was too confused. I did not then know what I was saying. I did not make more than the one internal examination. I made no attempt to hasten the labor by any means at all.

From this latter statement, it now seems that Honora died in circumstances of pain and solitude. It seems that Mary Dunn may have caused the membranes to rupture and that she performed the examination even though Honora had been losing blood from the uterus for some days. The midwife, then, was judged negligent in a number of ways. The official verdict was that:

> syncope probably caused by neglect on part of midwife during the confinement of the deceased.

This finding offers little to placate the sense of wrong and no deterrent to uninformed and neglectful practice by others. The case highlights the advisability of compelling midwives to undertake a course of study that would provide them with, at the very least, rudimentary knowledge of childbirth processes and the point at which childbirth becomes abnormal. It is that point of differentiation that the medical profession sought to instil in midwives.[47]

Mary Bowers, Dalby, October 1884.[48]

The use of alcohol by the attending nurse and the childbearing woman was implicated in the death of Mary Bowers of Dalby. Mary Bowers was at the Ryan's Hotel early in the afternoon of 16th October 1884. Her neighbour, Annie Walsh, recalls that at about three o'clock that afternoon:

> The deceased was in the back yard sitting down. She said come on Mrs. Walsh and sit down with me. She also said I don't think I will get over my confinement as I have been knocking myself about. She then asked me to go and get a shilling's worth of gin. I left to go for the gin and when I returned the baby was born.

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47 W. B. Nisbet, "The Education of Midwives", *AMG*, (June 1891), p.270. See Also, Anon, "A Meeting of the Medical Profession, Midwifery Nurses' Bill", *AMG*, (November 21 1898), p.481.
48 QSA, Justice Department, JUS/N109 84/455/1884.

> When I left she was not confined. I remained away about ten minutes and when I came back the baby was born and the deceased was lying on the bed. There was no other person in the house when I returned. She said, I am confined. I then went for Mrs. Hunt. I only gave the deceased a table-full of gin. I did not assist at the confinement before or after.

Nine witnesses provided statements to the coroner, but none was able to say unequivocally that Mary Bowers had been attended during childbirth. It seems probable that she was not. During the course of that afternoon, a number of acquaintances of Mary called at her residence. They each stated that the child was already born by the time they arrived. One, Mary Ann Hunt, said she had been sent for between eight and nine o'clock that morning to attend to Mary Bowers and that when Mrs. Hunt arrived at Mary's residence, Mary engaged her to attend her during her confinement. Mary then returned to Mrs. Hunt's house with her, stayed a short time and then left, according to Mrs. Hunt, "having a slight appearance of drink."

According to Mrs. Hunt, the next time she saw Mary Bowers was between two and three o'clock at Mary's house. Mrs. Hunt maintained that the baby had been born by then and that Mary seemed to be "all right". She said that Mary told her to go home, saying that she would send for her if needed. It seems that Mary Bowers had a steady stream of visitors to her house during the afternoon. When Mrs. Hunt arrived, Emma Murdock and Rebecca Rook were already there and she maintained that she was asked to return to Mary at between five and six o'clock the same evening. Mrs. Hunt stated that:

> I went there and found her in a cold perspiration and she would not stop in bed. I cannot tell what the cause of the excitement was as she did not want me to do anything at all for her. She was excited from drink. I remained in the house until Dr. Howlins arrived at about eight p.m. I then left and went home. …I had nothing to do with confining the deceased.

However, this evidence is at odds with a statement made by Sarah Warner, employed as a ”servant” at the Criterion Hotel, Dalby. Sarah had known Mary for about three years and considered her a ”healthy woman”. Sarah said that she was with Mary Bowers at seven thirty the evening of the birth. Mary was alone in the house when Sarah arrived. During the course of the hour and a half that Sarah was there, four other women arrived one of whom was Mrs. Hunt. Sarah maintains that Mary had told her that Mrs. Hunt had “attended her” and that, “Mrs. Hunt was drunk when I saw her”.

In his statement, William Howlins, Government Medical Officer, noted a request for him to attend the residence of Mary Bowers and that he had arrived there at about eight thirty that evening. He does not say who asked him to attend. When he arrived, he found Mary:

> In a state of collapse with the extremities cold and almost pulseless. The bedding on which she lay was saturated with blood. On enquiring I found that she had been delivered of an infant during the day. I saw the nurse Mrs. Hunt who was supposed to have attended her. She was under the influence of liquor and could not give me a clear account of what happened respecting the confinement.

Although Howlins assessed Mary to be in an extremely poor condition, he did not remain with her. Instead, he applied what he called, “the usual remedies in such cases” and left. The attitude of the medical practitioner appears dismissive and differs from others whose actions have been depicted previously. Although Mary is clearly in a debilitated state, the medical practitioner does not instigate resuscitative measures. Instead, he leaves Mary in a state of exsanguination. As previous chapters have shown, there were treatments that might have been attempted and which

other medical practitioners have used in similar situations.[49] Before leaving, he commented that he believed that Mary was "slightly under the influence of liquor" at that time. His findings at post mortem examination revealed that the cause of death was haemorrhage, which he concluded was the result of "want of proper care". It was Howlins' opinion that, "At the time I saw Mrs. Hunt she was not then fit to attend to a woman in that state".

The verdict of the coroner was that death was due to "Childbirth, through neglect", but no one was identified as being responsible for that neglect. While it might be that Mary Bowers' death was primarily the result of postpartum haemorrhage and that she either birthed alone or in the presence of a "neglectful" assistant, other factors impinged upon it. If the evidence of Annie Walsh is correct, Mary had a premonition that she might not survive the childbirth because, in her words recalled by Annie, "I have been knocking myself about". This admission, given that she was drinking alcohol before the birth of the baby, may reflect a socio-economic environment that impacted upon her subsequent birth outcome.

The thrust of parliamentary reform during the 1900s was directed at making people more accountable for their actions in terms of public responsibility and liability and included nutrition, sanitation, housing, and health.[50] The culmination of those debates was twofold in terms of legislation that affected childbirth; the Infant Life Protection Act in 1905,[51]

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49 Merck & Company, *Merck's 1899 Manual of the Materia Medica,* p.134. See also, J. Hamilton, "Midwifery Experiences", *AMG*, (April 1892), pp.183-184. And, QSA, Justice Department, JUS/N482 540/1911.
50 ORDLCA, Vols, LXXXIV (1900), LXXXV (1900). See Also, Vols. CVIII (1912), XCV. (1905) And Vols. CIX (1905), CX (1905).
51 *Infant Life Protection Act*, (5 Edw. VII, No. 19).

and the Health Act Amendment Act in 1911.[52] Arguably, The Maternity Act of 1922 was the third and final chapter in the propulsion of state to improve the lot of the childbearing woman and thus to protect the viability of the white population of Queensland.[53] In 1884, no such legislation was in place and Mary Bowers was likely to be in much the same position as many other women of her class. The experience of Mary Bowers was not unique in that social and economic factors were a significant influence on the way in which women birthed.

Neglect in which the husband is implicated

The following accounts involve what may be perceived as neglect on the part of the husband, but they suggest more than simply carelessness or wilful cruelty. It is worth noting that in the case of Hannah Willert, in finding that she contributed to her own death by failing to make provision for assistance in childbirth, the Police Magistrate, as a representative of the state, acknowledges the business of childbirth as the responsibility of the woman herself.

Hannah Willert, Beenleigh, May 1894[54]

Hannah Willert of Beenleigh died on 28th May 1894 as a result of exhaustion from haemorrhage after childbirth. According to evidence given by her husband, Mrs. Willert went into labour at around one o'clock in the morning. She told her husband that he would have to attend to her. The baby was born within minutes of her summoning her husband. He cut and tied the cord according to the directions of his wife. This was Mrs.

52 *Health Act Amendment Act,* (2 Geo. V, No. 26).
53 *Maternity Act, 1922* (13 Geo. V, No. 22).
54 QSA, Justice Department, JUS/N224 206/1894.

Willert's tenth child. Her husband stated that he asked his wife if he should get someone to attend to her but she said:

> Oh no! You can wait until you wake up Christian and send him for my sister. Everything is all right. There is no use to bother with strange people."

The woman subsequently bled to death. The medical officer stated that when he arrived:

> The body was warm, limp and pallid. She had evidently just been delivered of a well-nourished female child which I saw. The afterbirth had not been delivered. The bedding contained many large clots and was saturated with blood. The blood being far greater in quantity than is usual in ordinary confinements. In my opinion death took place within half an hour of my seeing the body and was due to haemorrhage in childbirth. I am further of the opinion that if anyone had been present who had the slightest knowledge of midwifery, the woman's life might have been saved.

The Police Magistrate concluded that:

> …the deceased woman unconsciously contributed to her own death by neglecting to make proper provision for her approaching confinement. The husband might possibly be blamed for not summoning medical assistance more promptly, but this fault may be said to be condoned by the awkwardness of the position in which he suddenly found himself.

The instances where women left their confinements to chance often ended in disastrous consequences and sometimes included the deaths of mother and child. The reasons behind this lack of provision on the part of women point to a reluctance to identify childbirth as an abnormal event and, at the same time, a sense of inevitability about childbirth and a perception that it was beyond the control of the woman herself. This attitude, coupled with naivety on the part of the woman herself and the harshness of the environment in which she often found herself, including isolation from other communities, often resulted in a reliance on strangers and limited options with regard to childbirth choices.

Annie Spendlove, Brisbane, April 1872[55]

The second example where the husband was identified as a contributing factor in the death of his wife is more complex and the alleged negligence occurred over an extended period of time. This example is of particular interest because it not only implicates the husband, but it also illuminates a social network that attempted to support the woman and her children. That network, which included police and local women, was thwarted by a reluctance or inability on the part of the woman to break away from the domestic situation in which she was engulfed. A part of the domestic circumstances in which this woman found herself was poverty. While poverty affected the way in which she lived and denied her of choice, it also prompted an offer of assistance that, for whatever reason, she did not grasp.

On Friday, 5th April 1872, the medical practitioner, Robert Hancock, was called to see a woman and a child who had "…died under irregular circumstances." On initial examination he found no external signs of violence, but based on his postmortem finding he made the following statement:

> I am of the opinion from the symptoms described to me by her husband that she first had diarrhoea about six weeks previous to her accouchement and that from culpable negligence on the husband's part in not obtaining proper medical attention the diarrhoea became worse and eventuated in hers and the child's death.

In evidence, John Armstrong Lewis, Inspector of Police for the Brisbane District, said that John Spendlove had called at his office in George Street on 7th March 1872, to ask why police were making enquiries into his treatment of his wife and children. Lewis told Spendlove that he had sent

55 QSA, Justice Department, JUS/N33 72/67/1872.

a constable out to see Annie Spendlove and the three children following claims that they were in a destitute state, and that the constable's report and the neighbour's statements confirmed that claim.

Lewis advised Spendlove to procure medical attendance for his wife, saying that if this was beyond his financial means, Annie Spendlove could be taken to the Lying-in Hospital for no charge. Lewis offered John Spendlove assistance in conveying his wife to hospital and suggested that if Spendlove did not want his wife admitted as a "pauper patient" the officers of the institution would take payment. Spendlove said he would consider the options presented to him, but that his wife and children were treated as well as he could afford. He produced a bill for provisions amounting to £6.1.9d in support of this.

Annie and John Spendlove had lived in a humpy two miles outside Cedar Creek since November 1871. Their neighbour, Julia Chilton, had visited Annie on a number of occasions in the months before her death. On the first visit Annie was "…laid up in bed with a bad knee…" which, she told Julia, had been injured when a tree fell upon it while she was helping her husband to clear the road. Julia Chilton related incidences in which Annie was pushed to the limits of her physical capacity and this Julia attributed to lack of consideration on the part of John Spendlove. Julia Chilton stated that, "Everytime I saw her she complained of the ill treatment she received from her husband and that she did not get enough to eat." Julia Chilton went on to say that:

> Knowing that her confinement was near and about a month or six weeks' before it, the deceased was at my house and I offered to put up a bed for her at my Humpy and to send for a nurse to attend her in her confinement. She said she would be very glad but was afraid to accept it in consequence of her husband.

Elizabeth Draper of South Pine River and Elizabeth Tullen of Samford confirmed that Annie Spendlove was in a poor state of health and that they had done what they could to support her. Elizabeth Draper said that Annie complained of physical abuse at the hands of her husband and said that if she stayed around her humpy she would have to engage in planting or other physically taxing work.

Elizabeth Tullen was a widow who lived at Samford. She first met Annie Spendlove on 29th January 1872 at the request of Annie's daughter. Elizabeth saw Annie twice on that day and once again on 1st April, a few days before her death. According to Elizabeth Tullen, when she first visited Annie in January, she found her to be, "…very weak and apparently suffering from bronchitis." Elizabeth Tullen went on to explain:

> I asked her if she had sufficient food in the house. She said she had, though they had been short from the dray disappointing them- she said her husband had been disappointed in getting money from the Emigration Office. I told her to send to me for anything she required and that if I had not what she wanted I would endeavour to procure it for her.

Elizabeth Tullen sought out John Spendlove and recommended that he send Annie to hospital. Elizabeth Tullen offered to provide a spring cart for the journey, but John Spendlove became indignant and refused her offers of help.

On 1st April 1872, Elizabeth Tullen's daughter, Dora, rode to see Annie Spendlove and to ask why she had not sent to Elizabeth Tullen for provisions. According to Dora Tullen, Annie looked intimidated by her husband. John Spendlove told Dora that he considered her visit was impertinent and that he was capable of managing his own affairs. Dora

Tullen described a conversation she had with Annie Spendlove in relation to her poor state of health:

> I asked her why she did not go to the hospital. She did not answer. Her husband said, "You didn't wish to go to the Hospital did you". She made no reply.

This visit occurred four days before the death of Annie and her newly born child. There is no record of the birth. Julia Chilton seems to have been the last person outside the Spendlove family to see Annie. Julia described the circumstances that surrounded Annie's death:

> I am the nearest neighbour and indeed the only woman living near her and was her most intimate acquaintance and I am certain she had no woman to attend to her during her confinement. Spendlove sent for me on Sunday and she was then dying and I then offered to have her brought to my house and he refused to allow her to come. My husband remained at home from his work on the Monday to assist in bringing her down. I returned then on Monday and Tuesday and on the Monday I offered again to have her brought down and he refused and she died shortly after I left on Tuesday.

The sad plight of Annie Spendlove and her family highlights a number of issues. First, there was a woman's network in place that might have made a difference to Annie's situation had she felt able to avail herself of its help.

Second, although the evidence against John Spendlove appears damning, it is possible that he was unrealistic about the condition of his wife and family and his ability to support them. Third, although the police and the neighbours did what they could to remedy the predicament that faced Annie Spendlove, they were reliant upon the cooperation of Annie's husband. It was only after her death that there was any prospect of subjecting him to scrutiny and, if indicated, apportioning him blame for his part in the death of mother and child.

The verdict of the coroner was based upon the opinion of the medical practitioner and was recorded as:

> Culpable neglect on the part of the husband previous to and after confinement.

There is no indication from the transcripts whether or not the deaths of Annie Spendlove and the infant child were regarded as constituting a criminal act. On occasions when the Inquiry found that there was a case to answer, the details of the Inquiry were sent to the Attorney General for review as a potentially criminal case.

Conclusion

The chapter has addressed the ways in which negligence in childbirth might be manifest and has isolated situations in which midwives, mothers and husbands might become the perpetrators or accomplices to death. The chapter has highlighted the problems in differentiating between deaths that were caused by wilful neglect and those that were the result of ignorance or misjudgement. What the chapter has also reinforced is that childbirth that took place in the home was inherently problematic in terms of conduct, surveillance and monitoring. Births were hard to trace, their outcome was impossible to predict, their registration was difficult to enforce and when childbirth ended in death, there was limited evidence to inform the investigation. In short, the whole culture of childbirth was a phenomenon that lay beyond the grasp of those who sought to control it. If a beginning was to be made, it should start by addressing the problems that were identifiable.

As this chapter has demonstrated, population issues were a major consideration in Queensland and other Australian parliaments during the

first decade of the twentieth century. The state looked upon infants as a precious resource and essential to national prosperity. That resource was threatened in its embryonic stage by abortion; at birth by carelessness, wilful neglect, or infanticide; and in the early years of infancy through maltreatment or imprudent management. The state held a vested interest in protecting this valuable asset and in maintaining its viability. It was inconceivable that the state would not intervene. And there is much in the Queensland parliamentary debates to support the argument that the state acted as much from altruistic motives as monetary ones. The plight of young women, conceded by politicians in their discussions and supported by coronial and magisterial testimonies, was clearly a matter for public concern.

The medical profession and later, the state, identified the home as a problematic environment. There was little that could be done about that aspect of childbirth at this stage. The replacement of the home with the institution as a preferred place of birth remained a challenge that would need to be met at a later date. First, it was necessary to address the issue of lay midwifery as one of the foremost factors in loss of life through childbirth. Official inquiries confirmed that women working as midwives were implicated in these deaths. But while members of the medical profession agitated for change and were specific in the ways and means by which improvement might be achieved, the women themselves and their families accepted death in childbirth as a part of the normal life process. None of the coronial or magisterial testimonies submitted by surviving women or members of their families indicated that they believed

loss of life in childbirth to be exceptional and an issue to be redressed. Rather, there was an acceptance of death in childbirth as very much a part of normal life.

The medical profession thought otherwise. Its members believed that childbirth was a medical event that should be screened to exclude abnormalities or complexities and that, if these were present, intervention strategies would need to be set in place. The medical profession was also in general agreement that childbirth should be located in the hospital institution and that the work of midwives should be focused in that arena where it might be brought in line with nursing and under the control of the medical profession. In this way, medical and state objectives might be satisfied as the responsibility for ensuring the continued propagation of infant Australians was shifted from the mother to the state. The following chapter explains the role of nursing as a major influence in the regulation of midwives and on the way in which their occupation was redefined. The chapter argues that the concept of a qualified nurse who had been trained in the hospital under the direction of a medical practitioner offered the prospect of bringing the disparate midwife group into a form of organised occupation and, in time, changing the location of midwifery practice from the home to the hospital. The thesis thus far has answered the question of *why* change occurred. The following two chapters discuss the means by which change was implemented.

CHAPTER SIX

THE "TRAINED NURSE" AND THE HOSPITAL INSTITUTION

> Every day sanitary knowledge, or the knowledge of nursing, or in other words, of how to put the constitution in such a state as that it will have no disease, or that it can recover from disease, takes a higher place. It is recognized as the knowledge which every one ought to have – distinct from medical knowledge, which only a profession can have.[1]

The previous chapters have shown *why* the medical profession and the state determined the need to regulate midwives. The chapters have illustrated the ways in which the deficits of midwifery practice entered into the public record and public debate. It has been argued that while the public perception of untrained midwives was generally complimentary, the views of the medical profession were frequently more controversial and often the source of disparaging remarks. Previous chapters have highlighted the confusion that surrounded the work of untrained midwives, the lack of understanding of what their work actually entailed and the concomitant tendency to confuse the roles of midwife and nurse.

This chapter looks at *how* midwives and their practice were transformed. It is argued here that the medical profession played a pivotal role in the development of nursing as an occupation for which women possessing a rudimentary education might be trained. Through their participation in the Australasian Trained Nurses Association and their

1 F. Nightingale*, Notes on Nursing: What it is, and What it is not,* (London: Harrison, 59, Pall Mall, 1859), preface.

membership of the Nurses' Registration Boards that were established in Australian states, medical practitioners helped to design and mould the certificated midwifery nurse.[2]

The chapter postulates that the trained hospital nurse became the prototype for the creation of the midwifery nurse. It argues that the promotion of nursing as a special sphere of knowledge that could be acquired only through a particular scheme of training that took place in the institution of the hospital acted to the advantage of both nursing and medicine, but not necessarily to midwifery. The certificated nurse provided the model for the reconstruction of the role of midwife and, in so doing, the vehicle for midwifery's amalgamation with nursing and its further subservience to medicine. The result was that the nurse gained a means of expanding her clinical role to the care of childbearing women and the medical practitioner acquired an assistant who could be relied upon to carry out his orders and to deputise for him at his discretion. While it might be argued that these benefits extended to midwives and that they were afforded the means of attaining an accredited status previously unattainable, it may equally be contended that the loss to midwives of occupational independence and the right to determine their own practice parameters and terrain outweighed such benefits.

The chapter demonstrates that nursing became the benchmark for the creation of the midwifery nurse and the means through which the practice of midwives was regulated. This is true not only in Queensland

2 ORDLCA, Vol. CVIII, 1912, pp.727-728.

but throughout Australia where legislation in the first quarter of the twentieth century cemented the relationship between nurse and midwife that was forged primarily through hospital training programs.[3] That relationship was achieved through an accreditation process that was on a par with that already undergone by the medical profession. For nursing it was a process that, while falling short of meeting the characteristics of a profession, represented an occupational equivalent that was consistent with the gender and class from which the majority of its workers were recruited. In supporting the modelling of the midwife on the concept of a trained nurse, the medical profession guaranteed its position as leader and adviser in the rapidly growing branch of obstetrics while at the same time ensuring a compliant collective sculpted on the dependent role of nurse rather than the independent practice of midwives. This process was assisted by the enhanced status of nursing which had shed its image of an occupation only for the lowest of social classes and had emerged in the late nineteenth century as an increasingly respectable occupation for women.[4]

But while the medical profession was an important element in redefining nursing and in locating it within the institution of the hospital, the efforts of visionary nurses who sought to combine nursing with midwifery cannot be overlooked. Although lay midwives made no claim to

3 Tasmania: *An Act to promote the better training of women as Midwifery Nurses, and for their registration as such,* (Tasmania, 1901, Edward VII Regis, No. 24): Western Australia: *Health Act,* (1 Geo. V. No. 34, 1911): Victoria*: Midwives Act 1915,* (6 GEO. V. No. 2773): South Australia*: The Nurses' Registration Act of South Australia, 1920, (George V Regis A.D.):* New South Wales*: Nurses' Registration Act,* (George V. No. 37, 1924).

4 C. Davies, "Introduction: The Contemporary Challenge in Nursing History", In C. Davies (ed) *Rewriting Nursing History*, pp.11-17. See also, K. Williams, "From Sarah Gamp to Florence Nightingale: A Critical Study of Hospital Nursing Systems from 1840 to 1897", In C. Davies, (ed) *Rewriting Nursing History*, pp.41-75.

nursing, qualified nurses were instrumental in grasping midwifery and in forging ties between midwifery and nursing that have resulted in the formation of almost inseparable links between them.[5] In identifying the concept of the trained nurse as a significant factor in the eventual reordering of midwifery practice that occurred in the early twentieth century, this thesis argues that nursing's relevance to midwifery lies in the social construction of nursing and midwifery practice as complementary and equivalent, even though some late twentieth century writers have contested this viewpoint.[6]

D'Antonio, in her reappraisal of the ways in which nursing's past has been understood and represented, highlights the importance of nursing to midwifery's history and development, arguing that:

> Understanding the work of nurses has reshaped historian's sense of the historical hospital, the treatment of disease, the birth of babies, and the role of women in their families and their communities.[7]

A difficulty that this thesis has encountered, and it is one that has been recorded by the historian, Barbara Mortimer, is that of applying a definition to the midwife and in differentiating the midwife role from that of the nurse.[8] However, while information related to the untrained nurse and lay midwife is limited and therefore presents something of a challenge to the analysis, the trained nurse is readily identified from the literature.

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5 G. Strachan, *Labour of Love: The History of the Nurses' Association in Queensland 1860-1950*, (New South Wales: Allen & Unwin, 1996), pp.70-71.
6 C. Flint, *Communicating Midwifery: Twenty Years of Experience*, pp. 6-8. See Also, West, C. "What Effect will the Nurses Act 1991 have on Maternity Care?" *ACMI Journal*, (December 1992), pp.28-30.
7 P. D'Antonio, "Revisiting and Rethinking the Rewriting of Nursing History", *Bulletin of the History of Medicine,* (73.2, 1999), pp.268-290.
8 B. Mortimer, "Independent women: domiciliary nurses in mid-nineteenth-century Edinburgh", Rafferty, A., Robinson, J., Elkan, R. (eds) Nursing History and the Politics of Welfare, (London: Routledge, 1996), pp.134-149.

Nursing in the hospital institution

An important factor in nursing's transition was the hospital institution. The chapter locates the hospital institution as the site chosen as the ideal training venue for nurses, and later, midwives. As chapter one has highlighted, the Church and the state were dominant in defining and overseeing the work of midwives in Britain and Europe until the eighteenth century and played an equally important part in founding and supporting hospitals.[9] The hospitals that developed from the late eighteenth century onward were larger institutions that were designed to facilitate the modern trend towards medical and scientific discovery. As hospitals increasingly became the venue where the human body might be assessed and treated and its diseases dissected and studied, specialised hospitals emerged where focus could be directed at "medical conditions" such as childbirth, contagious diseases and insanity.[10] In childbirth, an essentially healthy event, the hospital institution became fundamental in changing the social meaning of reproduction and of the birthing process. When hospitals became the principal training venues for nurses,[11] it was not long before the training of midwives, an inherently difficult group to organise or even to identify, was also placed in the institutional setting.

Abel-Smith has said that in Britain, nursing began in the communities and moved into the institution of the hospital as an aftermath of the intention to professionalise.[12] He argues that until the middle of the nineteenth century, nursing was a domestic function that was undertaken

9 R.H. Shryock, *The History of Nursing: An Interpretation of the Social and Medical Factors Involved,* (Philadelphia: Saunders, 1959), pp.153-170.
10 Ibid., pp.224-227.
11 B. Abel-Smith, *A History of the Nursing Profession,* pp.50-60.
12 Ibid., pp.1-16.

by family members. When health and illness came increasingly to be perceived by the public as a consequence of physiology and environment, there evolved a greater reliance on medical knowledge and a consequent need to create a group of practitioners who could carry out the orders of the medical man. Thus, the role of the nurse emerged as an occupation quite different from the act of nursing that had taken place for centuries in the domestic environment. This nurse was, in the words of Abel-Smith, "carefully selected and systemically taught".[13]

Abel-Smith contends that the services of the nurse, like those of the medical practitioner, were affected by the ability of the public to pay. That ability was more easily met by pooling medical and nursing resources into a specific venue where those in need could be grouped together.[14] Hospital institutions were founded in response to the need to cater for those who could not be looked after at home. While the wealthy continued to employ a doctor or a nurse to treat and attend upon them in the privacy of their own homes, the poorer classes came to rely on the facilities contained within the hospital. Until the middle of the nineteenth century, those facilities were concentrated on the unsupported poor; those people who had neither the means nor the extended family to see them through periods of ill health.

Industrialisation had brought about the creation of a class of people who had moved to city areas when work in their home locality was in short supply. At times of illness and in old age, the homeless poor were

13 Ibid.
14 Ibid.

admitted to workhouses and these institutions became hospitals for the destitute sick. The alternative to the workhouses was the voluntary hospital and in both these facilities, the care of the sick was left to untrained nurses.[15] Writers in the 1880s and 1890s described these nurses variously as, "…clever, dutiful, cheerful and kind" and "…too old, too weak, too drunken, too dirty, too stolid or too bad to do anything else".[16] The truth was probably somewhere in between the two descriptions, with extremes of both good and bad exhibited. It was this inconsistency of practice and low social standing that prompted nurse reformers to act and to seek change.

Nursing before Nightingale

The social practice of nursing and the development of the role of trained nurse in Australia derived from Britain and there were many similarities in nursing practices in the two countries. In Australia, nursing began within days of the landing of the First Fleet where it was first practised in the tents for the sick that were erected on the west side of Sydney Cove.[17] In letter written by Governor Phillip in 1788, it is clear that even the most basic requisites were omitted from First Fleet provisions and yet there was high demand for hospital care.[18] In July 1788, Phillip wrote that there were in excess of one hundred people on the sick list and the hospital tents had been full since the Fleet disembarked.[19]

15 Ibid., pp.4-5.
16 Ibid., p.5.
17 B. Schultz, *A Tapestry of Service: The Evolution of Nursing in Australia Volume I Foundation to Federation 1788–1900,* p.5.
18 G.B. Barton, *History of New South Wales from the Records*, (Sydney: Charles Potter, Government Printer, 1889, facsimile reprint published 1980 by Hale & Iremonger, Sydney), p.322.
19 Ibid., p.322.

The arrival of the Second Fleet in June 1790 was significant to nursing not only for the portable hospital it carried, but also for the hundreds of sick passengers it brought with it. The facilities for the ailing took the form of a series of tents that were designed to house not more than eighty, while the actual number of sick is said to have been almost five hundred.[20] Cushing points out that, in the early years of European settlement, nurses were recruited from the convict class and were *assigned* the job of nursing.[21] The assignment was made by the superintendent of convicts at the time of disembarkation and was based on need and on the individual ability of the convict.

Although the muster of July-August 1800 listed twenty-two women in Sydney working in the capacity of nurse, nursing was an occupation shared by men.[22] While the actual functions performed by these nurses are difficult to ascertain, Cushing suggests that gender-based segregation existed and there was a special medical role that attended to specific treatment such as wound management and medications. Cushing points out that:

> …male attendants were concerned with the supervision of male patients, the diet and the burial of patients. Duties of a similar kind can most likely be inferred for the female attendants in respect to looking after the female patients. In addition to these duties the attendants gave little, if any, attention to the patients' hygiene, toileting and bathing. Dressings, poultices and medicines were usually undertaken by the medical members.[23]

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20 B. Schultz*, A Tapestry of Service: The Evolution of Nursing in Australia Volume I Foundation to Federation 1788–1900,* p.6.

21 A. Cushing, "Convicts and Care Giving in Colonial Australia, 1788–1868". In A. M Rafferty, J. Robinson, J. Elkan, R. Elkan*, Nursing History and the Politics of Welfare,* pp.120-122.

22 B. Schultz*, A Tapestry of Service: The Evolution of Nursing in Australia Volume I Foundation to Federation 1788–1900,* p.8.

23 A. Cushing, "Convicts and Care Giving in Colonial Australia, 1788–1868". In A. M Rafferty, J. Robinson, J. Elkan, R. Elkan*, Nursing History and the Politics of Welfare,* p.122.

The standard of nursing was consequently poor, but as Schultz contends in her history of nursing in Australia, it was unlikely that it would have been otherwise:

> …when it is understood that wardsmen, nurses and servants were in the main uneducated reformed convicts and were often drawn from wards where they had been patients, it can be appreciated that the administration of any specific nursing care would be negligible.[24]

But it seems that the recruitment of nurses from the convict class was not the crucial factor in the low standard of nursing practice. Britain also employed untrained and poorly remunerated nurses.[25] The nurses who worked in London in institutions for the poor and destitute had much in common with the description of nurses in Australia provided by Cushing and Schultz. These nurses, known as 'pauper nurses', were enlisted from among the inmates of government-funded institutions including workhouses for the destitute, asylums for the sick and aged, and correction centres for vagrants,[26] in much the same way, convicts were recruited into nursing roles in Australia.[27] However, change had begun; at first in Britain and later, in Australia.

In Britain, the efforts of Elizabeth Fry did much to improve the status of home nursing during the 1840s.[28] Fry's input and the influence of Florence Nightingale in establishing a training school for hospital nurses

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24 B. Schultz, *A Tapestry of Service: The Evolution of Nursing in Australia Volume I Foundation to Federation 1788–1900,* pp. 20-21.
25 K. Williams, "From Sarah Gamp to Florence Nightingale: A Critical Study of Hospital Nursing Systems from 1840 to 1887", In C. Davies (ed) *Rewriting Nursing History* p.56.
26 M. Dean, G. Bolton, "The Administration of Poverty and the Development of Nursing Practice in Nineteenth-Century England". In C. Davies (ed) *Rewriting Nursing History,* pp.83-84.
27 A. Cushing, "Convicts and Care Giving in Colonial Australia, 1788–1868". In A. M Rafferty, J. Robinson, J. Elkan, R. Elkan*, Nursing History and the Politics of Welfare,* pp.120-122.
28 K. Williams, "From Sarah Gamp to Florence Nightingale: A Critical Study of Hospital Nursing Systems from 1840 to 1897", In C. Davies, (ed) *Rewriting Nursing History,* pp. 41-73.

in 1861[29] saw a gradual reversal of the conceptualisation of the role of the nurse as that of the lowest domestic servant. Baly maintains that nursing reform in Britain actually began in the 1830s, when medical demand and religious revival worked towards the objective of recruiting morally sound women and of training them to carry out medical orders.[30] Both Fry and Nightingale therefore played an essential part in sanctioning the positioning of women in the institution of the hospital in the care of the sick. Their example enforced the notion that women who turned to nursing did not compromise their social standing, but rather, they fulfilled both themselves and the wishes of God so that those women who, for whatever reason were unsuited to a life of religion, might instead devote their lives to the equally noble cause of nursing the sick.[31]

Whatever the "true" motives behind the reform of nursing or the "real" events that led nursing towards professional status, Nightingale gave nursing a respectability it had hitherto lacked. The significance of the Nightingale model of nursing to the subsequent teaching of midwives lies in its association with a strict training schedule that was located in a hierarchical institutional structure. Within the Nightingale regime, the novice nurse was selected from the lower middle class to ensure that she possessed the education and refinement lacking in pauper nurses and at

29 J. Donnison, *Midwives and Medical Men: A History of the Struggle for the Control of Childbirth*, pp.76-77.
30 M. E. Baly, "Florence Nightingale and the Establishment of the First School at St. Thomas's: Myth V Reality". In V. L. Bullough, B. Bullough, M. P. Stanton, *Florence Nightingale and her Era: A Collection of New Scholarship,* pp. 3-4.
31 K. Williams, "From Sarah Gamp to Florence Nightingale: A Critical Study of Hospital Nursing Systems from 1840 to 1897", In C. Davies, (ed) *Rewriting Nursing History,* p.45.

the same time was cognisant of the need to conform.[32] Dean and Bolton argue that in applying a class criterion to the recruitment of nurses to the Nightingale School, it was guaranteed to attract women of good moral character and unquestioned obedience, characteristics valued and displayed by nineteenth century women of middle and upper classes.[33]

The importance of the Nightingale model

The Nightingale model of nursing was the product of a fund that was proposed in Britain in November 1855 and whose stated purpose was "to establish and control an institute for the training, sustenance and protection of nurses paid and unpaid."[34] Nightingale maintained that women should be encouraged to exploit what she believed to be their natural capacity to nurse and her formula represented a wholistic approach to the care of the sick.[35] In isolating the elements that she believed constituted nursing, Nightingale argued that it was incumbent upon the trained nurse to exercise vigilance and precision in carrying out her duties so that she might accurately report her observations to the medical practitioner.[36]

At the outset then, the Nightingale model established nursing as ancillary to medicine and the work of nurses as intermediate to the medical practitioner and the patient. For while Nightingale may have had little faith in medicine's ability to cure, she was, in the military situation at

32 M. Dean, G. Bolton, "The Administration of Poverty and the Development of Nursing Practice in Nineteenth-Century England". In C. Davies (ed) *Rewriting Nursing History,* pp.88-89.
33 Ibid., p.88.
34 W. J. Bishop, S. Goldie, *A Bio-bibliography of Florence Nightingale*, (London: The International Council of Nurses, 1962), p.126.
35 F. Nightingale, *Notes on Nursing: What it is, and What it is not*, Preface.
36 Ibid., p.68.

least, prepared to concede the control of nurses to medical practitioners.[37] While Nightingale's contribution to the nursing management of the sick may be seen now simply as a replication in writing of what had already begun to happen in practice, her adoption of nurse training as a cause met a void at a time that was conducive to change. More than this, it was a model that assisted the hospital administrators to furnish an economical means of addressing the problems of the infirm poor. Baly argues that this was not Nightingale's intention and that her initial plan was to develop schools of nursing along the lines of medical schools but she met with such opposition from the resident medical officer that she was unable to proceed.[38]

Helmstadter, in her analysis of mid-nineteenth century nursing reform, highlights the importance of moral fortitude to the new trained nurse image.[39] Helmstadter maintains that it was the rise of clinical medicine that occurred at the end of the eighteenth century that initiated the need to provide a "more professional nurse" in line with the model that medical practitioners were beginning to demand.[40] She argues that it was not simply a question of meeting the needs of the medical fraternity. The medical profession had situated itself in the hospital institution for its teaching and learning purposes and had thus created the need for a nursing workforce. Hospital administrators were faced with the task of

37 W. J. Bishop, S. Goldie, *A Bio-bibliography of Florence Nightingale*, p.299.
38 M. E. Baly, "Florence Nightingale and the Establishment of the First School at St. Thomas's: Myth V Reality". In V. L. Bullough, B. Bullough, M. P. Stanton, *Florence Nightingale and her Era: A Collection of New Scholarship*, pp.7-8.
39 C. Helmstadter, "Old Nurses and New: Nursing in the London Teaching Hospitals Before and After the Mid-Nineteenth-Century Reforms", *Nursing History Review*, (1, 1993), pp. 43-70.
40 Ibid., p.43.

providing a cost effective and efficient body of workers. It was these factors combined that helped to mould the trained nurse.[41]

Helmstadter contends that elementary education in Britain had prepared the working class for apprenticeships by teaching them to accept their station in life, but a structured apprenticeship system for nurses within the rigid institution of the hospital had never existed.[42] It was therefore imperative that moral training and character building be included within nurse education in order that the trained nurse would demonstrate the unquestioning obedience that was required of her.[43] An additional factor in nursing reform was that it offered a means of attracting middle class women to its ranks, for if nursing was to become a well-respected occupation for women it would need direction from the better-educated classes. It had never been customary for middle class women to work as hospital nurses, but if they could be persuaded to do some, under the banner of "the profession of nursing" they would elevate nursing as a social status and give to nurses the respect that they currently lacked.[44]

Dean and Bolton contend that nursing reform happened when it did and in the form it took because the British government was looking for a means of eradicating pauperism in accordance with a specific view that it held in relation to "how the poor ought to behave".[45] According to this viewpoint, medical and nursing reforms were not actually in the hands of individual activists or campaigners, but were part of a greater plan

41 Ibid.
42 Ibid., p. 53.
43 Ibid., p.54.
44 Ibid., pp.52-56.
45 M. Dean, G. Bolton, The Administration of Poverty and the Development of Nursing Practice in Nineteenth-Century England". In C. Davies (ed) *Rewriting Nursing History,* pp.96-97.

devised and implemented by the state. The emergent capitalist state sought to increase population in order to protect itself. The poor were essential to the machinery of capitalism and by improving the health of the lower classes the state assured its continuance through the supply of a healthy labour force.[46] From this perspective, the changes that began within nursing during the mid-nineteenth century under the Nightingale banner were consistent with state objectives and were supported as such by state apparatus.

Dean and Bolton maintain that the full potential of the nurse role became apparent during a cholera epidemic in Oxford in 1854.[47] The Police Office held a list of respectable women who were prepared to nurse the sick. When police received a notice of cholera at the residence of a poor person, the nurse would be requested by a police messenger to attend. The expediency of grouping together a body of women who were willing and able to nurse those who had been rendered paupers through infirmity presented a feasible proposition that might be extended to all social classes to the ultimate benefit of the state.[48]

It might be that Nightingale's aspirations for nursing were perceived by the state to be in tune with political agendas and, if that were so, might account for the continued support for the Nightingale School despite its relative lack of impact in the provinces and its difficulties in recruiting nurses.[49] Baly has said that the Middlesex Hospital had a

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46 Ibid., pp.89-101.
47 Ibid., pp.92--94.
48 Ibid., pp.92-99.
49 M. E. Baly, "Florence Nightingale and the Establishment of the First School at St. Thomas's: Myth V Reality". In V. L. Bullough, B. Bullough, M. P. Stanton, *Florence Nightingale and her Era: A Collection of New Scholarship* pp. 8-9.

scheme of instruction for nurses firmly established by 1845 and that by 1870 most teaching hospitals in London had training schools for nurses that functioned more efficiently than St. Thomas's and with fewer restrictions.[50] Why, then, was the Nightingale model such an influence first on nursing, and later on midwife practice?

Certainly, Nightingale, belonging as she did to the nineteenth century upper class,[51] was at ease in elite circles and worked closely with representatives of both the church and the state.[52] The creation of a nursing model such as Nightingale's offered a nursing body that conformed to upper class ideals and at the same time was acceptable to the poor.[53] This model of nurse, trained in a hospital institution supervised by the state, was ideally placed to carry out government policies in furtherance of the good health of the nation. It mattered not whether nursing subsequently took place in the home or the hospital; once the nurse had been trained in the hospital, she understood the parameters of her practice and overstepped them only at great cost to herself and to her nursing career.

Abel-Smith highlights the importance of personal qualities and moral character in the Nightingale School where, he maintains, greater emphasis was placed on these than upon educational aptitude.[54] The two separate modes of entry that were open to trainees were probationers who received their training free of charge, and "lady-pupils" who

50 Ibid.
51 S. Veith, "The Recluse: A Retrospective Health History of Florence Nightingale", In *Florence Nightingale and her Era: A Collection of New Scholarship*, p.78.
52 B. Abel-Smith, *A History of the Nursing Profession,* pp.65-66.
53 M. Dean, G. Bolton, The Administration of Poverty and the Development of Nursing Practice in Nineteenth-Century England". In C. Davies (ed) *Rewriting Nursing History,* pp.92-99.
54 Ibid., p.22.

contributed to their maintenance.[55] The schedule for nurses who had trained in other hospitals displayed a variation of the Nightingale model, but the lady-pupils became advocates of Nightingale's values and they disseminated her teachings. In the period 1860 to 1903, almost two thousand nurses had trained in the Nightingale School.[56] In 1866, five trained nurses from the Nightingale School arrived in Sydney under the leadership of Lucy Osburn and by 1868, had founded a training school that promoted Nightingale ideals.[57] According to Burchill, by the 1870s many other countries had implemented Nightingale reforms including Sweden, Germany and North America.[58]

The dissemination of the Nightingale model in Australia

The decision to formalise nursing practice in Australia is reputed to have been in response to an official inquiry into the death of a youth at the Sydney Infirmary in June 1866.[59] The inquiry heard that the conditions at the hospital were extremely poor and that the boy had suffered as a direct result of inefficient nursing care.[60] This finding was supported by medical staff and coincided with pressure being put upon the Board of Directors to improve the care available to patients at the Infirmary.[61]Schultz points out that calls for change had begun some years earlier, but this inquiry acted to reinforce the need to investigate the circumstances that prevailed within

55 Ibid., 23.
56 Ibid., 24.
57 E. Burchill, *Australian Nurses Since Nightingale 1860-1990,* J. Morley (ed) (Victoria: Spectrum Publications), 1992, pp.26-27.
58 Ibid., 27.
59 B. Schultz, *A Tapestry of Service: The Evolution of Nursing in Australia Volume I Foundation to Federation 1788–1900,* p.77.
60 Ibid.
61 Ibid., p.78.

the Sydney Infirmary.[62] A government audit of the hospital was proposed, but it met with some degree of opposition from the Board of Directors. As a consequence of the mayhem that followed, the decision was made to look to England for assistance.

Sir Henry Parkes, Colonial Secretary for New South Wales, made a direct approach to Nightingale and arranged for a group of her protégés to relocate to Sydney.[63] The close links between Australia and Britain that Parkes evoked are reflected in a letter from Nightingale to the Colonists of South Australia dated 28 January 1858, published in the *Daily News* on 6 August. The letter was a response to support of the Nightingale Fund by "the gentlemen colonists of South Australia" in which Nightingale made the observation:

> The country you live in, gentlemen, is indeed part of our well-beloved country and home. England is one wherever her people dwell. [64]

Nightingale's acquiescence to Parkes' request and the subsequent absorption of the Nightingale model into the culture of nursing in Australia marked the beginning of the reform process and the eventual emergence of the 'trained nurse' throughout Australia.

<u>The training of nurses in the hospital institution</u>

Inherent within the Nightingale model was the notion that, once trained, the nurse would train others and the dissemination of nurse reform would thus be achieved.[65] In this way, nurses trained under the Nightingale regime subsequently took up posts in hospitals in other

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62 Ibid.
63 M. Vicinus, B. Nergaard, (eds) *Ever Yours, Florence Nightingale: Selected Letters*, (Massachesetts: Harvard University Press, 1990), p.299.
64 W. J. Bishop, S. Goldie, *A Bio-bibliography of Florence Nightingale* p.126.
65 R. L. Russell, *From Nightingale to Now: Nurse Education in Australia,* (New South Wales: W.B. Saunders, 1990), p.9.

Australian colonies.[66] Russell identifies eleven hospitals in which nurses trained by Osburn became matrons between the period 1870 and 1885.[67] This number does not take into account the appointment of matrons from among the nurses who accompanied Osburn, one of whom, Annie Miller, was appointed as matron to the Brisbane Hospital in 1871.[68] According to Gregory, although Miller's appointment was short, it marked a turning point in the development of nursing at the Brisbane Hospital. For the first time the conservative faction, which represented traditional hospital care provided by untrained nurses, had been challenged by the modern notion of the trained nurse.[69]

A fundamental aspect of nurse reform was the positioning of nursing practice within the institutional setting. The institution provided a structured venue for training nurses and an effective means of overseeing their practice that ensured the promotion of the middle class ideals that underpinned nurse reform. Those ideals drew sustenance from the organisational framework of the family unit and from the patriarchal framework upon which it was based. Maggs has described the hospital structure as one in which position and rank were intrinsic to the smooth running of the unit as a whole, commenting that:

> In the hospital world the doctors assumed the role of the father and in his absence (since he had little to do with nurses anyway) the functions of the father were subsumed under the functions of the mother, the senior nurse. Obeying the senior nurses, ward sisters, nurse-tutors, matrons as well as Home Sisters, meant that the trainee was obeying the doctor/father…[70]

66 Ibid., pp.10-11.
67 Ibid., p.11.
68 H. Gregory, *A Tradition of Care: A History of Nursing at the Royal Brisbane Hospital*, pp.15-16.
69 Ibid., pp.15-16.
70 C.J. Maggs, *The Origins of General Nursing*, (Kent: Croom Helm, 1983), p.15.

Kingston concurs with the suggestion that the family structure formed the basis for nurse education within the hospital institution. She also draws an analogy between the mid-nineteenth century household and the mid-nineteenth century hospital to argue that each was subject to a stipulated hierarchy that was socially constructed and gender based. The outcome was the increasing subordination of women by the more powerful social group, men:

> The early Nightingale nurses were superior, nineteenth-century housewives. The medical profession was the husband and ruler of the house (the hospital). Proper servants, scrubbers, wardsmen, porters, cooks, laundresses and gardeners, were engaged to do the heavy work, as they were in any well-run Victorian household, while the nurses themselves supervised, co-ordinated, inspired, 'poured tea' (administered the prescribed medicine), and above all saw that the wishes of the head of the house, were fully carried out.[71]

The power that Nightingale nurses held within their own schema and their docile deference to the medical profession was the means by which midwives were ultimately subordinated to both nursing and medicine. Summers makes the point that Nightingale rendered the position of nurse inferior to that of doctor and it therefore followed that in order for the medical profession to control midwives it had to begin with nursing, an occupation that was already auxiliary to medicine.[72]

The lying-in hospital as a birth venue and training arena

As chapter three has shown, the inauguration of public lying-in facilities assisted the ascendancy of medical practitioners in the sphere of childbirth and promoted the conceptualisation of childbirth as a physiological trial that benefited from medical involvement. The lying-in

71 B. Kingston, *My Wife, My Daughter, and Poor Mary Ann: Women and Work in Australia*, (Melbourne: Nelson, 1975), pp.85–86.
72 Summers, A. "'For I Have Ever So Much More Faith in Her Ability as a Nurse': The Eclipse of the Community Midwife in South Australia 1836-1942", p.128.

hospital provided a location for training medical practitioners and for investigating and treating complications of childbirth and the puerperium.[73] The hospital also offered a means of disseminating the philosophy of obstetrics by ensuring the human and material resources that enabled a public scrutiny impossible to achieve in childbirth that took place in the home.

By the mid-nineteenth century, the lying-in hospital was an acclaimed institution in many parts of Europe and these hospitals acted as a precedent for maternity facilities that were being built in Britain.[74] But while lying-in hospitals in Britain emerged as a consequence of the charitable intent of the wealthy middle class and were intended to provide for the poor and destitute, the lying-in hospital in Europe was a response to government strategies to populate.[75] Donnison has attributed what may be interpreted as a relative tardiness in founding lying-in institutions in Britain, compared with the zeal of European countries, to the adoption of pro-natalist policies in Europe that did not emerge in Britain until after the Boer War.[76] Unlike the countries of Europe that had to rely upon large conscripted armies for their defence, its island location and a strong volunteer navy protected Britain.[77] The governments of European countries subsidised lying-in hospitals in order to reduce maternal and infant mortality rates and, ultimately, to boost population growth.

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73 A. Wilson, *The Making of Man-Midwifery: Childbirth in England, 1660-1770*, p.4.
74 I. Loudon, *Death in Childbirth: An International Study of Maternal Care and Maternal Mortality 1800–1950*, pp.428-429.
75 J. Donnison, *Midwives and Medical Men: A History of the Struggle for the Control of Childbirth*, pp.36-38.
76 Ibid., p.51.
77 Ibid.

As early as the 1830s, European lying-in institutions were the principal means by which midwives were trained and their practice regulated.[78] One such hospital, the Hôtel Dieu in Paris, that was the birthing venue of almost fifteen hundred women each year at a time when British lying-in hospitals were in their infancy, became renowned for high standards of maternity care and for the proficiency of its midwives.[79] When, in 1861, Florence Nightingale introduced midwifery training in an annexe of King's College Hospital in London, she is reported to have observed that Britain was one of the few European countries that did not provide a "Government School" for midwives.[80] Donnison draws upon a King's College Hospital report on midwifery pupils dated 15 July 1863 to make the point that it was Nightingale's hope that the midwifery training school established at that institution would act as model for subsequent midwifery training schools throughout Britain.[81]

The example provided by British and European lying-in institutions offered guidance for those established in Australia. But, in contrast to their overseas counterparts, Australian lying-in facilities emerged almost by accident. In Australia, institutional lying-in facilities began with the female factories and it was only following their closure that responsibility for pregnant destitute women fell to the community.[82] The challenge was taken up predominantly by women of the middle class whose involvement in charity organisations, especially in lying-in

78 Ibid., pp.51-77.
79 Ibid., pp.30-31
80 Ibid., p.77.
81 Ibid.
82 B. Schultz, *A Tapestry of Service: The Evolution of Nursing in Australia Volume I Foundation to Federation 1788–1900*, p.154.

hospitals and female refuges, is thought to have begun in Britain with the appearance of middle class society.[83] In this new social order wealthy women were well placed to promote the religious consciousness and social compassion advocated by the Evangelist movement. As Windschuttle points out, middle class women emerged as a powerful influence on the social consciousness and moral conduct of the developing nation. In Sydney alone, during the period 1800 to 1850, there were eighteen charitable agencies that received some form of active support from middle class women.[84]

This thesis contends that the role of middle class women in public-funded lying-in institutions is significant in that it strengthened the influence of the medical profession and the state within these facilities. It was the relationship of middle class women to the male policy-makers that compounded the influence that the medical profession and the state were able to exert on midwives and childbirth. When, in 1856, the Women's Hospital, Melbourne, became the first purpose-built lying-in institution to be established in Australia,[85] it was supported by a strong Ladies' Committee comprised mostly of wives of clergymen, who managed the non-medical aspects of hospital administration and the admission of patients.[86]

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83 E. Windschuttle, "'Feeding the Poor and Sapping their Strength': the Public Role of Ruling-Class Women in Eastern Australia, 1788–1850". In E. Windschuttle, (ed) *Women, Class and History: Feminist Perspectives on Australia 1788–1978,* (Melbourne: Fontana, 1980), pp.55-61.
84 Ibid.
85 B. Schultz, *A Tapestry of Service: The Evolution of Nursing in Australia Volume I Foundation to Federation 1788–1900,* pp.154-160.
86 McCalman, *J. Sex and Suffering: Women's Health and a Women's Hospital: The Royal Women's Hospital, Melbourne 1856–1996,* pp.9-10.

Similarly, in Brisbane, the Servant's Home was opened in Margaret Street on 2 November 1863 at the behest of the wives of statesmen, clergymen, jurists and medical practitioners, led by the wife of the Governor who acted as patroness.[87] The Servant's Home proved so much in demand by unmarried pregnant and parturient women that a lying-in institution was founded the following year.[88] At the inaugural meeting of the Brisbane Lying-in Hospital that took place in the Armoury, Brisbane, on 16 August 1864,[89] the same social elite was represented and the Ladies' Committee of the hospital was formed from this group.[90] The following day, the *Brisbane Courier* explicated the altruistic attitude adopted by middle class women in founding the Servant's Home with the observation that:

> Many of the ladies who were most active in the formation of that establishment are now endeavouring to found a Lying in Hospital for the relief of the poorer classes. The need of such a building has for long been apparent to ladies who regard it as their duty to visit their poorer sisters, and the quest has been most warmly taken up by Lady Bowen who has hitherto, at her own expense, greatly assisted to relieve the sufferings of those unable to pay for medical advice or medicines.[91]

From the outset, hegemony of the hospital lay firmly in the hands of women committee members with control deflected downwards, first to visiting medical officers and then to the matron. The visiting surgeons were limited to those registered with the Queensland Medical Board and were responsible for the "medical care of the patients".[92] The matron was appointed by the Management Committee and took charge of "the

87 Ibid., p.101.
88 *The Brisbane Courier,* (Vol. XIX, No.2045, Wednesday, August 17, 1864), p.2.
89 R. Patrick, *The Royal Women's Hospital, Brisbane -The First Fifty Years*, p.10.
90 *Pugh's Almanac, Directory, and Law Calender for 1865*, p.101.
91 *The Brisbane Courier,* (Vol. XIX, No.2045, Wednesday, August 17, 1864), p.2.
92 *Minute Book of Committee Meetings of the Lady Bowen Hospital, 5 January 1869 to17 August 1875*, (PRV9294, Minute Books).

Hospital and Stores, and, subject to the visiting surgeons, the control of the nurses".[93]

Institutional childbirth in Queensland and elsewhere in Australia, was therefore constructed, as it had been in Britain a century before, on the basis of middle class values and ideals that were upheld by the notion that responsibility should be taken for women of the poorer classes. The liability that middle class women shouldered in founding lying-in institutions extended to the appointment of women they deemed suitable for training as midwives. The institutionalised midwife provided a predictable and compliant replacement for the lay midwife who, as this study has demonstrated, took many forms and was defined by varying degrees of knowledge and skill. Yet, the lying-in institution itself, although an important precursor to the institutionalisation of midwifery, catered for very few birthing mothers.

State involvement in lying-in: Queensland 1864-1912

Queensland's first formal lying-in hospital was opened in Leichhardt Street, Spring Hill, in November 1864 as the Brisbane Lying-in Hospital.[94] This was a cottage building with a total of four beds.[95] The hospital received both paying and non-paying women and was to be supported by visiting surgeons who were appointed on an annual basis and were to give their services "gratuitously".[96] Pugh explains the principles on which the hospital was founded:

> Pay-patients (for whom the sum of £3 shall have been guaranteed by a subscriber) will be entitled to the Hospital privileges for one fortnight,

93 Ibid.
94 *Pugh's Almanac,* p.101.
95 W. Love, "Records of the Lady Bowen Hospital, Brisbane", *AMG*, (May 1893) p.145.
96 *Pugh's Almanac,* p.101.

> and will be allowed to stay any additional time required at the rate of £1 per week.[97]

In 1865, the state placed itself in a key position in relation to hospital management when, under the terms of the Hospitals Act of that year, it took on the power to assume a control that was directly proportional to the amount of funding allocated to the hospital by the state.[98] This meant that if Parliament placed an amount of money at the disposal of a hospital committee, it was entitled to nominate a corresponding number of people to that committee.[99] Further, this Act allowed for the appointment of medical officers to manage the hospital at the discretion of the Governor in Council.

In 1867, the state government allocated a plot of land in Ann Street for the purposes of extending the facilities of the Lying-in Hospital and a brick hospital was erected on the site and named after the Lady Bowen.[100] This was a two-storey building, built at a cost of £1,110 and with accommodation for twelve women and a matron.[101] The Fourth Annual Report for the year ending 29 December 1868 indicates the relative minor role of this benevolent institution. At a time when the birth rate of Queensland was 2, 883,[102] the lying-in hospital dealt with a total of fifty-six women. The following report illustrates the nature of their residence at the hospital and identifies the care providers:

> Fifty-six poor women – 43 married and 13 single – received shelter, sustenance, medical attention attendance, and necessary comforts in this charity during the year – some of the cases being such as must have proved fatal under less favourable circumstances; but under the

97 Ibid.
98 *The Hospitals Act of 1865, 29 Vic. No. 19.*
99 Ibid., (Section 1).
100 W. Love, *"Records of the Lady Bowen Hospital, Brisbane",* AMG*, (May 1893)* p.145.
101 R. Patrick, *The Royal Women's Hospital, Brisbane -The First Fifty Years,* p.11.
102 S*SQ, for the Year 1920* Part VIII, H, Table No. XVII.

> unremitting attention of the medical officers and matron, by Divine favor (sic), they recovered and did well. One case only proved fatal to the mother, who was so exhausted by previous suffering before she entered the hospital, that there could be no reasonable hope of her recovery.[103]

Although the facilities offered by the Brisbane Lying-in Hospital were available only to the most needy, the state government demonstrated commitment to the project. In 1887, the government stepped in once again to assist the hospital when it provided an area of land located in "the county of Stanley and parish of North Brisbane".[104] The building and site of the Lady Bowen Hospital in Ann Street was sold for the sum of £6,000 and building was commenced on the government-allocated land at Wickham Terrace.[105] On 10 May 1889, Lady Musgrave laid the foundation stone of the new Lady Bowen Hospital,[106] and Lady O'Connell opened the hospital on Saturday 28 December 1889.[107] This new hospital was equipped to accommodate fifty women, paying and non-paying.

By 1895, there were four lying-in institutions in Queensland.[108] The Lady Bowen recorded the highest number of births for the year with 283. That institution and the Salvation Army Maternity at Normanby Hill, which dealt with 67 births, were the foremost lying-in facilities in Brisbane. There were two others in the state, the Lady Musgrave Lying-In Hospital, Maryborough, which had 59 births and the Lady Norman Maternity Hospital, Rockhampton, with 47. The total number of births

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103 *Minute Book of Committee Meetings of the Lady Bowen Hospital.*
104 The Lady Bowen Lying-in Hospital Land Sale Act of 1887, (51 Vic, 1887).
105 W. Love, *"Records of the Lady Bowen Hospital, Brisbane", AMG, (May 1893)* p.145.
106 Ibid.
107 QSA, *Minute Book of Committee Meetings of the Lady Bowen Hospital, 2nd January 1889 to 27 June 1899*, (PRV9294 Minute Books).
108 *SCQ for the Year 1895*, Table CXLV.

registered in these institutions was 456 against 5,152 total births in Queensland for that year.[109] In July 1898, the numbers of women and infants treated at the Lady Bowen Hospital had risen to a little under three hundred.[110] Although this number was small in relation to total births, financial support by the state government for the Lady Bowen Hospital and other such institutions located in larger cities, increased over the years.[111] Government statistics of 1900 included a fifth lying-in institution, the Salvation Army Maternity Home at Charters Towers. These five facilities recorded a total of 634 births against a total recorded birth rate throughout the state of 5,747.[112]

The role of Ladies' Committees

The role of government in the business of the lying-in institution was not one-sided and the Ladies' Committee of the Lady Bowen Hospital, at least, was an intrepid challenger to policies with which it did not agree. While it is not possible to estimate the full extent of committee pressure, it is clear that this particular Ladies' Committee was instrumental in orchestrating government policies pertaining to this particular lying-in institution that may well have been replicated elsewhere. In 1910, the Secretary of the Lady Bowen Hospital, Muriel Burnett, attempted to recover expenses in relation to the burial of bodies of infants of destitute women who had been stillborn or who had died following premature birth. The subsequent interchange between

109 Ibid., Table CXLV.
110 QSA, Lady Bowen Hospital, Annual Report of the Lady Bowen Hospital held in the Mayor's Room at the Town Hall, Brisbane on 26 July 1898, *Minute Book of Committee Meetings of the Lady Bowen Hospital, 2 January 1889 to 27 June 1899*.
111 Ibid.
112 *SCQ for the Year 1900,* Table CLIX, p. 348.

the Ladies' Committee and the Home Secretary's Department exhibits a political wrangling which ends in favour of the Lady Bowen Hospital and which suggests that government intervention in childbirth did not occur without support and was not always initiated by the state.

In her quest to obtain government funds for the burial of premature and stillborn infants, Muriel Burnett initially approached the Commissioner of Police in Brisbane who, in a letter to the Under Secretary at the Home Department dated 29 September 1910 summarised the situation in the following manner:

> …a request from the Committee of the Lady Bowen Hospital that Govt. pay cost of burial of prematurely-born and still-born infants of destitute women.
>
> I have the honour to enclose copy of a letter addressed to me by the Committee of the Lady Bowen Hospital, asking that the Government relieve the Committee of the expense of burying the bodies of prematurely-born and still-born infants of destitute women, and to ask for instructions with regard to such request.[113]

In a reply from the Under Secretary to Commissioner of Police dated 6 October 1910, the Commission was informed that, "the request cannot be complied with",[114] and the Ladies' Committee was duly notified. The Secretary of the Lady Bowen responded to the Home Secretary, in uncompromising terms, in a letter dated 2 November 1910:

> In reply to my letter to the Commissioner of Police re the burial of infants of destitute women, he informed me he had referred the matter to the Home Secretary's Department, and that their reply was, they could not comply with my request. As no reason is given for refusing to place the Lady Bowen Hospital on the same footing as other Institutions and seeing that if an infant of a destitute woman dies (after leaving the Hospital) at any of the Houses, the expense of its burial is defrayed by the Government -, my Committee wish to know what

113 QSA, *Correspondence Records and Reports Re: Hospitals and Hospital Boards, Brisbane, 1 January 1885 to 31 December 1925*, (PRV8699).
114 Ibid.

> reason that Government has for refusing to meet them in this matter. They understand it only costs the Government a normal sum to bury these infants, and as it costs the Hospital 10/- to 15/- in each instance, my Committee hope the Home Secretary's Department will reconsider the matter.[115]

This strongly worded letter had the desired effect and in a letter dated 22 November 1910, the Under Secretary confirmed government support in rather more formal terms:

> In reply to your letter of lst instant, I have the honour, by direction, to inform you that the Minister has approved of the Government paying the cases of burying the bodies of infants whose mothers have been sent to the Lady Bowen Hospital from Industrial Homes.[116]

The pressure brought to bear by the Hospital Secretary on this occasion was not an isolated incident. In a letter to the Home Secretary's Office dated 10 May 1922, Mrs. Buchanan, Secretary of the Lady Bowen Hospital, made a fervent appeal for £15,000 to complete "necessary additions" to the Lady Bowen Hospital.[117] The letter is significant because it poses the Ladies' Committee of the Lady Bowen Hospital as instrumental in the decision to donate proceeds from the Golden Casket Lottery to fund the extensive expansion of lying-in institutions begun in Queensland later that year.

Mrs. Buchanan made her forceful and emotive appeal, "For and on behalf of the Committee of the Lady Bowen Hospital and in the nature of the motherhood of Queensland…[and]…in order to assist in the "borning of better babies."[118] Mrs. Buchanan pointed out that in meeting the needs of the poor, the Lady Bowen Hospital had been so overwhelmed by demand that it urged, "…the Government to devote

115 Ibid.
116 Ibid.
117 Ibid.
118 Ibid.

the proceeds of one 'Special Golden Casket to the Lady Bowen Hospital'".[119] This suggestion was acceded to in September 1922 when the Legislative Assembly made available the sum of £200,000 from "Golden Casket" funds[120] in order to establish maternity hospitals throughout the State.[121]

While the Queensland government initiated intervention in the childbirth culture of Queensland on the basis of pro-natalist ideals, the mode of intervention was, to some extent, determined by the influences directed upon it. As the efforts of the Ladies' Committee suggest, the state was not alone in wanting to provide for childbearing women and, as the previous chapters have shown, there was a need for such provision. The lying-in hospital provided the means through which the state was able to meet its perceived obligations to populate Queensland. An important part of those obligations was the provision of trained midwives to replace the lay practitioners that the medical profession had identified as hazards to safe childbirth.

The hospital as a training venue for midwives

The training of midwives in Queensland was focused, as in Britain and Europe, in the hospital institution and, as with their British counterparts, lying-in hospitals in Australia sought to provide their pupils with the rudiments of midwifery skills that would differentiate the "trained" midwife from the lay practitioner who acted as midwife, nurse

119 Ibid.
120 ORDLA, Vol. CXL, 1922, p.1871.
121 Ibid., p.1855.

or mortician as the circumstances dictated.[122] However, although the management of lying-in hospitals in Britain, at least in the early years of their emergence, exhibited some commitment to the continuance of midwifery practice as a discrete body of knowledge for midwives,[123] in Australia there was, from the outset, a tendency to construct the role of the midwife around that of the trained nurse.[124]

The history of midwifery training in Britain depicts, on the one hand, a well-educated and clinically proficient "lady-midwife" modelled on what were considered to be the highly professional midwives of France and, on the other hand, a midwife whose knowledge source derived from the medical profession and was limited to childbirth that fell within the parameters of "normal". According to Donnison, the former midwife proved too strong a contestant to the medical profession who agitated in favour of the latter, a midwife who would be prepared to work amongst the poor rather than to compete against medical practitioners for the patronage of the wealthy.[125] It was this type of midwife that the medical profession in Queensland sought to nurture.

In 1890, a year after the Lady Bowen Hospital moved to Wickham Terrace, a course of training for midwives was commenced that included lectures from honorary medical staff.[126] It had been customary for medical practitioners to be involved in the theoretical instruction of nurses at the Brisbane Hospital since 1886 when Ernest

122 J. Donnison, *Midwives and Medical Men: A History of the Struggle for the Control of Childbirth*, pp.84-85.
123 Ibid.
124 B. Schultz, *A Tapestry of Service: The Evolution of Nursing in Australia Volume I Foundation to Federation 1788–1900,* pp. 54-160.
125 J. Donnison, *Midwives and Medical Men: A History of the Struggle for the Control of Childbirth,* pp.72-93.
126 *Minute Book of Committee Meetings of the Lady Bowen Hospital.*

Jackson, who had been appointed to the hospital as a permanent House Surgeon in 1882, began a series of lectures that culminated in the issuing of certificates of competency.[127] The course of nurse training was of eighteen months duration and comprised lectures and practical experience in the wards that led to examination.[128] Gregory claims that Jackson was "firmly in control of the nursing staff during his years in charge" and that he was an advocate of trained nurses.[129] In 1888, a school of nursing was opened in Townsville Hospital, administered by the matron and the resident surgeon who were responsible for providing the lectures.[130] It was customary at this time, as Gregory points out, for some exchange of nurses between the general hospitals and the lying-in hospital.[131] This movement between the lying-in hospital and the general hospital cemented the relationship between nurses and midwives and created a culture in which midwife practice became an adjunct to nursing practice.

There appeared to be a steady stream of women wanting to avail themselves of instruction in "midwifery nursing", but few vacancies. The Ladies' Committee was an omnipotent force and the principal mechanism for the selection of midwifery trainees. An entry in the

127 H. Gregory, A *Tradition of Care: A History of Nursing at the Royal Brisbane Hospital* p. 23. See also H. Gregory, C. Brazil, *Bearers of the Tradition: Nurses of The Royal Brisbane Hospital 1888–1993,* (Brisbane: Boolarong Publications, 1993), p. xii.
128 H. Gregory, A *Tradition of Care: A History of Nursing at the Royal Brisbane Hospital* pp.18-23.
129 Ibid., p.19.
130 L. Harloe, "Nursing – Across the Frontier". In J. Pearn, M. Cobcroft, (eds) *Fevers and Frontiers,* (Brisbane: University of Queensland, 1990), pp.189–191.
131 H. Gregory, A *Tradition of Care: A History of Nursing at the Royal Brisbane Hospital* p.23.

Minutes dated 23 April 1889, records that:

> A request was [also] made by a Mrs. Costello to be allowed to remain in the Hospital as nurse for a few months for instruction in midwifery. This could not be granted at present, but if a vacancy were to occur, Mrs. Costello was to have the first offer.[132]

By March 1890, rules had been drawn up by the Secretary governing the admission of what are termed "nursing midwives" and for their subsequent "guidance and behaviour when in the Hospital (sic)". At this time, pupil nurses were paying for the privilege of receiving instruction in midwifery. An entry on the 18 March 1890 states that:

> Five guineas was received from a nurse, Mrs. Marr, who entered the Hospital on the 5th of March for the purpose of being instructed in midwifery.[133]

In 1898, the length of training for pupil nurses at the Lady Bowen Hospital was extended to one year on the recommendation of the honorary medical officers. The Annual Report of the Lady Bowen Hospital, tabled in the Mayor's Room at the Town Hall, Brisbane on 26 July 1898, recorded this change and reflects the circumstances in which midwife students received instruction:

> Early in the year, by the advice of the honorary medical staff, the term for the training of pupil nurses was extended to one year, and so far it certainly appeared as though the alteration would work exceedingly well. Two nurses had received their certificates and passed out of the hospital since the publication of the last report. Six were at present under training.[134]

The admission of women into a hospital institution to be trained as midwives had two principal effects upon the role of the midwife. The first effect was to produce a midwifery culture that was derived, not from the characteristics of community-based practice, but from the

132 QSA, *Minute Book of Committee Meetings of the Lady Bowen Hospital.*
133 QSA, Lady Bowen Hospital, *Annual Report of the Lady Bowen Hospital held in the Mayor's Room at the Town Hall, Brisbane on 26 July 1898.*
134 Ibid.

hierarchical and sterile world of the hospital. This world gave midwives greater exposure to the practice of nursing and was instrumental in revising the way in which midwives viewed their role. It promoted a shared consciousness resulting from the merging of midwifery and nursing cultures that fostered the acceptance of midwifery as an institutional practice.

Over time, midwifery became transformed from a social role centred in the community to a nursing role based in the institution. This changing attitude toward midwives and their work is exhibited in the language of the Lady Bowen Hospital in which childbearing women become "patients" and their midwives "nurses".[135] From the outset, novice midwives were not accorded a title that was commensurate with their role. The Minutes of the Lady Bowen Hospital consistently adopt the title of "nurse" when discussing midwives and that of "Pupil Nurse" to denote the midwife trainee.[136]

The second effect was to strengthen the presence of the medical practitioner and the senior nurse in the education and practice of midwives. In an institutional environment where disciplinary controls and constant monitoring were important features of working life, the trained midwife became conditioned to accepting authority over her practice. In Queensland, the extension of the Australasian Trained Nurses' Association in that state in 1904[137] provided an occupational

135 QSA, *Minute Book of Committee Meetings of the Lady Bowen Hospital, 5 January 1869 to 17 August, 1875: 24 August 1875 to 28 December 1880:2 January 1889 to 27 June 1899,* (PRV9294 Minute Books).
136 Ibid.
137 G. Strachan, *Labour of Love: The History of the Nurses' Association in Queensland 1860-1950*, pp.36-38.

structure that the lying-in institution was keen to acknowledge and promote. The impact of this Association was reflected in the actions taken at a special meeting of subscribers to the Lady Bowen Hospital held after the Meeting of Committee on 1 March 1910 when it was agreed that "nurses holding certificates for general nursing of the Australasian Trained Nurses Association shall be eligible for a qualifying certificate in midwifery after a residence of six months on passing the necessary examinations".[138]

With little attempt to cultivate a midwife role that espoused the traditions of that practice, the ideal midwife of the early 1900s was a trained nurse who furthered her occupational skill by acquiring a certificate in midwifery. This was exactly the position that the medical profession in Britain and Australia had pursued in its support of the regulation of midwives. Indeed, Nightingale herself had promoted the notion of "Midwifery Nurses" rather than "Midwives" and while it may be argued that her reasons for so doing lay in an attempt to emulate the proficiency possessed by midwives in France at that time,[139] it may equally be proposed that the effect was to condone the amalgamation of the two roles. Within the hospital system the midwife was devoid of the independence that attendance in the home offered. But while the experienced midwife who wanted to enhance her skills may have gained from short-term exposure to the hospital environment, the novice midwife was a pliable tool that became an instrument of change.

138 QSA, *Minute Books,* (PRV9294).
139 J. Donnison, *Midwives and Medical Men: A History of the Struggle for the Control of Childbirth*, p.78.

The hospital training of midwives not only offered the prospect of creating the ideal midwife, but also created a means through which medical and political thought might be disseminated to local communities. This possibility was identified in political debates that underpinned the Maternity Act of 1922. When the Honourable A. J. Jones, member for Paddington, introduced the second reading of the Maternity Bill to the Queensland Legislative Assembly he asserted that, "It has for its object the training of mothers and the care of little children".[140] It was further pointed out by Mr. Riordan of Burke, that it was important to have itinerant nurses who would be able to move around the country to advise mothers in association with childbirth and child rearing. In this way, the trained nurse might become an instrument of the state and the medical profession in promoting their ideals for health and reproduction. The comment was made that:

> …advice from a trained nurse at that particular time is much better than advice from a doctor.[141]

Thus, the training of midwives represented a crucial part in remedying the loss of infant life that was attributed to maternal ignorance and one that could be better addressed in the institutional setting with a simultaneous reduction in the powers of midwives.

However, the hospital-based training of the midwife that was a characteristic of midwifery training in Queensland and other Australian states was only one option. A different course, that of midwifery re-skilling, might have serviced the maternity needs of Queensland women at less

140 ORDLCA, Vol. CXL, 1922, p.1854.
141 Ibid., pp.1862-1863.

cost to the government. This was the choice made by two governments outside of Australia when faced with a similar dilemma. When the government of Sweden was confronted with the problem of supplying a healthy labour force to boost its mercantile ideals in the nineteenth century, it chose to extend the scope of its midwives' practice.[142] Although under the authority of the medical profession, Swedish midwives were trained to undertake a broader scope of practice and given the power to employ instruments if, by so doing, they might save lives. Romlid has explained these extended powers in the following terms:

> …the training of midwives came to be viewed as being of great national value, especially since statisticians, economists, and doctors argued that trained and licensed midwives would reduce the unnecessary high level of infant mortality, saving infants' lives and thereby stimulating population growth.

Similarly, in Holland, the role of the midwife did not decline in the way that it did in other countries.[143] Instead, the emphasis was on reforming practice rather than replacing it with a different model or with a medical presence. Although during the eighteenth century the right of the Dutch midwife to use instruments was withdrawn and her practice was concentrated on "normal" childbirth, her professional practice remained intact within that stipulated territory. Australia, depending as it did on Britain as an overriding influence in government and medical policy-making, looked to Britain for precedence and for a solution to its problem. In Britain, that solution centred around curtailing midwifery

142 C. Romlid, "Swedish Midwives and Their Instruments in the Eighteenth and Nineteenth Centuries". In H. Marland, A. M. Rafferty, *Midwives, Society and Childbirth: Debates and Controversies in the Modern Period,* pp. 39-40.
143 H. Marland, "The 'burgerlijke' Midwife: The Stadsvroedvrouw of Eighteenth-Century Holland". In H. Marland, H. (ed) *The Art of Midwifery: Early Modern Midwives in Europe,* pp.192-213.

practice rather than expanding it and bringing about a reduction in the scope of midwives through statutory means.[144]

Moves to professionalise nursing

Formal training schemes for nurses had been in existence for a relatively short period of time when some senior nurses began to call for further reforms.[145] In the same way that the medical profession had imposed regulations and standards upon its practice in the latter part of the nineteenth century, nurses began to redefine the foundations and scope of their work. While Nightingale has been hailed as the greatest influence on the occupation of nursing in the nineteenth century, she was not the only one. As early as 1887, Ethel Fenwick began to agitate for state registration for nurses in Britain.[146] The basis of her appeal derived from the inconsistencies of practice that were evident in Britain at the time. For, although nurse training had done much to improve the overall quality of nurse practice, there were wide discrepancies in the length and characteristics of the training courses.[147] What many nurses were now asking for was a standardised training and the right to regulate their practice through the mechanism of a central body that would oversee their training and practice.[148]

In the last decade of the nineteenth century, professional associations were being established for the purpose of improving the occupational status and practice of midwives and nurses. The first of

144 *Midwives Act 1902*, (2 EDW. 7, 31st July 1902).
145 B. Abel-Smith, *A History of the Nursing Profession, pp.50-60*
146 N. D. Anderson, "Ethel Fenwick's Legacy to Nursing and Women", *Image*, (Vol.XIII, June 1981), pp.32-33.
147 B. Abel-Smith, *A History of the Nursing Profession*, p.61.
148 Ibid., p.62.

these was the Midwives' Institute, which was founded in Britain in 1881 and whose principal aim was the regulation of midwifery practice.[149] Leap and Hunter maintain that the Midwives' Institute was keen to replace the handywoman with a trained midwife in order to promote the professional status of the midwife.[150] In 1887, the British Nurses' Association led by Ethel Fenwick and the Hospitals' Association promoted by its spokesman, Burdett, were established to further the nurses' professional cause.[151] However, given that the affairs of the British Nurses' Association were placed, "in the hands of doctors and London hospital matrons" and the register created by the Hospitals' Association was, according to Abel-Smith, little used by any concerned, [152] it is difficult to envisage anything other than an oligarchic mode of control.

In the United States, Lavinia Dock founded the Superintendents' Society in 1893 and the Associated Alumnae in 1896 and thence proceeded to seek an alliance between these professional groups and women's organisations outside of nursing.[153] Lewenson contends that Dock believed that nurses' issues were inextricably interwoven with women's rights and she was a tireless campaigner.[154] In 1899, the inaugural meeting of the International Council of Nurses that had been established by the Matron's Council of Great Britain and Ireland was attended by Dock and trained nurses from Denmark, Holland, America,

149 N. Leap, B. Hunter, *The Midwife's Tale: An Oral History from Handywoman to Professional Midwife,* pp.1-33.
150 Ibid., pp.2-3.
151 B. Abel-Smith, *A History of the Nursing Profession*, pp.67-69.
152 Ibid., p.69
153 S. Lewenson, "Of Logical Necessity…They Hang Together": Nursing and the Woman's Movement, 1901-1912, *Nursing History Review*, (2, 1994), pp.99-117.
154 Ibid., pp.99-102.

Canada, and Australia.[155] Strachan maintains that by the beginning of the twentieth century, trained nurses in Australia were working with their counterparts overseas to bring about change.[156] The focus of that change was nurse registration with the enhanced accountability and occupational status with which it was associated.

Witz, analysing on the politics that underpinned the registration of nurses in Britain, points out that the *Nursing Record and Hospital World* of 1895 warned Ethel Fenwick to be wary of allowing the establishment of a Nursing Board that did not totally comprise nurses.[157] However, as Witz argues, by the time the practice of nurses in Britain was regulated under the Nurses Registration Act of 1919, they were already the product of the institutional hospital and therefore bereft of the autonomy required to organise and determine independent professional scope.[158]

The regulation of midwives

When the New South Wales Royal Commission made the recommendation in 1904 that lay midwifery should be eradicated and replaced by trained midwives whose practice was formally monitored and supervised, it stipulated the form that training should take and mode of regulation that should be employed.[159] However, the Commission was mindful of the limited places available in which to train midwives and indicated that a longer-term plan would be most feasible.

155 Ibid., p.106.
156 G. Strachan*, Labour of Love: The History of the Nurses' Association in Queensland* 1860-1950, pp.30-31.,
157 A. Witz, *Professions and Patriarchy,* pp.155-159. See Also, R. G. DeVries*, Making Midwives Legal: Childbirth, Medicine, and Law, 2nd edition*, (Ohio: Ohio State University Press, 1996).
158 A. Witz, *Professions and Patriarchy,* pp.165-167.
159 Ibid.

As far as the training and practice of midwifery was concerned, the Commission advised that:

> We would [therefore] like to see the practice of midwifery restricted solely to legally-qualified medical practitioners, and to trained midwifery nurses who should be subject to examination, license, and control. In view, however, of the very few trained obstetric nurses who are as yet available, and of the fact that it is not at present possible to train more than forty or fifty a year, such a restriction is not yet practicable. In order, however, to encourage the training of midwifery nurses, and to put that training on a sound basis, we would recommend that an administrative body, constituted, incorporated, and empowered for the purpose by statute, be entrusted with the examination and certification of obstetric nurses: and that the Act should provide (inter alia) that no institution or private home for lying-in women shall be presided over or kept, except by an obstetric nurse, registered under the proposed Act.[160]

The regulation of midwives and nurses that began In Queensland in 1912 mirrored the recommendations of the New South Wales Report that had been published in 1904.[161] Although the legislation that was first enacted to control the work of midwives and nurses in Queensland appeared as a section in the Health Act Amendment Act, it contained clauses that were consistent with both the suggestions of the Royal Commission and the New South Wales Nurses' Registration Act of 1924.[162]

The term "regulation" is defined by Butterworth's Legal Dictionary defines as:

> The act of making a list in a register, particularly of an official character in which the existence of some thing or state of affairs is recorded.[163]

In Australia, the regulation of midwives began in 1902 when Tasmania became the first state to register its midwives.[164] In Britain, the Midwives' Act came into effect the same year.[165]

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160 Ibid., p.32 (114).
161 RCDBR, Vol.1, p.32.
162 *Nurses' Registration Act, 1924*, (New South Wales).
163 Nygh, P. E., Butt, P., (eds) *Butterworths Concise Australian Legal Dictionary, 2nd edition*, (Chatswood, NSW: Butterworths, 1998), p.373.

In the United States, the issue of midwifery regulation was overshadowed by debates related to midwifery's viability as an occupation outside of medicine. Lay acknowledges that four separate groups were vocal either in support or condemnation of midwives and only one, New York City and State that was prepared to tolerate the regulation and training of midwives.[166] The majority opinion was that the midwife role should be totally abolished. As Roberts indicates in her discussion of the tenuous course that midwifery practice in the United States has taken since the early twentieth century, there was considerable diversity underlying the whole midwifery question and a consequent disparity in midwifery's development.[167] The legislation pertaining to midwives in the United States during the first half of the twentieth century was directed at eliminating the role completely.[168]

In Queensland, on Friday, 1st November 1912, the Government Gazette carried a detailed explanation of the regulations as they applied to nurses and midwives.[169] Entitled, "'The Health Acts, 1900 to 1911' The Nurses' Registration Regulations, 1912", this legislation covered the establishment of a Nurses' Registration Board, the provision of hospital training for nurses and midwives, and the examination and certification of candidates.[170] The three separate sections of the regulations related to "general nurses", "midwifery nurses", and "mental

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164 *Midwifery Nurses Act, An Act to promote the better training of women as Midwifery Nurses, and for their registration as such, (Edward VII Regis, No. 24, 1901).*
165 *Midwives Act 1902*, (2 EDW. 7, 31st July 1902).
166 M. M. Lay, *The Rhetoric of Midwifery: Gender, Knowledge, and Power*, (New Jersey: Rutgers University Press, 2000), p.61.
167 J. Roberts, "The role of graduate education in midwifery in the USA", In Murphy-Black, T. (ed) *Issues in Midwifery,* pp.119-161.
168 Ibid., p.130.
169 *Queensland Government Gazette*, (Friday, 1 November 1912. No.118, Vol. XCIX).
170 Ibid., p.167.

nurses" with a detailed and itemised list of particular training that was applicable to the individual nursing specialties.[171] There followed information about the training schedules together with the regulations and documentation related to them. A replica of the badge to be awarded on successful completion of the training appeared on the final page.[172]

Conclusion

The influence of the trained nurse, both as an ideological concept and as a reality played a significant part in the regulation of midwives throughout Australia. The trained nurse became a readily identifiable social figure and one to emulate and respect. In comparison, the lay nurse and the lay midwife were barely distinguishable in terms of occupational boundaries and almost invisible as practitioners. They did not wear a nurses' uniform, they did not display a badge of training and they did not possess a certificate that confirmed their worthiness. In the rapidly changing world of the early twentieth century the days of the lay midwife were clearly numbered.

As this chapter has demonstrated, the moves to change the role and status of the nurse in Australia came about as a reaction to similar attempts in Britain. Utilising the pattern of nurse reform being introduced in Britain, Australia followed Britain's example with the result that nursing practice came to be instilled with the theories of Nightingale and the ideals of the middle class. The hierarchical order that ensued found a base in

171 Ibid., pp.167-172.
172 Ibid., 167-181.

the institution of the hospital where it mirrored the middle class family structure in which the father figure was substituted by the medical practitioner and the mother by the matron. This structure was especially important to the transition of midwives' practice because it underpinned their training in what was, to them, the foreign environment of the hospital. Whereas organised nursing practice had taken place predominantly in the hospital setting, midwives were, with few exceptions, located in the community where childbirth had, historically, been placed.

This chapter has argued that the correlation of nurses' practice with the work of midwives closed the division between the two and cemented the notion of the certificated midwifery nurse. In promoting that concept and locating the midwife in the institution rather than the home, the medical profession strengthened its position in childbirth and the state initiated its plans to enhance the health of its population. And while it may be argued that both lay midwife and trained nurse benefited from the close ties that hospital training forged, it might equally be contended that the hospital was not a natural environment for birth and therefore inappropriate for the training of midwives. However, in creating the midwifery nurse a comprise might be reached that would, ultimately, suit all concerned.

The following chapter examines the debates that took place amongst medical practitioners and politicians in their attempts to address the problems that they felt were issues that might hinder the prospective

advancement of Queenslanders in terms of reproductive capabilities. In short, if Queensland was to prosper as a state, it needed to populate and in order to populate it needed to provide the best possible means of doing so. A part of that commitment was the provision of birth attendants who were capable of meeting the task. More than simply the provision of suitable attendants, it was incumbent upon the state to legislate to ensure that their efforts would not go to waste and that subsequent maternity care would reflect the ideals already identified. The chapter shows that the combined efforts of the medical profession and the state acted as a united and powerful force that was instrumental in regulating midwives in accordance with state policies and medical aspirations.

CHAPTER SEVEN

CREATING THE MIDWIFERY NURSE: MEDICAL, POLITICAL AND NURSING OBJECTIVES

> Those who lived in the backblocks for a number of years must realise how necessary it was, especially in sparsely populated places, that the motherly women should be allowed to act as midwives. They did not want any women of the "Sairey Gamp" variety, but there were plenty of women who carried on nursing in the far out places who were just as competent to do that work as those who receive their training in a lying-in hospital.[1]

The previous chapters have highlighted the experiences of women giving birth and have shown the suffering and loss of life, maternal, foetal and infant, which was associated with childbirth and in which the midwife was frequently implicated. Those chapters have identified the role of the midwife as a presence that, whether actually or potentially, was so closely related to childbirth that it came to be perceived as a crucial element in the scenario of safe birthing. As such, the role of midwife was the focus of scrutiny by those who believed that the midwife role held too much power. In terms of both dominating the childbirth arena and in being able to affect childbirth outcomes, the role of the midwife represented a challenge to the medical profession. The medical profession rose to that challenge by amplifying the negative aspects of the midwife role and demanding that the state curtail the scope of midwives' practice.

For its part, the state was prepared to accede to demands to regulate the practice of midwives. The state saw such a strategy as the

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1 ORDLCA Vol. CVIII, 1912, p.734.

means through which it might monitor more closely the event of childbirth and impose accountability on midwives that had previously been lacking. The result was the Health Act Amendment Act,[2] which, building upon the 1905 legislation that afforded some protection for infants,[3] sought to enhance the security of the young child from conception to infancy. This Act attempted not only to address the needs of infants at the time of birth, but also, the needs of mothers.

As Chapter Six has shown, the medical profession presented the concept of the trained nurse as the means by which the work of midwives might most effectively be changed. If midwives were to be compelled to demonstrate their competency through training and examination conducted in the institutional setting under the watchful eye of the medical superintendent, then they might be allowed to continue to be a presence in childbirth albeit in a tailored and more controlled mode. This chapter investigates the way in which the midwife role was altered and brought in line with the expectations and requirements of the medical profession.

The chapter explores the deliberations of the medical profession and the state in their efforts to tackle the midwife question. It illuminates the arguments put for and against the statutory regulation of midwives and examines the subsequent legislation that was formulated. The thesis contends that the statutory regulation of midwives was achieved by combining the roles of midwife and nurse and highlighting the similarities between them rather than seeking out differences that might

2 *The Health Act Amendment Act of 1911*, (2 Geo. V. No. 26).
3 *Infant Life Protection Act, 1905* (5 Edw. VII. No. 19).

support the continuation of midwifery as a separate entity. It is argued that it was on the basis that nursing had already been remodelled as an adjunct to medical practice that the decision was made to align midwives with nurses and to create the *midwifery nurse.* It is further argued that the joint strategies of amalgamating the roles of nurse and midwife and situating the trainee in the hospital institution where she could be taught the foundations of *midwifery nursing*, reinforced by state legislation, were crucial to and a sustaining influence upon the development of the midwife role in Queensland throughout the twentieth century.

The options as the medical profession saw them

The desire on the part of medical practitioners to control the work of midwives in Australia was a recurring theme identified at formal meetings of the medical profession and recorded in medical journals throughout the 1890s and early 1900s.[4] This was a time when the role of midwives in Britain was also the focus of extensive debate as the medical profession sought ways of delineating midwives' practice.[5] To this end, the Midwives Bill first went before the House of Commons in 1890.[6] Witz refers to the options debated by the medical fraternity in Britain in terms of a demarcation between medicine and midwifery to be achieved either through deskilling the midwife and bringing midwifery

4 W.B. Nisbet, "The Education of Midwives", *AMG* (June, 1891): Anon. "The Issue of Certificates to Midwives", *AMG*, (Sept. 15, 1894): Anon. "A Meeting of the Medical Profession: Midwifery Nurses' Bill", *AMG*, (Nov. 21, 1898), pp.480-485: Anon. "Editorials: Midwifery Nurses' Bill of N.S.W", *AMG,* (Oct. 20, 1898): M.D. Nesbitt, "Midwifery Nurses", *AMG,* (July, 20, 1912): Anon. "The Registration of Midwives", *Intercolonial Medical Journal*, (Nov. 20, 1909).
5 J. Donnison, *Midwives and Medical Men: A History of the Struggle for the Control of Childbirth*, pp.94-174.
6 Ibid., p.126.

practice under the sphere of medical control, or the complete incorporation of midwifery practice within the discipline of medicine.[7]

Advocates of midwifery registration wanted the midwife role to be preserved as a distinct entity from that of medicine but in a modified form determined by the medical profession. This choice would enable the medical profession to determine the parameters of midwifery education and practice and exert control over what midwives were taught, the level of competence they should achieve, and the form their practice should take.[8] The registered midwife would therefore be allowed to deal with ”normal” childbirth while that which was “abnormal” would fall within the province of medicine. In this way, members of the medical profession could be selective in their involvement in childbirth while at the same time have overriding management.[9]

Those opposed to the state registration of midwives sought to eliminate the midwife role altogether and to incorporate it within the sphere of medicine. The advantage of this strategy to the medical profession was that the midwife would be replaced by an obstetric nurse who, devoid of occupational and legislative support to practice independent of the medical profession, would be obliged to act under the orders of the medical practitioner in all occupational situations.[10] Witz points out that the projected outcomes of these two approaches

7 A. Witz, *Professions and Patriarchy*, p.104-106.
8 Ibid., pp.104-105.
9 J. Donnison, *Midwives and Medical Men: A History of the Struggle for the Control of Childbirth*, pp.94-106.
10 A. Witz, *Professions and Patriarchy*, p.109.

were quite different in that:

> …the deskilling strategy sought to preserve the role of the midwife as an independent practitioner who had her own clients and who was therefore called out to attend women in the first instance; whereas the incorporatist strategy sought to dissolve the independent midwifery role into the obstetric or monthly nurse role directly supervised by medical men, who were called upon by the client in the first instance.[11]

When the registration of midwives was introduced in Britain in 1902 and after protracted debate and considerable controversy, it was the deskilling tactic that was endorsed. Witz argues that this was in part due to convenience, but it also represented a boundary between the provision of midwifery services for the poor and obstetric services for the wealthy.[12] She points out that when similar debates took place in the United States during the ten-year period 1908 to 1918, the consequence was the obliteration of midwifery as a practice for midwives and its total overthrow by the medical profession.[13]

Australia adopted features from both approaches whereby the roles of midwife and nurse were merged into that of "midwifery nurse" and were regulated by Nurses' Boards.[14] Thus, while the medical profession in Australia did not outlaw the midwife role altogether, neither did it sustain the concept of an independent practitioner. Instead, it supported the retention of the midwife role in principle but in a modified form and actively encouraged its incorporation into nursing. The result was the creation of a midwifery nurse whose occupational

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11 Ibid.
12 Ibid., p.116.
13 Ibid., p. 109.
14 *Health Act Amendment Act of 1911*.(2 Geo.V. No. 26), Sections 82–92 [154]-154K]): *An Act to promote the better training of women as Midwifery Nurses, and for their registration as such,* (Edward VII Regis, No. 24, Tasmania, 1901): *Health Act*, (1 Geo. V. No. 34, 1911, Western Australia): *Midwives Act 1915*, (6 Geo. V. No. 2773): *The Nurses' Registration Act of South Australia, 1920*, (George V Regis A.D): *Nurses' Registration Act*,(George V. No. 37, 1924, New South Wales).

structure was reliant upon ideals and values that originated from the hospital nurse rather than the local midwife. The distinction is important because, while the trained nurse was a relatively recent construct devised by the medical profession, the lay midwife was a social role whose roots stemmed from traditions and rituals that were woman focussed and which had developed over time.

The previous chapters have shown that the midwife role in Australia emerged in the absence of the traditions that had bolstered and guided the practice of midwives in Britain and Europe. Yet, despite the comparative newness of the midwife role Australia, the work of the midwives took on the same appearance and eventuated in similar outcomes. In the same way, the medical debates that underpinned the question of midwife registration in Britain were concerned with the same types of issues and generated the same sort of arguments that were evident in Australia. Why then, did the registration of midwives in Australia, lend itself to subsequent practice that was less self-directed and more closely aligned to nursing than that of Britain and certain countries of Europe?

The answer lies in part in the way in which the medical profession in Australia presented the work of midwives and in its commitment to aligning nursing and midwifery so closely that eventually few people, including midwives themselves, were able to differentiate between the two disciplines. A second important difference was that in Britain there was not only a strong midwifery presence, historically, but also, from 1865, women medical practitioners began to impact upon the childbirth

scene.[15] When the issue of the regulation of midwives was raised in Britain, a strong midwifery core used its connections to work with political, medical and nursing leaders and the general public to achieve its own professional ambitions and thus weaken the power of the medical profession to dictate the parameters of midwife practice.[16] The result was that the medical profession in Britain was neither successful in its bid to amalgamate nurses and midwives nor to bring the midwives' registering authority under the control of the General Medical Council.[17] Nevertheless, the medical profession still dominated the culture of childbirth.

In Britain, the initial moves to regulate midwifery practice came from medical practitioners who wanted to differentiate between those amongst them who were qualified in midwifery and those who were not.[18] As early as 1826, a group of London midwifery lecturers formed the *Obstetrical Society* in order to press for recognition of midwifery as a special medical qualification. The admission of women into medical schools in 1862[19] and the subsequent registration in 1865 of Elizabeth Garrett as the first woman medical practitioner in Britain,[20] served to bring the matter of midwifery regulation in Britain to the fore. Until that time, the regulation of midwifery was a matter that concerned only the male medical practitioner. Once women started to become qualified as medical practitioners, it became even more imperative to make a

15 J. Donnison, *Midwives and Medical Men: A History of the Struggle for the Control of Childbirth*, p.81.
16 Ibid., p.140-174.
17 Ibid., p.161-174.
18 Ibid., p. 57.
19 Ibid., p. 81.
20 Ibid.

distinction between the medical practitioner and the midwife, not simply from an occupational standpoint but from the perspective of gender.[21]

In 1872, London midwives and pupils of the London based Ladies Medical College established the *Obstetrical Association of Midwives.*[22] Although this Association lasted only until 1874, its replacement in 1880 by the Midwives' Registration Society provided midwives with professional representation that was to extend into the twenty-first century as the Royal College of Midwives.[23] Four prominent women led by the wealthy activist Louisa Hubbard founded this Society that later became the Midwives' Institute.[24] The remaining three women were midwives; two were matrons of large lying-in institutions in London and one was the holder of the Obstetrical Society's diploma and wife of a professor in surgery.[25] The Midwives Bill, first presented to the House of Commons in 1890, was the result of a tripartite agreement between the Midwives' Institute, members of the public and the Council of the Obstetrical Society.[26] Thus, although the Midwives Act of 1902 was heavily weighed towards medical interests, it reflected the efforts of influential and motivated women and of childbearing women themselves.[27] The participation of campaigners and the views of women whose welfare they promoted, acted to modify the terms of the Midwives' Act and to reduce the powers of the medical profession accorded within it.

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21 Ibid., pp.53-94.
22 J. Towler, J. Bramall, *Midwives in History and Society*, pp.164-165.
23 J. Donnison, *Midwives and Medical Men: A History of the Struggle for the Control of Childbirth*, pp.111-112.
24 Ibid., pp.112-117.
25 Ibid., pp.111-112.
26 Ibid, p.126.
27 Ibid., pp.125-139, 161-174.

In Australia, there were fewer distractions to the midwife question. The first woman to be registered as a medical practitioner was Constance Stone who was accepted into the medical profession in February 1890, only after obtaining her qualifications in universities outside of Australia, in Philadelphia, Toronto and London.[28] The only organised body outside of medicine that showed any interest in midwives was a nursing association whose agenda was to see midwives brought in line with nurses rather than to promote them as a separate occupational group.[29] Thus, when calls for the registration of midwives were made in Australia, they were initiated by members of the medical profession and supported by senior nurses on the basis of what was best for medicine and nursing rather than for midwives and parturient women. To this end, the integration of midwives and nurses into one complimentary role was advanced as the most appropriate manoeuvre and one that would best serve the interests of all concerned.

The medical debates

In 1891, in Queensland, the medical practitioner Nisbet argued that the education of midwives was essential to the improvement of childbirth outcomes.[30] Nisbet, in looking to Britain for inspiration in the management of midwives, maintained that while Queensland was different from Britain in some ways, the issues that surrounded childbirth corresponded closely enough to enable a meaningful

28 F.A.. Crowley, *Documentary History of Australia Volume 3. Colonial Australia 1875-1900*, (Victoria: Nelson, 1980), p.79.
29 G. Strachan, *Labour of Love: The History of the Nurses' Association in Queensland 1860–1950*, .p.34.
30 W. B. Nisbet, "The Education of Midwives", *AMG*, (June, 1891) pp.269-271.

comparison to be made. He believed that if Queensland were to follow the example of Britain in providing education for midwives, there was every reason to suppose that a reduction in maternal mortality would occur. Nisbet contended that, regardless of the outcome of the deliberations that were taking place in the House of Commons, Queensland should have qualified midwives and a formal structure for their practice that was approved by the medical profession. He argued that, in Britain, there was an abundant supply of medical expertise that women might access during childbirth, whereas in Queensland, women were forced to employ midwives as the only option.

Nisbet maintained that, in rural areas in particular, the sparsity and remoteness of the population meant that women could not be sure of obtaining the services of a midwife who had the knowledge and skills to facilitate the birth. Nisbet cautioned that:

> …we must not forget that the conditions of life are vastly different in Great Britain to what they are in Queensland. There, skilled medical men are always available, trained in the art and science of obstetrics, and ready to render assistance whenever required. Here, unfortunately, women are only too frequently located far from the centres, or even outskirts of civilization, and have to depend solely on the aid of some professed nurse or self-trained midwife.[31]

Nibset further argued that an enforced period of training for women who worked as midwives was essential if death and disability were to be avoided. The nature of the training was to be such that the midwife would act as an ancillary to the medical practitioner, able to adhere to medical guidelines that would teach her the circumstances in which she would summon medical aid. Nisbet was explicit in his prescription for

31 Ibid., p.270.

training the midwife:

> Teach her to recognize dangers, but not to treat them. Show her what nature is trying to do in a normal labour, and let this be the line from which the nurse, in her treatment, must not deviate.[32]

In training the midwife along the lines suggested by Nisbet, medical practitioners would secure the services of an obedient and compliant helper and one who could be relied upon to deputise for them. Nisbet believed that by providing the midwife with training that was compatible with medical expectations, the medical practitioner would be free to carry out other duties. He made the point that, if such a person were to be created:

> …we could safely leave them to manage any case they might undertake; and, instead of our spending many weary hours over confinement cases, we could feel sure our assistance would be sought when and not before it was wanted.[33]

As this thesis has demonstrated, the custom of remaining with their charge for the duration of their labour was a habit that medical practitioners did not generally adopt. This was quite different from midwives who almost invariably stayed with the woman throughout labour and frequently attended upon her for a number of days afterwards. Donnison has argued that when the question of midwifery registration was debated in Britain, those medical practitioners who supported it intended to concentrate on the more lucrative business of childbirth offered by the wealthy middle classes and to leave the maternity care of the poorer classes to the midwife.[34] Registered midwives could therefore never be rivals of the medical practitioner, but

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32 Ibid..
33 Ibid., p.271.
34 Ibid., p.105.

merely, "…competent watches of what was usually a natural process, and as useful assistants should emergencies occur."[35]

In 1894, a significant development in Britain unnerved medical practitioners in Australia and highlighted the damage that unlicensed midwifery practice might cause. During a meeting of the General Medical Council in Britain and as reported in *The Australasian Medical Gazette*,[36] it was proposed that any medical practitioner who sanctioned the practice of midwifery by a midwife, or any other person who did not hold a licence issued under the terms of the Medical Act of 1886, should be found to be "guilty of infamous misconduct in a professional aspect."[37] This proposition caused concern amongst the medical fraternity in Australia who were, like their British counterparts, accustomed to providing written testimonials for midwives and nurses. Their alarm was compounded by a situation that had occurred in Victoria and which had been reported in the previous edition of the Australian Medical Gazette. On that occasion, a woman had been prosecuted for practising as a midwife without having first gained sanction from the Victorian Branch of the British Medical Board.[38] This event, along with the more recent experience of the British medical profession, prompted the Gazette to explore the issue further.

The case was put that it was unreasonable to place the responsibility for the practice of a midwife on a medical practitioner merely because the medical practitioner had provided a testimonial.

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35 Ibid.
36 Anon. "The Issue of Certificates to Midwives", *AMG,* (September 15 1894), pp.317-318.
37 Ibid., p.317.
38 Ibid.

Members of the British Medical Board had argued that the issuing of such a testimonial did not constitute legal qualifications to practice and was merely "the opinion of certain gentlemen that such a person was qualified to do a certain thing" and that in denying medical practitioners the right to provide such a testimonial they were really asking them to prohibit a woman from helping another women in her labour.[39] The British debate concluded that:

> The Council could, after due inquiry, pronounce a given man guilty of infamous conduct, but they dare not pronounce a general anathema against a whole class, untried and unheard.[40]

The outcome of the British debate was taken as vindication of the stance of the Australian Medical Gazette in its evaluation of the actions of the Victorian Branch. Nevertheless, it also presented a worrying precedent. Medical practitioners began to wonder whether it would not be simpler and shrewder to insist that all midwives become accredited. To this end, the article suggested that the Council would do better to press for the "compulsory registration of all persons purporting to be midwives" rather than to waste time in discussing testimonials held by nurse-midwives that were unlikely to be examined by anyone anyway because: "Whoever looks at the papers, diplomas, or certificates held by a nurse-midwife?"[41] While the British case convinced some medical practitioners that midwifery registration was a shrewd step, others disagreed.

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39 Ibid., pp.317-318.
40 Ibid., p.318.
41 Ibid.

The introduction of a Midwifery Nurses' Bill in New South Wales

The deliberations that took place in Australian medical circles during the 1890s culminated in the introduction of a Midwifery Nurses' Bill in the Parliament of New South Wales in August 1898.[42] The Bill was initiated by James Graham, a medical practitioner and a lecturer in midwifery at the Sydney University and a strong advocate for midwives' practice to be confined to nurse-midwives who had completed a period of training in a state-controlled lying-in institution.[43] The Bill is significant because the terms of the Bill are remarkably similar to those that underpinned the regulation of midwives in Queensland under the terms of the Health Act Amendment Act of 1911, which guided the subsequent development of the midwife role in that state.[44]

In 1898, a General Meeting of the medical profession was held in Sydney for the purpose of debating the Midwife Nurses' Bill that was before Parliament.[45] Implicit within the discussion was an understanding that the professional interests of medicine, rather than the welfare of mothers and babies, provided the motivation for a regulatory system to govern midwives. The Bill was introduced as one that was designed, "to promote the better training of women as midwifery nurses."[46] Graham maintained that he had introduced the Bill in order to compel:

> …all women who were now acting as midwives, and all who desired to act as such in the future to have their names placed on a register.[47]

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42 RCDBR, Vol. II, p.112.
43 Ibid., p.111.
44 *The Health Act Amendment Act of 1911*, (2 Geo. V. No. 26).
45 Anon. "A Meeting of the Medical Profession: Midwifery Nurses' Bill", *AMG,* (Nov. 21, 1898) pp.480-485.
46 Ibid., p.483.
47 Ibid., p.482.

Graham admitted that his intention was, "…to serve the medical profession, and not to create an instrument that would deprive it of any of its privileges."[48]

In defence of his Bill, Graham posed a weak argument against midwives that some might consider to have been little more than rhetoric. In the absence of specific claims, Graham pursued a number of generalisations. He protested that an "army of midwives" who belonged to an "inferior order" that had existed for centuries, were contributing to "the present chaotic condition."[49] It seems that Graham's contention had more to do with the social role and location of the midwife and her popularity with women than with misconduct associated with midwifery practice by lay midwives. He implied that untrained midwives were ignorant and that they needed to be made to understand the limitations of their abilities. Bemoaning the role of the midwife as "one of the most fixed institutions amidst the order of social affairs", Graham stated that:

> She could no more be created than she could be obliterated – she is the product of human necessity – like topsy of old she was not born, but "growed," and whether she was acceptable to us or not we had to bow to the inevitable, and grin and bear it, by putting up with her.[50]

A number of assumptions underlay Graham's remarks, not least of which was that midwives presented a formidable force that could not be eliminated outright. Yet, as Graham implied, the role of the midwife was too volatile a presence to remain as it was. It was a role that occupied a position outside the parameters of medical control and one that was

48 Ibid., p.480.
49 Ibid., p.482.
50 Ibid.

seemingly strongly supported by women. Graham saw this as sitting uncomfortably within a culture in which the medical practitioner occupied a central and supervisory role. He maintained that, for the greater good, the practice of midwives should be placed under scrutiny and control, arguing that:

> The midwife occupied a unique position, a position which is different entirely from that occupied by the surgical and medical nurse, because it falls to the lot of the former to look after a parturient woman often without receiving any instructions from a medical practitioner; while the latter type of nurse always acts under instructions. Acting "under instructions" is the proper sphere for every nurse, be she midwifery or general, but custom and usage – a custom born of ages has permitted the midwife to act by public consent "on her own". For that reason a test of character and a test of fitness were all the more necessary as applied to the midwife, and how could we better secure such qualifications by means other than registration[51]

As previous chapters have shown, the midwife role lacked structure and consistency. The medical profession grasped these perceived deficits and used them, not only to protect childbearing women from well meaning but unskilled neighbours and friends but also to build a network of trained assistants who could be relied upon to follow medical directives.

Thus, the medical profession saw changes to the role of midwife in terms of subordination. It was beyond the social schema to assist the midwife to an elevated professional status that lay outside medical control. The midwife role was equated, as far as the medical profession was concerned, with that of the nurse and thus subordinate to medicine. At the same time, most midwives were women and therefore could only assume a subsidiary social and occupational role to medical men. While some nurses were middle class, most midwives were not,

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51 Ibid., p.483.

so that even their ”natural” social positions defeated any prospect of professional elevation. From this perspective, domination by medicine was the most realistic path and the only one that the medical profession considered to be the proper and rightful outcome.

Not all medical practitioners agreed that the registration of midwives was an appropriate objective. Dissenters to Graham's viewpoint argued that the inclusion of midwives on a register of nurses might bring greater harm to the medical profession in usurping the position of medical practitioners in the field of midwifery.[52] The registration of midwives would be tantamount to putting them on a par with medicine, at least as far as the general public was concerned. Underlying this viewpoint was the existing relationship between midwives and medical practitioners. Midwifery practice largely circumvented the control of medical practitioners and midwives were the choice of women as demonstrated in their greater share of childbirth attendance. From this perspective, the registration of midwives would not necessarily guarantee the submission of midwives to medical dictates, but might act to undermine the medical presence in childbirth rather than to enhance it.

The problems inherent to the question of midwives' registration were reflected in the words of Hankins, the Branch Secretary, who, in articulating the extent of the difficulties that faced the medical profession, observed that:

> So it would appear that the midwifery nurse is a mixture of monthly nurse and midwife, intended to fulfil one or the other functions, or both. Really, the two callings are quite distinct. They require different

52 Ibid., pp.480-482.

> training, and hold a different relation to the medical practitioner. A nurse always means one who is subordinate to the doctor, who acts under his orders, and has no independent authority. A midwife is one who does not necessarily act under the supervision of a doctor (so long as the case remains uncomplicated). She is individually responsible for the case under her charge. To call her a nurse, with whatever qualifying adjective, is to confuse one who has independent charge with one who has not, but who received her orders from a superior.[53]

Hankins was arguing that the relative independence of midwives was a potential threat to the medical profession if given legitimacy through registration. Yet this distinction was also central to the argument for regulating midwives under the banner of nursing. It is this issue that also underpins present day discontent with the professional alignment between nursing and midwifery and the resultant disinclination to acknowledge midwifery as a distinct area of practice.[54] The significance of a blurring of this distinction lay in the loss to midwives of professional territorial boundaries and the gain to nurses of midwifery as an extension of nursing practice. In proposing a midwifery nurse to replace the midwife, the medical profession brought about a redefinition of the midwife role based upon its own vision of what a midwife should be and what midwifery practice should entail.

The differences that Hankins amplified between nurse and midwife were not restricted to occupational functions but extended to the differing power relations between their respective roles and the medical profession. The independence, to which Hankins referred, set midwives apart from nurses and closer to the practice mode of the medical profession, a threat that was especially applicable to women

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53 Ibid., p.481.
54 C. Flint, *Communicating Midwifery: Twenty Years of Experience*, pp.7-8.

medical practitioners. In Britain, Elizabeth Garrett Anderson had written to *The Times* to relay her concern in relation to the proposed registration of midwives. Garrett Anderson maintained that she represented the views of "medical women" and Hankins paraphrased Garrett Anderson's views to put the case that such women would:

> …suffer more from a class of independent registered midwives than medical men; for a medical woman would be more readily confounded with a midwife in the minds of ignorant people, and many patients would expect her to take the fee of a midwife rather than that of her medical colleagues.[55]

A further point made by Garrett Anderson was that medical women deplored the prospect of being party to the creation of a "class of practitioner in midwifery only", maintaining that such a situation:

> would be disadvantageous to the public, since if a certain number of medical practitioners are needed for the difficulties of midwifery, they must not as a preliminary be deprived of the great majority of ordinary cases.[56]

Hankins then summarised his argument with the warning that:

> …we must also remember that humble midwifery has always been regarded as a stepping stone to family practice. In this domain a young man has the opportunity of proving that he has the patience, kindliness of disposition, and sympathetic manner which is sure in time to make for popularity.[57]

Hankins concluded his address with the following recommendation:

> I therefore beg to move that this meeting objects to the Midwifery Nurses' Bill becoming law, on the ground that its alleged advantages to the public are more than outweighed by the fact that it is injurious to the interests of the medical profession.[58]

What the medical profession was essentially debating then was the means by which they could secure their own professional grounding

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55 Anon. "A Meeting of the Medical Profession: Midwifery Nurses' Bill", *AMG*, (Nov. 21, 1898), p.482.
56 Ibid., p.482.
57 Ibid.
58 Ibid.

in childbirth. The midwife was an obstacle to the prospect of medical advancement in obstetrics. Without monopoly over midwifery practices the medical practitioners' financial and professional capabilities would be compromised. The aspirations of the medical profession coincided with moves on the part of the state to address depleting populations. Childbirth became a compelling target and the lay midwife became the means by which both medical and state control over childbirth was achievable.

When Graham assured his audience that the registration of midwives would not work against the medical profession he was right. Graham's plan effectively incorporated midwifery into nursing under the guise of a maternity nurse. The result was that, whether in the hospital environment where they emulated the role of midwifery nurse, or in rural and remote areas where they worked with greater independence, the practice of midwives was controlled by the medical profession. That control was secured through the establishment of a Nurses' Registration Board, with a majority representation of medical practitioners, to govern midwives. Graham countered opposition to his plan to register midwives with the assurance that:

> The registration Board is one composed of more medical men than laymen, and so it might be truly argued that the midwifery nurse under this Bill would be placed practically under the control of the medical profession.[59]

When senior nurses and medical practitioners met in Sydney in 1899 to discuss the formation of an occupational association which only trained

59 Ibid., pp.482-483.

nurses would be eligible to join, James Graham was a founding member and the proposer of its underpinning objectives.[60]

Graham's Bill was not successful in 1898. In evidence to the *Royal Commission on the Decline of the Birth-Rate and on the Mortality of Infants in New South Wales*, Graham attributed the defeat of the Bill to opposition from the Council of the British Medical Association.[61] Graham indicated that the Bill had passed the Lower House without difficulty and had survived keen criticism from members of the Upper House, but that opposition from the medical profession caused the Bill's downfall. Graham explained that:

> I was led to withdraw it mainly on the representation of the medical profession. Their chief reason for opposing it was that it might create and license an inferior type of practitioner, who would be in opposition to the general practitioner. That was the main argument from the professional point of view. It was withdrawn largely on that ground.[62]

It was to be some years before midwifery registration was finally passed in New South Wales, but the principles that Graham adhered to were met within the Nurses' Registration Act of 1924 which, in keeping with the statutory regulation of midwives in most other states in Australia, firmly entrenched midwives within the practice territory of nurses and gave ultimate control to the medical profession.[63] The partnership between medicine and nursing

An important factor in the reform of the midwife role was the collusion between the medical profession and trained nurses. The previous chapter has demonstrated that the concept of a trained nurse

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60 G. Strachan, *Labour of Love: The History of the Nurses' Association in Queensland 1860–1950*, pp.30–33.
61 RCDBR, Vol. II, p.112.
62 Ibid.
63 *Nurses' Registration Act*, (George V. No. 37, 1924, New South Wales).

became a reality as a result of the efforts of influential middle class women and notably Nightingale and Fry, who sought to improve the standard of nursing practice through a system of training and credentialing. Integral to that process was the acceptance of the medical profession as a superior and controlling mechanism outside the realm of which neither the trained nor the untrained nurse could survive.

In Australia, public acceptance of the trained nurse role was underpinned and reinforced by a project that originated from a partnership between nurses and medical practitioners. This partnership culminated in the formation of the Australasian Trained Nurses' Association (ATNA), which would become the leading influence in nurse education and reform in Australia in the first half of the twentieth century.[64] Russell, drawing on an article published in the Australian Nurses' Journal in 1958, has argued that:

> The ATNA has the distinction of being the only voluntary organisation of nurses anywhere in the world to succeed before state registration, in imposing educational standards for nurse training in hospitals.[65]

The membership of the Association was drawn from leading members of the medical profession who worked with senior nurses to determine a training schedule for nurses that included midwives and children's nurses.[66]

The ATNA was founded on a set of clear objectives that were framed at its inaugural meeting on 21 June 1899 and which focused on promoting the interests of "trained nurses" within a formal structure that

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64 Ibid., pp.30-43. See also, R. L. Russell, *From Nightingale to Now: Nurse Education in Australia*, pp.3-26.
65 R. L. Russell, *From Nightingale to Now: Nurse Education in Australia*, p.24.
66 ORDLCA, Vol. CVIII, 1912, pp.727-728.

derived from a codified system of practice monitored by statutory means.[67] Integral to the business of the Association was the devising of a means whereby the "trained" nurse might be differentiated from her "untrained" counterpart. The registration of the trained nurse was, therefore, paramount in the aims of the Association.[68] The objectives were concentrated upon the social construction of a body of nurses that was identifiable as "a class" in itself.[69] If class, here, is to define professional status and class is relational, it would seem that there was a class within a class: a body of trained women within a shared gender. The nurses who were recruited to the Association were those who had the financial means and intellectual capacity to both access and complete the training.

The Association determined that nurses eligible for membership of the Association had either completed a training course in a hospital approved by the Association, or had gained between three and five years' experience in an approved hospital institution.[70] In addition, all applicants for membership of the Association were required to furnish testimonials in support of their moral character and, where certificates of competency were required, any disruption to nursing practice had to be explained and justified. Those nurses who did not meet the criteria, but who were nevertheless able to put forward a sound case that was supported by the evidence of "at least three reputable medical

67 G. Strachan, *Labour of Love: The History of the Nurses' Association in Queensland 1860–1950*, pp.30-31.
68 ORDLCA, Vol. CVIII, 1912, pp.727-728. .
69 G. Strachan, *Labour of Love: The History of the Nurses' Association in Queensland 1860–1950*, p.31.
70 Ibid., pp.30-36.

practitioners", could be admitted to the Association at the discretion of its Council.[71]

The measures put in place by the ATNA guided both the legislation for nurse registration and the structure of the Registration Board that was subsequently created and were an important influence in the remodelling of the midwife role.[72] During the first decade of the twentieth century, the Association opened branches in other states, including Queensland in 1904.[73] Midwives were eligible for membership either through the program of midwifery nurse training that was becoming characteristic of the government subsidised lying-in institution, or on the basis of proven competency in midwifery nursing and written evidence of "good moral character".[74] The alignment of nurses and midwives that had already begun in the lying-in hospitals was reinforced by the ATNA, which promoted the concept that midwives were nurses who specialised in childbirth. Indeed, at a special meeting of subscribers to the Lady Bowen Hospital on 1st March 1910, it was agreed that "nurses holding certificates for general nursing of the ATNA shall be eligible for a qualifying certificate in midwifery after a residence of six months on passing the necessary examinations."[75]

The equivalence of midwifery and nursing was augmented in a deputation to the New South Wales parliament in 1911 by members of the ATNA who voiced their support of a Nurses' Registration Bill that

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71 Ibid., p.33.
72 *Health Act Amendment Act of 1911*, (2 Geo.V. No. 26, Section 82).
73 ORDLCA, Vol. CVIII, 1912, p.727.
74 G. Strachan, *Labour of Love: The History of the Nurses' Association in Queensland 1860–1950*, p.34.
75 QSA, *Minute Book of Committee Meetings of the Lady Bowen Hospital, 3 January 1905 to 25 October 1910*, (PRV9294 Minute Books).

had been introduced by Dr. Mackellar and was before parliament at that time.[76] Coincidentally, Mackellar had been the Chairman of the of the 1904 Royal Commission into declining birth rates.[77] The deputation pointed out that there were three thousand members of the Association and it proposed that only its members should be accepted as trained nurses and be entitled for appointment as hospital matrons. By these means, the Association sought to dominate and manipulate the practice of nurses in the hospital arena, a strategy compatible with the aspirations of the medical profession to monopolise midwifery.

In August 1911, the Legislative Assembly in Queensland noted that there were, "…500 odd nurses belonging to the Queensland branch of the Australasian Trained Nurses' Association".[78] This Association was also identified as an advisory body, which, together with the Ladies' Committee of the Lady Bowen Lying-in Hospital, medical officers from other Brisbane institutions and the Commissioner of Public Health, assisted the government to formulate its legislation for midwives.[79] The power that the ATNA held, reinforced by medical practitioner membership, encouraged the notion that midwives and nurses constituted one body. More significantly, midwifery assumed an ancillary status to nursing. Nurses who sought a qualification to practice as a midwife were granted a reduction in training on the basis of their existing knowledge of nursing.[80] The creation of the midwifery nurse

76 Anon. "Medical Notes" *AMG,* (April 20, 1911), p.234.
77 RCDBR, Vol I, p.iii.
78 ORDLCA, Vol. CVIII, 1912, p.727.
79 Ibid., p.735.
80 QSA, *Minute Book of Committee Meetings of the Lady Bowen Hospital, 3 January 1905 to 25 October 1910*, (PRV9294 Minute Books).

thus reflected a redefining of both the midwife and nurse, but it was left to the state, under direction from medical and nurse advisors, to authorise the full incorporation of midwifery into nursing.

Parliamentary debates

In the first decade of the twentieth century, influenced by the medical profession and senior nurses, the benefits of the "trained nurse" and the regulation of nurse practice through registration was becoming more familiar to the Queensland government. While political, medical and nursing agendas differed, they were unanimous in their support for state registration of midwives under the umbrella of nursing. The state perceived regulation of public services as a necessary strategy for improving the conditions in which people lived and worked.[81] It was concerned, as this thesis has argued, with the population of Queensland and its focus was directed towards ways in which the population might be increased.

The deliberations undertaken by the state to identify strategies for population increase were centred on factors that influenced childbirth practices and the rearing of infants. The state understood the implications of poor public health, particularly with regard to infants below the age of one year. It was aware of the dangers associated with illegitimacy and saw infanticide and accidental death as directly linked to births out of wedlock. It was suspicious of deaths that were claimed to be stillbirths, hypothesising that stillbirths might mask infanticide. The practice of boarding out babies to women in their own homes who were,

81 ORDLCA, Vol. CVIII, 1912, pp.513-738.

or purported to be, baby minders, was perceived as having a negative impact on the state's population.[82]

The state had gone some way to addressing the problems associated with infant rearing in passing the Infant Life Protection Act in 1905, that sought to safeguard infants from unscrupulous carers.[83] Illegitimate infants were deemed to be at particular risk because of a tendency for them to be abandoned by their mothers and to be placed in the homes of paid women carers. At times, such women were ill equipped to deal with an infant and death resulted from maltreatment caused by either ignorance or neglect.[84] This Act required women to be registered in order to take in infants for profit and to ensure that they notified the district registrar of births and deaths of illegitimate infants within the predetermined timeframe.[85] The time had now come to address problems associated with childbirth in terms of birth attendants and birth venues. In keeping with the findings of the New South Wales Royal Commission of 1904, the state in Queensland viewed deaths in childbirth as a consequence, in part, of substandard practice by people, mostly women, who acted as midwives.[86]

Legislating to control midwives

The Health Act Amendment Act was initiated on 27 July 1911 at the instigation of the Home Secretary, Hon. J. G. Appel, representative for Albert.[87] The first reading of the Bill took place on 1 August 1911[88]

82 Ibid.
83 *Infant Life Protection Act*, *1905,* (5 Edw. VII. No. 19).
84 ORDLCA, Vol. XCV, 1905, pp.1652-1662, 1753-1761.
85 *Infant Life Protection Act*, *1905,* (5 Edw. VII. No. 19)..
86 Ibid., pp.1652-1663, 1752-1761.
87 ORDLCA, Vol. CVIII, 1912, pp.282, 331.

and its stipulated purpose was the "protection of the health of the people" and it was founded on the principle that the government held a duty to "promote the health, happiness, and comfort of the people."[89] Three aspects of the Health Act Amendment Act of 1911 are of particular significance to the role of the midwife in Queensland. The first provides for a registering authority to be shared by midwives and nurses for the purpose of overseeing training and practice in accordance with the 1911 Act. The second defines the compulsory training schedule for midwives and outlines the ways in which midwives might render themselves eligible to practice. The third concerns the registration of private hospitals where the midwife role was most commonly located outside the home environment.

The formulation of a supervisory authority

The months preceding the passing of the Health Amendment Act saw considerable debate among politicians over the ways in which midwifery practice by midwives might be regulated. Although, initially it was intended that the Queensland Medical Board consisting of five "medical men" should oversee the registration of nurses,[90] James Forsyth, Member of Parliament for Moreton, proposed the establishment of a Board that allowed for more diverse membership. He suggested that while male medical practitioners, two of whom should be nominated by the Medical Board, should dominate the Board there should be two further positions open either to qualified nurses *or*

88 Ibid., pp.282, 331.
89 Ibid., p.512.
90 Ibid., p.728.

medical practitioners nominated by the ATNA.[91] Under this proposal, which was accepted, the membership of the Board was to derive from medical practitioners and nurses, but the balance of power was to rest with the medical profession.

The Honourable Robert Philp of Townsville agreed, rejecting any suggestion of establishing a Board for nurses that was not adequately represented by nurses, arguing that:

> …two women should take the place of two men on the board as representatives of the nurses. Surely nurses had the right to be represented on the board, and to examine members of their own sex.[92]

John White of Musgrave supported Philp and maintained that the trained nurse was sanctioned by the medical profession and, as such, should be allowed representation on the Board. He justified his view by assuring the Assembly that during a recent visit to a hospital he had witnessed the process involved in authenticating the trained nurse role and had seen:

> …doctors conducting an examination of nurses. They were examined both theoretically and practically, and the papers were very carefully examined.[93]

As far as White was concerned, the authentication of nurses' knowledge by the medical profession was sufficient reason for nurses to be given a degree of power over their training and practice. The Home Secretary supported this view and attempted to allay fears that the medical profession might be disadvantaged, pointing out that:

> The nurses will only have two representatives on a board of five members. How can the minority rule the board?[94]

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91 Ibid., p.727.
92 Ibid., p.728.
93 Ibid., p.729.
94 Ibid.

The most likely option for nurse representation on the Board was through nomination by ATNA and, as Strachan points out, the business of the Association was focussed so heavily on Brisbane that anyone outside of the metropolitan area would be unlikely to be involved in the organisational management.[95] Indeed, some members suggested that nurses were more likely than medical practitioners to discriminate against applicants from rural areas. The argument was put that:

> The girls working in the outside hospitals were entitled to as much consideration as the nurses. In many outside places the doctors found it difficult to get nurses, and they had to get girls who were born in the places to do the work, sometimes for very small pay; and in passing a Bill of this nature they should see that those girls were given a fair deal.[96]

The prospect of hostility against new recruits directed by their occupational association added a new dimension to the debates. William Murphy of Croydon observed that some thought that, in placing medical practitioners in charge of the Registration Board, nurses from outlying areas would have a better chance of being accepted as probationers than if their applications were left in the hands of nurses.

The threat of losing midwives from remote areas of the state as a result of regulation that did not value the experiential nature of practice, was clearly an issue of concern. The ATNA came under attack as a union that, in keeping with other unions, would do its best for its members without worrying about the effects on the greater community.[97] The ATNA was identified as an organisation that gave primacy to the interest of the metropolis over country areas. Murphy

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95 G. Strachan, *Labour of Love: The History of the Nurses' Association in Queensland 1860–1950*, p.38.
96 Ibid., p.729.
97 Ibid.

argued that the sheer size of Queensland and the isolation of its settlements, discouraged nurses from moving to rural areas. He maintained that under the terms of the Bill and as supported by the ATNA, there would be fewer nurses available and those who undertake training would be unlikely to be prepared to work in outlying districts. According to Murphy, although it was customary for the Brisbane General Hospital to supply nurses for areas such as Croydon and Etheridge, the supply was frequently inadequate. The onus was then upon the medical practitioner to do what he could to gain an assistant. As Murphy pointed out:

> …in those outside centres where they could not get trained nurses the doctor had to take any woman he could get and train her.[98]

In support of Murphy, Philps recalled that:

> On one occasion, during an epidemic, one doctor at Townsville died and the other cleared out, the only persons left to attend to the sick being an old Congregational parson, and a chemist who sold coloured water at 7s.6d. a bottle….There were some male nurses, but there were no women nurses.[99]

In accordance with the amendments suggested during parliamentary debates, when the Nurses' Registration Board was established with effect from 1st March 1912,[100] two members of the Australasian Trained Nurses Association, Florence Chatfield and Emily L. Hunter, comprised the nursing presence. Dr. Halford chaired the Board and Dr. McLean and an un-named Inspector of Asylums for the Insane completed its membership.[101] The Nurses' Registration Board was charged with the establishment of three registers to reflect the

98 Ibid., p. 728.
99 Ibid., pp. 728-729.
100 *Health Act Amendment Act of 1911*, Section 82 (2).
101 QSA, Statistical Register for the year 1913, Blue Book 1913,p.44.

classifications of General Nurse, Midwifery Nurse, and Mental Nurse. The names of nurses so registered were to be published in the Queensland Government Gazette in January of each year.[102]

The probationer midwifery nurse

There were certain prerequisites to be met before an applicant might be accepted as a "probationer midwifery nurse".[103] First, it was incumbent upon her to supply proof of age, preferably in the form of a "certified extract from an official register of births" and "two certificates of good fame and character".[104] Second, the applicant had then to produce evidence than she had "satisfactorily completed the fifth standard of a primary school within the Commonwealth of Australia" or equivalent.[105] The candidate who had been accepted into training would complete a one-month probationary period and, at its completion, she was required to obtain:

> …a certificate from a member of the medical staff of their physical fitness, and from the matron of their general fitness to undergo the training herein prescribed.[106]

The influence of medical superintendents and their deputies, medical officers and hospital matrons, was central in shaping the training of the midwifery nurse from the outset. Furthermore, the institution and content of training was organised around explicit hierarchical principles.

The curriculum of training for "pupil nurses" comprised twenty lectures in midwifery, twelve in general nursing and six in "invalid

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102 *Health Act Amendment Act of 1911,* Sections 82 [154] – 92 [154k]).
103 Appel. J. Geo. Home Secretary's Department. "'The Health Acts, 1900 to 1911' The Nurses' Registration Regulations, 1912'" Part III [8] *Queensland Government Gazette*, (Vol. XCIX, Friday, 1st November 1912, No. 118), p.1118.
104 Ibid., p.1124.
105 Ibid., p.1124.
106 Ibid., p.1118.

cooking".[107] The institutionalisation of a hospital hierarchy is reflected in two General Nursing subjects entitled, "Distinction between the doctor's work and that of the nurse" and "Methods of observing symptoms and manner of reporting to the doctor."[108] The midwifery lectures emphasised the differentiation between "normal" labour and "abnormal" labour and instruction in the various mechanisms of labour took on some importance, as did the recognition and treatment of complications of childbirth such as haemorrhage and eclampsia.[109] The "pupil nurses" were also expected to "…conduct at least twenty cases of labour and nurse at least twenty lying-in patients during the ten days following labour".[110] Those cases of labour were to be conducted "under medical supervision".[111]

Certification that the course of instruction had been successfully completed was to be signed by both the hospital matron and a member of the medical staff of the hospital.[112] It had been agreed during meetings of the Queensland Legislative Assembly that, at the end of the stipulated period of training, the medical profession would hold the power to determine whether or not the pupil nurse aspiring to certificated maternity nurse status met the criteria for qualification. Thus, it was acceded without dispute that:

> The candidate would be examined by a duly qualified medical practitioner, and as soon as he sent in his report to the board, no board would dream of refusing registration.[113]

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107 Ibid.
108 Ibid.
109 Ibid.
110 Ibid.
111 Ibid.
112 Ibid., p.1124.
113 ORDLCA, Vol. CVIII, 1912, p.729.

It was decided by the Legislative Assembly that examinations would be conducted throughout Queensland in accredited training hospitals.[114] The principal criteria in determining the appropriateness of a hospital to act as a training venue was that there were sufficient numbers of beds and that the patients were under the supervision of a medical practitioner.

Those women who had received an appropriate course of training prior to the last day of December 1912 and who could provide evidence from a "…Medical Officer or authorities of a hospital…" would be deemed eligible to qualify as a midwifery nurse.[115] The final examinations, the "practical and oral", were conducted by "duly qualified medical practitioners and matrons of hospitals recognised by the Board".[116] For those women whose applications for registration as a midwifery nurses were based upon previous experience as a midwife, evidence of competency signed by "three legally qualified medical practitioners" was required.[117] However, in the absence of such testimonials the options were, either to provide references from two qualified medical officers or, one medical practitioner together with a certificate from a police magistrate to the effect that the applicant had been practising as a midwifery nurse during the prescribed three-year period.[118]

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114 Ibid., p.730.
115 *Queensland Government Gazette*, (Vol. XCIX, Friday, 1st November 1912, No. 118), p.1124.
116 Ibid.
117 Ibid., p.1122, Section 10.
118 Ibid.

Establishing the parameters for practice

As far as the members of the Legislative Assembly were concerned, the preferred nurse was one who had experience in a variety of practice settings.[119] In their view, the more accomplished the nurse in terms of clinical practice, the better able she would be to perform her role. A maternity hospital was considered to be just one of a number of clinical settings that the nurse might access in her quest to be "a good all-round nurse", as John Mann of Cairns pointed out when he observed that:

> …the nurses trained in the Brisbane General Hospital were sent round to the different wards, and thereby got a good general training, but, even nurses trained there had to serve a six months' course in the Lady Bowen or some other maternity hospital before they could act as midwife.[120]

Indeed, Mann seemed surprised that the trained nurse was not automatically equipped to "act as midwife" but must, instead, receive extra training in order to do so. The Home Secretary who, in acknowledging the state's indebtedness to the advice proffered by medical practitioners and nurses in relation to the midwife question, emphasised the lack of distinction between the two roles, as the Hansard report records:

> The amendment had been submitted to and carefully considered by the Commissioner of Public Health, who furthermore had the assistance of Dr. Mclean, resident surgeon of the Brisbane General Hospital, of Dr. Turner, surgeon in charge of the Diamantina State Hospital for Incurables, and Dr. Halford, who represented the Australasian Trained Nurses' Association. All the necessary provisions were contained in the rules of that association, and he (Mr. Appel) proposed, at a later period, to move an amendment which set forth the necessary training which a nurse engaged in a lying-in hospital must have.[121]

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119 ORDLCA, Vol. CVIII, 1912, pp.730-731.
120 Ibid., p.727.
121 Ibid., pp.727-728.

The emphasis was clearly on creating a bi-functional nurse rather than a skilled midwife. At no point was there a proposal to create a midwife whose training might be based solely on practices associated with childbirth and lying-in. Rather, value was placed on the midwife as a trained nurse. Therefore, in suggesting the length and type of training that a midwife would need, the Home Secretary proposed an amendment that stipulated that:

> Nurses of lying-in hospitals would have twelve-months' training in a general hospital and six months' training in a lying-in hospital which was considered all that was necessary to qualify a person for that profession. Every precaution was being taken to insure that the nurses had every qualification for their particular duties. [122]

While the government was keen to demonstrate a commitment in providing an adequate course of training with the objective of improving the overall standards of health, it was becoming increasingly aware that tough regulatory requirements might inhibit the numbers of midwives able to practice.

The need for a discretionary clause

The requirement that midwives should complete a formal period of instruction in a lying-in institution in order to be eligible to register as a midwifery nurse was a source of concern to some Members of Parliament and particularly those who represented country electorates and who were worried that their districts would lose valuable midwife expertise if the Bill was to proceed in its current form.[123] When Godfrey Morgan of Murilla argued for a discretionary clause to be included in the Act, he spoke on behalf of the women in his district who took on "cases"

122 Ibid., p.728.
123 Ibid., pp.730-735.

of midwifery and who were, as far as he was concerned, every bit as able to fulfil the task as the trained midwife. Morgan called for flexibility when he argued that:

> We who represent districts far ways from towns where doctors reside know that there are women practising who are qualified in every respect; they have proved themselves capable of dealing with cases of this sort and have been very successful, yet they are not able to pass examinations as required by this clause. It would be inflicting a serious hardship on the people in these districts if these women were prevented from practising. I hope the Home Secretary will give this clause particular attention, and when the Bill gets into Committee, try to see if he cannot make the qualification easier, or provide that any one of them only is necessary in order that a woman who is already practising as a midwife may become a registered midwife.[124]

Morgan's argument, which substantiates the accounts of the work of lay midwives presented in Chapter Two, challenged the dominant medical view that all lay midwives constitutes a menace. It was Morgan's opinion that rural areas would lose an invaluable asset if the legislation failed to take into account the value of experiential learning. When the issue was revisited the following week, Vincent Lesina of Clermont proposed that Queensland should be treated as a special case. Lesina received much support from colleagues in arguing that:

> In Queensland, where people had to do pioneering work, necessarily a great deal of nursing had to be done by amateurs, and some of the most successful nurses in the back country were women who could barely write their names. (Hear, hear!)[125]

The problem of supply of trained nurses and midwives to more isolated areas saw O'Sullivan propose an amendment to the Bill on the basis that many women acting as midwives had acquired sufficient knowledge and skill to be considered qualified. O'Sullivan argued that

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124 Ibid., pp.532–533.
125 Ibid., p.725.

experienced women should be allowed to register:

> …simply through length of service. There were women in the far North and West of Queensland who had been carrying on nursing for half a lifetime, and in order to give them an opportunity to continue to do so he moved the insertion of the words "or has followed the profession of midwifery for the preceding two years" after the word "institution" on line 15. If women could be registered through length of service, it would be a great improvement to the Bill.

O'Sullivan was of the view that experienced midwives should be retained because:

> The maternal instinct in them was so strong that they at first went to the assistance of their neighbours, and then afterwards qualified to become midwives, and these women were just as good midwives as could be found anywhere else, even in the cities.[126]

Murphy supported the contention that experienced midwives should received special consideration, arguing that:

> Those who lived in the backblocks for a number of years must realise how necessary it was, especially in sparsely populated places, that the motherly women should be allowed to act as midwives. They did not want any women of the "Sairey Gamp" variety, but there were plenty of women who carried on nursing in the far out places who were just as competent to do that work as those who receive their training in a lying-in hospital. A great injustice would be done to the wives of the fossickers at the Oaks Rush and Chillagoe and such places if the amendment were not accepted.

When the conditions under which midwives would become eligible to practice were eventually agreed upon, the primary condition of registration rested on the completion of a formal course of instruction in a stipulated hospital institution.[127] The majority of midwives were unable to meet this criterion and the discretionary clause offered the only prospect for continuation of practice.

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126 Ibid., p.734.
127 *Health Act Amendment Act of 1911*, Section 85 [154C].

Constructing a framework for practice

Under the terms of the Health Act Amendment Act and enforced by the Nurses' Registration Board, eligibility for registration as a midwifery nurse in Queensland was dependent on one of three criteria.[128] A woman was rendered eligible for immediate registration as a *midwifery nurse* provided that she held "a certificate of midwifery from a hospital or other institution recognised by the Board" and proved to the satisfaction of the Board that she had, "…received systematic instruction in midwifery from the medical officer and matron of that hospital or institution…".[129]

The second criterion applied to those applicants who were ineligible to register under the conditions of the first part of this section and to all new recruits to midwifery. After the first day of January 1912, there were two options for the prospective *midwifery nurse* who had reached the age of twenty-one years. The first option applied to a person who was registered as a general nurse and who would be entitled to certification if she had received "systematic instruction in theoretical and practical nursing", had attended a lying-in hospital for a minimum period of six months, and was successful in the examination prescribed by the Board.[130] The second option was available to non-nurses who were required to complete a one-year period of instruction in a lying-in hospital and to pass the examination prescribed by the Board.[131] This period of instruction was one third of that required by

128 Ibid.
129 Ibid.
130 Ibid., Section 85 [154C].
131 Ibid.

nurses whose names appeared on the Register of General or Mental Nurses.[132]

The third criterion reflects the influence of rural members of the Legislative Assembly. This criterion stated that practising midwives who, prior to the first day of January 1912 and up until the thirty-first day of December 1912, had received instruction in *midwifery nursing* in the past, had practiced as a *midwifery nurse* for a minimum of three years prior to January 1912, or had been "employed in the calling of a nurse" in the three years preceding initiation of the Act, would be permitted to register as a midwifery nurse.[133] In the Register of Midwifery Nurses for year ending 31 December 1912, the names of five hundred and eighteen women were recorded, the majority of whom had attained registration under this final clause. In comparison, during the period 1919–1925, the most common means of achieving *midwifery nurse* status was by examination,[134] which suggests that in a relatively short period, the trained *midwifery nurse* rapidly replaced the lay midwife.

The regulation of midwives outside Queensland

Queensland was not alone in initiating legislations to control midwives. Tasmania was the first state to legislate the training of midwives and to make provision for their registration in a Midwifery Nurses Act that was initiated in 1901.[135] The Act, which came into effect on 1st June 1902, included midwives on a register of "Midwifery

132 *Queensland Government Gazette*, (Vol. XCIX, Friday, 1st November 1912, No. 118), pp.1115-1128.
133 *Health Act Amendment Act of 1911*, Section 87 [154E]).
134 QSA, *Register of Midwifery Nurses*, (RS113169 Register of Nurses).
135 *An Act to promote the better training of women as Midwifery Nurses, and for their registration as such*, (1º EDWARDI VII, No.24, Tasmania).

Nurses" and established a Court of Medical Examiners empowered to control the conduct and practice of midwives. The Registrar kept the Midwifery Nurses Register[136] and, under the terms of this Act, midwives were given the right to appeal a decision or determination of the Court of Medical Examiners.[137] In Queensland, the Nurses' Registration Board did not allow right of appeal to those persons who felt themselves aggrieved by a Board ruling.[138] In contrast to registering authorities for midwives in certain other areas, the Queensland Board was an autocratic structure that did not hold itself accountable to the people registered with it.

In 1912, a medical practitioner in South Australia suggested that the regulation of midwives should be taken up forthwith both in South Australia and Victoria and that it should follow the example of the Midwives' Act of Tasmania, arguing that:

> Some of the Sarah Gamps that are allowed to "practise" are a disgrace to any community, the worst type being those that consider they know everything worth knowing. I had a case with one of the latter lately while a locum tenens in Victoria. The people actually preferred her to a well trained nurse in the town, mainly, I think, because she was cheap.[139]

However, Western Australia was the next state to regulate midwives under the Health Act of 1911.[140] Effective from I January 1912, this Act established a Midwives Registration Board that kept a "Midwifery Nurses' Register" for midwives and midwifery nurses.[141] Membership of the Board comprised a total of five and included two medical

136 Ibid, Section 5.
137 Ibid., Section 14.
138 *Health Act Amendment Act of 1911*, Section 82.
139 M. D. Nesbitt, "Midwifery Nurses" *AMG*, (July 20, 1912). p.68.
140 *Health Act,* (1 GEO. V, 1911, No.34, Western Australia).
141 Ibid., Sections 254 & 255.

practitioners and two nurses overseen by a Commissioner.[142] The Act did not allow for appeal by midwives who were aggrieved by a judgement made by the Board.

In 1915, Victoria passed a Midwives Act that was more comprehensive than those of other states.[143] The Governor in Council, who was empowered to appoint Board members from among public servants, convened a Midwives Board.[144] The Victorian Act stipulated the circumstances in which the midwife should call in medical aid and allowed for the recovery of medical practitioners' fees for such attendance.[145] This Act also allowed the right of appeal, required midwives to notify their intention to practice annually, and provided for the temporary suspension of a midwife from practice if, by so doing, the spread of infection might be minimised.[146] Somewhat later than their counterparts, South Australia and New South Wales introduced midwives' regulations in 1920 [147] and 1924[148] respectively. In both these states, midwifery practice was contained within Nurses Acts.

New Zealand introduced legislation pertaining to midwives under the Midwives Act of 1904 that appeared three years after the Nurses' Act from which it was quite separate.[149] The Midwives' Act allowed for a Register of Midwives to be kept by the Inspector-General of Hospitals who became its Registrar. The form and location of the register was

142 Ibid., Section 252.
143 *Midwives Act 1915*, (6 GEO. V., No.2773, Victoria).
144 Ibid., Section 7.
145 Ibid., Section 26.
146 Ibid., Sections 18, 21 (a) & (b), 20.
147 *The Nurses' Registration Act of South Australia, 1920.*
148 *Nurses' Registration Act,* 1924, (New South Wales).
149 *The Midwives' Act, 1904* (New Zealand). See also, *The Nurses Registration Act, 1901* (1 EDW. VII, 1901, No. 12, New Zealand).

required to be "a book kept by him in his office".[150] This Act also provided for the establishment of state maternity hospitals where the "pupil nurse" might be taught some aspects of "midwifery work", although provision was also made for community-based instruction. In contrast to the structure of the Australian Acts, the hospital did not represent an exclusive training venue in New Zealand and the supervision of midwives was the responsibility of the local supervising authority in the form of the District Health Officer. Significantly, this Act went further than Australian legislation in not excluding midwives from using certain drugs or instruments in the course of their work, although it did adopt discretionary powers in determining usage.

In the same way that New Zealand acknowledged a midwife role and not solely a nurse-midwife combination, the British Midwives Act of 1902 established a Central Midwives' Board to frame the rules relating to the regulation of midwives' practice.[151] Although this Act was considered to be British legislation, it applied to England and Wales only and did not extend to Scotland or Ireland.[152] The Act was consistent with those initiated to govern midwives in Australia and New Zealand, but it differed from this legislation in two ways. First, membership of the Central Midwives' Board included a representative from the Incorporated Midwives' Institute, so that while the remaining three registered medical practitioners were nominated by the Royal College of Physicians of London, the Royal College of Surgeons of England, and the Society of Apothecaries, midwives were at least given

150 *The Midwives' Act, 1904*. (4 EDW. VII, No. 31, Section 3).
151 Ibid.
152 Ibid., Chapter 17, Section 8.

the opportunity to participate in the process and to identify a spokesperson acceptable to them.[153] Whereas the Nurses' Registration Boards in Australia provided only for medical practitioners and nurse representatives from the ATNA, the Central Midwives Board allowed for rather more diversity, with two persons appointed by the Lord President of the Council, one of whom was required to be a woman; one person nominated by the Association of County Councils; one appointed by the Queen Victoria's Jubilee Institute for Nurses; and one person appointed by the Royal British Nurses' Association.[154] While the composition of the Board exhibited a significant medical and nursing presence that shared similarities with the Nurses' Registration Boards in Australia, the Act allowed for greater autonomy for midwives. This autonomy was achieved in part through the representation of midwives on the Central Midwives Board and through the involvement of local councils.

Second, local authorities rather than the General Medical Council oversaw the practice of the State Certified Midwife in England and Wales.[155] This effectively took control away from the medical profession and placed it with satellite representatives of the state in the form of local authorities. The dissemination of power that resulted was something the medical profession in Britain had opposed throughout its deliberations on the question of regulating midwives.[156] Thus, while the Central Midwives' Board determined the practice code for midwives, it was left to the local council or borough council where the midwife's

153 Ibid, Section 3.
154 Ibid.
155 Ibid., Sections, 8 & 10.
156 J. Donnison, *Midwives and Medical Men: A History of the Struggle for the Control of Childbirth*, p.165.

practice took place, to ensure conformity under the terms of the Midwives' Act. Donnison has portrayed the involvement of local authorities as an extension of medical control, pointing out that the local supervision of midwives was in the hands of Medical Officers of Health who constituted medical authority for the district.[157] But, in the twelve years that it had taken to formulate midwifery regulation in England and Wales, the medical profession had lost ground.[158] At the same time, support for midwives' regulation came from nursing associations who were desirous of achieving a similar status for nurses and who saw midwifery regulation as a precedent that nurses might follow. While some prominent nurse leaders were keen to see midwives and nurses registered jointly, when it came to choosing between medical and midwifery interests, nurses put their weight behind midwives, upholding the moves for separate registration.[159] In keeping with some Australian legislation, the Midwives' Act of 1902 provided the State Certified Midwife with the means to contest the decision of the Central Midwives Board in certain circumstances.[160]

Lying-in facilities

The Queensland state government also debated the question of registration of lying-in facilities and tried to determine the qualifications that owners and managers of such facilities should possess. As this study has shown, it was not unusual for women who acted as midwives or nurses to manage lying-in facilities. Although there was general

157 Ibid., p.177.
158 Ibid., pp.161-166.
159 Ibid., pp.167-168.
160 Midwives Act, 1902, (2 EDW.7, Chapter 17, England and Wales), Sections 3 & 4.

agreement that such premises should be regulated, discussions in the Legislative Assembly reflect conflicting interests in relation to both mothers and the midwives in rural areas. Again, concerns centred on the ineligibility of many women who acted as midwives and who managed lying-in facilities to qualify for registration under the impending Act. It was argued that the regulations that were intended to govern private hospitals, including lying-in facilities, would further disadvantage women currently practicing as midwives. Those midwives who allocated one or two beds in their own homes for lying-in purposes would be prohibited from continuing this practice at considerable loss to a local community. The Home Secretary explained that the issue of registering private hospitals had come about because:

> It is considered desirable that local authorities should have some control over private hospitals and nurses and that both should be registered.[161]

A proposal was put to the Legislative Assembly that nurses who had been managing a private hospital during the three-year period immediately prior to the first day of January 1912 should be exempt from any conditions associated with registration.[162] It was argued that to require such nurses to undertake formal examination would be an injustice to midwives who made one or two beds available for women during their confinement but who received no financial recompense for this action. It was suggested that a compromise might be reached if a medical practitioner could be called upon to vouch that the women had

161 ORDLCA, Vol. CVIII, 1912, p.519.
162 Ibid., p.724.

practised as a nurse for three years and was competent in the performance of her duties.

James O'Sullivan of Kennedy took the argument further, declaring that he was unsure that the amendment would fulfill the need because it did not take into account the many women who were proficient nurses but who had never been in charge of a private hospital. His position is recorded in the following terms. Hansard paraphrased O'Sullivan's oration thus:

> There were scores of women who were well versed in midwifery who, had never been in a private hospital, and yet the amendment provided that they must have been nurse in charge of, or had performed other responsible duties in connection with a private hospital during the three years immediately preceding the first day of January, 1912. In his own district the amendment would not do at all. There were women there who were as capable nurses as any to be found in the city of Brisbane. In fact, not long ago a case came under his notice where a certificated nurse did not give the satisfaction that one would expect, whereas they knew that these women in the bush, who had got on diplomas, did far better work than the qualified nurse did here.[163]

The state had, then, come some way to addressing the issue of infant death through concealment. It had made it difficult for mothers and midwives to obscure loss of infant life through abortion or infanticide under the guise of a lying-in establishment. Similarly, those child minders whose neglect or ignorance was responsible for the deaths of infants in their care would be less likely to go undetected.

Under the terms of the Health Act Amendment Act, only a registered nurse or a medical practitioner could apply for a certificate of registration for a private hospital. There were two categories of private hospitals.[164] The first was a general hospital that included "midwifery

163 Ibid.,p. 725.
164 *Health Act Amendment Act of 1911*, Section 69–70.

cases" and the second, a lying-in hospital that dealt exclusively with midwifery care. The terms under which the certificate of registration was granted were, seemingly, empowering for nurses. The Act enabled a registered nurse to obtain a registration certificate for a private lying-in or nursing institution provided that she resided continuously on the premises.[165] In the case of the proprietorship being issued to a medical officer, he (the Act does not allow for female medical practitioners) could nominate either a registered nurse or a medical practitioner to deputise for him during his absence.

The hospitals were to be available for inspection by the medical officer of health (sic) and heavy penalties were to be imposed if the hospitals were put to any use other than that for which they were registered.[166] Certificates were to be issued annually by the local authority and the records of the hospital were to conform to government guidelines and be available for inspection at the government's discretion. For lying-in hospitals, a fee of two pounds sterling was payable for initial registration and subsequent renewal of the registration certificate. By these measures, the state sought to discourage practices that it associated with infant death. It now had the means of ensuring that only those people determined by the state as appropriate, would be placed in charge of a lying-in facility or one that took in infants. Were any recalcitrant practices to occur, they would be difficult to conceal under the pressure of impromptu government inspections and government-regulated bookkeeping. An additional

165 Ibid., Section 76.
166 ORDLCA, Vol. CVIII, 1912, p.519.

clause in the Act sought to reduce the incidence of infanticide by concealment as a stillbirth. Specifically, the Act stated that:

> When a female is delivered in a private hospital of a still-born child, no interment or other disposal of the body of such child shall take place without its being authorised by the written certificate of a medical practitioner or police magistrate.[167]

Non-compliance with this directive carried the penalty of a maximum financial outlay of up to one hundred pounds sterling, or up to one years' imprisonment, "with or without hard labour".[168] The Health Amendment Act of 1911 had, therefore, gone some way to address the pressing concerns of state. In the process, it provided the means through which the medical profession was able to gain a stronghold over childbirth and paved the way for the Maternity Act of 1922 that consolidated medical and political agendas in relation to childbirth and midwifery practice.

The Maternity Act, 1922

While the Infant Life Protection Act and the Health Act Amendment Act focused on the regulation of childminders and midwives and the premises in which infants were born and reared, the Maternity Act of 1922 attempted to teach mothers mothering.[169] In its initial stages, debaters of the Maternity Bill admitted that:

> Probably, in connection with a lot of legislation that passes through this Chamber, we lose sight of the fact that women constitute very nearly half the population.[170]

It was further pointed out that every child was, "an asset to the State", and the question was posed:

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167 *Health Act Amendment Act of 1911,* Section 79 [153L].
168 Ibid.
169 ORDLCA, Vol. CXL, 1922, p.1854.
170 Ibid., p.1763.

> What Bill can be more important for hon. Members to consider than one which aims at decreasing the death rate of the mothers and children of this State, which aims at minimising the risk during the critical period of childbirth, which aims at increasing the birth rate, and making it easier for mothers to bear children?[171]

In 1922, the Queensland Legislative Assembly heard that during the First World War Australia lost 17,672 lives in the years up to the end of 1916. In the same period, the loss of infant life in Australia amounted to 32,000 children.[172] In speaking of "the Australian baby" as "the best asset that we can have",[173] the Assembly was urged to support the Bill and assured that the amount of £150,000 that would be needed to implement the provisions of the Bill would be made available from "Golden Casket" lottery funds.[174] In what might be considered the final phase in Queensland's commitment to childbirth reform, the Maternity Act of 1922 set Queensland upon a path of hospitalisation that would take the culture of childbirth and the role of the midwife into the next millennium.

Conclusion

As this chapter has demonstrated, the medical and political debates that surrounded the transformation of the role of the midwife in Queensland culminated in the passing of legislation that has endured and strengthened. While previous chapters have conceded that changes were necessary to midwifery practice, education and the role of the midwife in society, this chapter has explored the motivation for creating a midwifery nurse rather than a midwife. It has shown that

171 Ibid., p.1854.
172 Ibid., p.1860.
173 Ibid., p.1862.
174 Ibid., pp.1872-1876.

although the medical fraternity was divided on the issue of the regulation of midwives, the overall objectives were the same. One argument saw registration as a means of controlling the autonomy of the midwife, while the other proposed that registration would only enhance the scope of midwives' practice. Both viewpoints agreed that the midwife was a source of nuisance, but the way in which that nuisance should be treated was the point of difference. The solution, when it came, met the needs of the medical profession and those of politicians. It also served Queensland society by providing women with a consistency in the midwife role that had hitherto been absent.

While the medical profession was preoccupied with ensuring the subjugation of midwifery, the state was devising ways of increasing its population through enhancing the capacity of its human resources. Its most prized possession was infant life and the state's attention was directed to the preservation of that life. The previous chapters have highlighted the conditions and circumstances that were linked to maternal and infant deaths. In the passing of the Health Act Amendment Act, the Queensland government addressed some of the most important factors that, along with the medical profession it had identified as contributing to loss of life in childbirth and infancy. The provisions instituted for the regulation of midwives served both as a structural framework for controlling midwifery practice and a basis for subsequent legislation in relation to midwifery and nursing in the years to come.

CHAPTER EIGHT

DISCUSSION AND CONCLUSION

> …the facts of history never come to us 'pure',…they are always refracted through the mind of the recorder.[1]

This thesis has explored the factors that underpinned the regulation of midwifery practice that began in Queensland in 1912 when the Nurses' Registration Board was established to oversee the practice of nurses and midwives. The thesis has addressed the question of *why* and *how* the role of the midwife in Queensland was transformed from a lay practice situated predominantly in the home, to a certificated occupation located in the hospital institution. It has argued that the founding of the Nurses' Registration Board was a crucial factor in the framing of the midwife role in Queensland and a sustaining influence on the subsequent development of midwifery practice in that state. In support of this contention, the thesis has focussed on the work of lay midwives and the forces that impacted upon the transition of midwifery practice by midwives from untrained to qualified.

The thesis has identified the medical profession and the state as the foremost influences on the regulation of midwives. However, these pressures were themselves products of the broader social, cultural, political and economic environment within which they existed. It would be too great a simplification, therefore, to accept the regulation of midwives as a medical and state tactic directed solely at limiting the

[1] E. H. Carr, *What is History? 2nd edition*, p.22.

practice of lay midwives and to omit from the account the importance of death in childbirth. Although the correlation between lay midwives and maternal and infant death has since proved invalid, using contemporaneous statistics, the medical profession was keen to advance this theory.

Loss of maternal and infant life preceding, during and following childbirth, therefore provided the motivation for medical and state intervention in the practice of lay midwives. Whether as a contrived objective or an unanticipated aftermath, the medical profession took up the issue of childbirth mortality and used it to demonstrate its scientific prowess in a clinical field that had hitherto been, essentially, outside its sphere of practice. By isolating lay midwives as a discrete social group and directing the blame for maternal and infant deaths at them, the medical profession was well positioned to claim midwifery as its own. With midwifery as a branch of medical practice the medical profession could steer childbirth culture in the direction *it* felt was best for all concerned.

While death in childbirth may have acted as an enabling device for the medical profession, to the state, it represented a serious obstacle to its plan to populate through reproduction. And the medical profession and the state were not alone in their endeavours. They were assisted by women of the middle class, whose humanitarian ideals motivated them to concentrate their efforts on people whom they considered to be less fortunate than themselves. The willingness of these middle class women to accept responsibility for assisting the

poor and destitute emerged as a significant factor in the decision to provide institutional lying-in facilities that, in turn, became crucial to the moulding of the midwife role.

With the focus upon the preservation of maternal and infant life, medical men and politicians sought the backing of their wives and daughters to establish a benevolent facility where the "unfortunates" might give birth in relative safety. Here, birth could be managed and supervised by "medical experts" who were aided by a team of "midwifery nurses". The increasingly popular notion of the "trained nurse", that was itself the product of the hospital institution, therefore proved to be an additional source of support for the advocates of midwifery regulation. The functions of midwife and nurse were already indistinct and the title "midwife" and "nurse" was often interchanged. Combining these designations therefore acted as a catalyst by which the work of midwives was re-defined and re-interpreted. It is a revision that continues to thwart those who seek to classify and understand the work of midwives and the sphere of midwifery practice in Australia.[2]

The lay midwife

Integral to this thesis has been the notion that the role of the midwife was manipulated from outside. Further, the argument has been put that midwives were not representative of a recognisable group and that this, together with the haphazard nature of their practice, defeated accurate classification of the midwife role. An adjunct to this contention is that lay midwives were poorly positioned to

2 P. Brodie, L. Barclay, "Contemporary issues in Australian midwifery regulation", pp.109-110.

identify and develop their own practice. For the most part, these were women who stepped in, often with little prior warning, to *do what they could* at a crucial time. The lack of organisational structure and the tendency of midwifery work to be re-active rather than pro-active disadvantaged lay midwives and robbed them of the opportunity to contemplate their role, to predict the implications of their practice, and to determine their future direction.

In the absence of sound occupational foundations developed by midwives themselves, the lay midwife was vulnerable and impotent. Without a comprehensive knowledge base and bereft of the support of informed colleagues, the lay midwife was something of an anomaly, an incongruous being that fulfilled a need at a time when few other options were available. As such, the midwife role became an easy target for manipulation, or even capture, by any group that might be interested in extending its occupational parameters or promoting its professional standing. While the medical profession sought to dominate midwives, the nursing body hoped to amalgamate with them. The combining of midwives with nurses that began in Queensland in 1912 eventually resulted in the capitulation of midwifery practice and its total submersion by nursing. The channelling of midwifery practice into the assemblage of nursing has been demonstrated throughout Australia and has been underpinned by legislation.[3]

In Queensland in the opening years of the twenty-first century, the roles of midwife and nurse exist in a contrived union that began

3 *Nurses Act, 1999*, (South Australia); *Nursing Act, Dec. 2001*, (Northern Territory); *The Nurses Act, 1992*, (Western Australia); *Nurses Act, 1991*, (New South Wales); *Nurses Act, 1993,* (Victoria); *Nurses Act, 1988,* (Australian Capital Territory).

almost a century before. To some, such unification represents a necessary and proper extension of nursing practice. To others, nursing and midwifery *are not* complementary and *do not* share the same professional ideals.[4] When, in 1912, the decision was made to forge an alliance between midwives and nurses, midwives lost both the opportunity to establish their own secular identity and the ability to determine their professional fate. In relinquishing their uniqueness and distinctiveness as midwives and in merging with nurses, midwives lost the potential for self-determination that has proved to be a key factor in the strengthening of the midwifery role overseas.[5]

In 1912, lay midwives in Queensland allowed the medical profession to define their occupational structure, senior nurses to determine their practice parameters, and the state to articulate their territorial boundaries. In so doing, midwives forfeited the right to the professional status that has been equated with midwives in countries overseas. For example, Britain, where a midwife is considered to be "an independent practitioner in her own right"[6] rather than an instrument of nursing or medicine, [7] or the Netherlands, which has held a long tradition of midwife-led births.[8] But, realistically, in 1912 midwives in Queensland had neither the collective vision nor the professional scope to achieve much else.

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4 C. Flint, *Communicating Midwifery: Twenty Years of Experience*, pp.7-8.
5 P. Brodie, L. Barclay, "Contemporary issues in Australian midwifery regulation". See Also, S. Tracy, L. Barclay, P. Brodie, "Contemporary Issues in the Workforce and Education of Australian Midwives".
6 V.R. Bennett, & L.K. Brown, (eds) Myles Textbook for Midwives 12th edition, p.4.
7 Ibid.
8 M. Tew, *Safer Childbirth? A Critical History of Maternity Care, 2nd edition,* pp.79-80.

The medical practitioner and the medical profession conglomerate constituted a powerful influence on the way in which midwifery practice developed in Queensland. An important aspect of that influence was the differences that existed between the work lay midwives and that of medical practitioners and the ways in which those separate roles were perceived. In any comparison between the lay midwife and the qualified medical practitioner, the absence of defining characteristics that fully represent the lay midwife role constitutes a serous handicap to the analysis. Whereas the medical practitioner and the medical profession conformed to a certain type that encapsulated their work as individuals and conveyed a sense of what they were as a collective, the untrained midwife took many forms and defied a communal definition. There were, however, overriding features in relation to the roles of midwife and medical practitioner that were seldom, if ever, broached.

For the most part, the lay midwife existed on a social level that was far removed from that of the medical practitioner. Midwives were working class women who had received little more than a rudimentary education and who were often illiterate. Their gender and class were limiting factors that inhibited their social mobility and contained their political prowess. They were mature practical women who relied upon their experiences of life and death to guide them in their work as midwives. Their skills in midwifery constituted a combination of domestic remedies and tried practices that were based upon women's knowledge of women's business. Their understanding of childbirth was

grounded in the everyday realities of their lives and those realities were often harsh and unremitting.

The world of the untrained midwife was one in which she was born, herself gave birth, and died, without receiving or expecting to receive an acknowledgement of the contribution she had made to childbirth, to midwifery practice, and to the community she served. Those whom she succoured remember her as a good woman who *did what she could* in times of need, but no lasting monument to her work was committed to the history books of Queensland. The lay midwife was virtually invisible, except on those occasions when the death of a mother or an infant in childbirth drew attention from outside and placed the work of the untrained midwife under intense scrutiny.

For many of the women who looked to the untrained midwife for assistance in childbirth, life was a relentless struggle that was frequently worsened by poverty and the hardships that accompanied it. These women were familiar with the trials and dangers that they took to be normal accompaniments to childbirth and they approached it with an inevitability borne of acceptance and conditioning that was culturally perpetuated and socially diffused. To put it another way, working class women expected nothing more than they were offered and they were offered nothing more than they could afford.

The working class women, who have been the focus of this study, depict a life of drudgery and hardship. Those whose efforts were sustained by husbands and whose childbirth was assisted by a midwife relative or friend, or one who had been called in for the

purpose, represent a relatively fortunate group in comparison with the unmarried mother who gave birth to her illegitimate offspring alone and without any form of financial or social support. Medical and state involvement changed that and provided women with an option for childbirth that had hitherto been available only to the minority.

It is from official records that this thesis has examined the work of the lay midwife. In so doing, it has been forced to focus on problematic childbirth and to base its assessment on the *minority* and the *unusual* rather than to evaluate the *majority* and the *mundane*. It has also had to take into account that these testimonies were often written *about* untrained midwives rather than *by* them and that those accounts were compiled and assessed by literate men of elevated social status. When childbirth resulted in the death of mother or infant, the birth situation was suddenly caught, as though in spotlight, as the actions of those involved, family members, neighbours, friends, and midwives, were tested and examined.

The lay midwife was an easy target. She was exposed in both a social and occupational sense. She was the principal birth attendant, she was without benefit of formal training, and she lacked credentials. The circumstances in which the woman had given birth and in particular, the people who attended her, became the centre of interest as reasons were sought for the untimely demise. When childbirth resulted in death, blame had to be apportioned somewhere. Blame was unlikely to be directed at the medical practitioner. Occasionally, blame was attributed to the woman or her husband, but most often, it

was centred on the midwife. Midwives were a persistent and dominant presence in childbirth, yet the nature of their work made rendered them unobserved, unmonitored, and unaccountable.

The medical practitioner

The medical practitioner contrasted in every way to the lay midwife. As a financially secure and socially respected male in a strongly patriarchal society, the medical practitioner was able to access the education and lifestyle that his middle class status naturally afforded him. The Medical Acts laid the foundations for professional medical practice and enabled its practitioners to adopt exclusionary techniques to protect this elite group from outside interference. The medical profession thus became an expert group whose advice was sought in all matters of health and illness. This group was an eminently powerful force that was able to influence policy-making from inside and outside its own professional territory.

Medical knowledge was based upon a conceptualisation of the human body as a machine that either functioned as expected or exhibited signs of malfunction in the form of injury or disease. Medical practitioners acquired their initial understanding of wellness and disease in a university environment and they built upon this knowledge in a contrived clinical setting where people were amassed for the purpose of being examined and having their clinical “condition” diagnosed and treated. The medical profession shared its accrued knowledge at collegial gatherings and through the medium of professional journals. The work of the medical practitioner and the

accumulated wisdom of the medical profession were transferred into histories of medicine through the annals of those who practised it.

The differences that existed between the untrained midwife and the qualified medical practitioner may not have mattered overly had the issue not arisen over the right to dominate the province of childbirth. When that happened, and the medical profession was forced to recognise the unsolicited power that the lay midwife held in childbirth, change was inevitable. Change, when it came, coincided with the state pursuit of population growth through reproduction and occurred at a time when childbearing women were becoming increasingly receptive to the promise of safer and more humane childbirth.

The institution of the hospital

The lying-in hospital, while not without its faults, met the joint objectives of the medical profession and the state. It provided a teaching venue for medical students, a training facility for nurses and midwives and a clinical practice setting for all. The hospital institution gave women a place to birth where they were guaranteed, free of charge, the services of a midwife and the expertise of the medical practitioner. As a birth location, the hospital was less familiar than the home and the attendants it provided were likely to be strangers rather than friends or relatives, but it was promoted by the state and sanctioned by the medical profession.

The alternative might be to give birth in a tent or a humpy, with or without assistance from a woman acting as midwife, who may or may not be competent or experienced. Women had little to lose when

the alternative to entering a hospital might be to birth alone or to be attended by a lay midwife whose occupational scope relied upon outmoded and ineffectual practices and whose ability to bring about the safe birthing of mother and child was likely to be inhibited by lack of adequate facilities.

The advent of the lying-in hospital brought with it not only other *options* for childbirth but also a different *type* of childbirth from that which had existed previously. The lying-in hospital became the hub where medical practitioners learnt about "obstetrics" and obstetricians applied the new technological advances that were rapidly becoming characteristic of their practice. In this, the domain of the obstetrician, the midwife was imbued with principles intrinsic to the role of "obstetric nurse", the mother was taught the foundations of motherhood, and both she and her infant were perceived of as "patients". In 1912, the hospital as a birthing venue played a minor role in the culture of childbirth in Queensland, but it created an exemplar that met the needs of the medical profession and the state, and its importance escalated.

The dual function of the institution as a sanctuary for the destitute parturient woman and a venue for teaching obstetrics was challenged in the latter years of the twentieth century. [9] The argument was put that hospitalised childbirth both strengthened the position of the already powerful hospital obstetrician and situated childbirth as a medical event. While the use of the lying-in institution might now be seen in this light, it is difficult to suggest other options that might have

9 M. Tew, *Safer Childbirth: A Critical History of Maternity Care, 2nd edition*, p. 46.

provided solutions to the problems with which childbirth and infancy were plagued during the study period.

Perhaps one possibility might have been to support the continuance of childbirth in the home, but the argument against domiciliary births in Queensland at the time was the size of its land area, the relative spareness of its population, and the distances between settlements.[10] Indeed, given the complications that have been highlighted in this thesis, it is difficult to see how such challenges might have been overcome without removing childbirth from the home environment.

The impact of the trained nurse

The redefining of the midwife role was strongly dependent upon the social construct of the trained nurse. But midwifery practice is different from nursing practice in that it derives from a wellness perspective in which the focus of its attention, childbirth and the rearing of the neonate, are looked upon as normal life events that benefit from facilitation rather than as clinical conditions that require treatment. In 1912, this distinction was overlooked, ignored or misunderstood and the roles of midwife and nurse were drawn inextricably toward a merger that continues to the present day.

To the trained nurse, the acquisition of midwifery certification offered occupational versatility and greater opportunity to work in rural and remote areas than a nursing qualification alone. The formation of a nursing group under the direction of the Australasian Trained Nurses'

10 ORDLCA, Vol. CVIII, 1912.

Association distinguished the “trained nurse” from the “untrained” and promoted the interests of nursing as a female occupation. This Association made little of the distinction between midwives and nurses but, rather, promoted the conceptualisation that being a nurse was somehow more “professional” than being a midwife. The creation of a “midwifery nurse” and the conceptual linking of midwifery and nursing practice, gave credence to the belief that the work of midwives and nurses was complementary and interchangeable. As this thesis has argued, this perception ultimately acted to the detriment of midwives.

While the alignment of midwives and nurses served to bring to nursing practice an enhancement it had previously lacked, it denied midwives the independence they would need in order to establish their practice parameters and determine their professional scope. Prior to 1912, the untrained midwife had enjoyed a degree of freedom that was not shared by the trained nurse. The lay midwife pursued an occupation that was home based and community oriented; the trained nurse was a product of the hospital institution and the subject of an organisational structure that guided and controlled her working life. After 1912, the midwife role was slowly and systematically incorporated into the confines of the hospital and placed within the parameters of its control.

Although the decision to send trainee midwives into the hospital and to require them to “nurse” their “patients” may now be seen as an unsuitable option, at the time, there were few other choices. It was improbable that in 1912 the regulation of midwives could have taken

any form other than that which it took. The inclusion of midwives within the controlling mechanism of the Nurses' Registration Board might, arguably, have set them on a path towards *greater* professional status rather than *less*. In the same way, there was logic in providing institutional facilities where available resources, monetary, material and human, might be amassed for the benefit of those in need. That the end result was the ascendancy of the medical profession within the hospital institution and its dominance over other occupations was as much a consequence of the value society placed on what the medical profession had to offer as on its power as a united body to attain its occupational goals.

The agenda of the state

The state shared with the medical profession the burden of transforming midwife practice and in creating the "midwifery nurse". As far as the state was concerned, its prime objective was to devise a means of increasing population through the mechanism of reproduction and of maintaining the health of Queenslanders through revisions to food practices and improvements in environmental health. The state anticipated achieving its aims by making people accountable for the services they offered. In terms of childbirth, the state devised a regulatory process that, over time, would enable it to monitor and control the factors that impinged most notably upon population growth that occurred through childbirth.

The first step in the process was the Infant Life Protection Act of 1905 that required the registration of baby-minders and nursing homes

where babies might be housed.[11] The next step was the Health Act Amendment Act of 1911, that provided for the regulation of midwives and nurses and the registration of premises used for lying-in.[12] Although midwives were connected with lying-in facilities as both owners and workers, their presence was most significant in the environment of the home. The state could not legislate for every home that was the site of childbirth. It could, however, legislate to contain the work of midwives wherever they practised. Thus, the Health Act Amendment Act obliged midwives to practice according to specified guidelines and it prevented them from acting as midwives unless these directives were met. The final phase of the campaign to populate and preserve life was the Maternity Act of 1922, which endorsed lying-in facilities throughout the state and in so doing, removed the stigma of pauperism. This Act is of particular significance to the history of midwifery practice in Queensland because it represents the point at which women began to be actively encouraged to move from the home to the hospital for childbirth. This Act took into account the impact that prenatal and postnatal issues may have upon the wellbeing of mother and infant by providing for the "nursing" of antenatal and parturient women and their infants.[13] By these means, the state discharged *its* responsibility to the citizens of Queensland in doing what *it* could to promote state and federal ideals.

11 *Infant Life Protection Act of 1905,* (5 Edw. VII. No. 19).
12 *The Health Act Amendment Act of 1911*, (2 Geo. V. No. 26).
13 *The Maternity Act of 1922*, (13 Geo. V. No. 22).

Summary

It remains to be determined who benefited the most from the transition of midwifery practice from lay to qualified. On the face of it, the medical practitioners have had the greater percentage of gain. In the twenty-first century the medical profession holds the monopoly on maternity care and promotes itself as the optimum service provider. Nurses continue to claim midwifery as a branch of their own particular science and are content for it to continue as an endorsement to nurse registration. But circumstances are changing and there are indications that the work of midwives is coming under scrutiny once again.

For, just as history is not a static chronicle of past events, childbirth culture and the role of the midwife within it are part of a vibrant and developing process. In the twenty-first century, midwives in Queensland continue to provide an essential service and to act as principal birth practitioner in the majority of uncomplicated childbirth. The restrictions that inhibited them in the early years of the twentieth century do not pose the obstacles they once did. Midwives are no longer excluded from educational programs on the basis of class or gender. And, as long as they are prepared to gain a qualification in nursing, they are free to pursue a career in maternity care without hindrance. In some states outside Queensland, university courses are available that focus on preparing a *midwife practitioner* rather than a *nurse who practices midwifery*. These are important innovations in the history of midwifery practice in Australia that represent a deviation from the prototype that has guided it for almost a century.

However, midwives in Queensland currently show little inclination to re-define the parameters of their role. They seem, for the most part, content to remain under the auspices of nursing and to work within the mantle of the hospital institution. Yet, moves are afoot, instigated by a minority group of midwives both in Queensland and elsewhere in Australia, to re-examine the viability of the midwife role on behalf of *all* midwives. It remains to be seen whether this reappraisal will alter the enforced bonds between midwives and nurses and whether the links that exist between them will strengthen or weaken as a result.

It is possible that the occupational path that was etched out for midwives in 1912 was one that suited them then and continues to meet their expectations now. Conversely, it may be that only when universities in Queensland offer prospective midwives courses specific to midwifery and which lead directly to qualification as a midwife, will midwives in Queensland begin to recognise their potential for professional advancement. The time may be approaching when midwives in Queensland will have to decide whether to grasp the discipline of midwifery and reclaim it as their own, or to continue to preserve it as a specialist branch of nursing that lies within the greater authority of obstetrics. Whereas the untrained midwife of the past *did what she could* to help women in childbirth, the midwife of the present may have the equally onerous task of determining the future direction of midwifery practice in Queensland for the remainder of the twenty-first century.

A P P E N D I C E S

APPENDIX ONE

APPENDIX ONE

CARTOGRAPHICAL REPRESENTATION OF LOCATIONS OF MATERNAL AND INFANT DEATHS EXAMINED IN THE THESIS

A P P E N D I X T W O

APPENDIX TWO

EXAMPLE OF CORONIAL AND MAGISTERIAL TESTIMONY UPON WHICH THE STUDY HAS BEEN BASED

A P P E N D I X T H R E E

APPENDIX THREE

INFANT DEATHS DISCUSSED IN CHAPTER TWO

1868-1895

NAME	PLACE	DATE	CAUSE OF DEATH	LOCATION NUMBER
Pillows, (newborn infant)	Roma	21.08.1868	Natural causes few hours after birth	JUS/N19 68/170
Gardner, (illegitimate child of Susan)	Dalby	12.02.1873	Died while being born	JUS/N36 73/56
Rawcliffe	Toowoomba	18.12.1876	Stillborn	JUS/N51 76/336
Bray, Nellie	Mount Morgan, Rockhampton	16.06.1895	Premature birth	JUS/N233 193/1895
Dagg, infant of Amy Jane Dagg	Oakley Flat Caboolutre	25.06.1895	Natural causes	JUS/N234 201/1895
Kucks, (infant of Julia Degen and Rudolph Kucks	North Brook Creek Sandy Creek Esk	21.07.1895	Bladder on the navel string	JUS/N234 235/1895

Source: QSA, Justice Department, Index to Inquests 1859-1886, 1887-1897.

APPENDIX FOUR

APPENDIX FOUR

PROPORTION OF BIRTHS AND DEATHS TO THE MEAN POPULATION FROM 1860 TO 1912

YEAR	EST. MEAN POPULATION	BIRTHS	DEATHS	NUMBER PER 10,000 POPULATION	
				BIRTHS	DEATHS
1860	25 788	1 236	478	47.93	18.58
1861	31 211	1 423	500	45.59	16.02
1862	39 722	1 702	797	42.85	20.06
1863	53 358	2 221	1 275	41.62	23.89
1864	67 838	2 883	1 446	42.49	21.32
1865	80 920	3 532	1 733	43.65	21.42
1866	92 003	4 127	2 362	44.85	25.67
1867	98 025	4 476	1 745	45.66	17.80
1868	103 638	4 460	1 799	43.03	17.36
1869	108 662	4 654	1 761	42.83	16.21
1870	112 732	4 905	1 645	43.51	14.59
1871	120 356	5 205	1 785	43.25	14.83
1872	129 350	5 265	1 936	40.70	14.97
1873	140 122	5 720	2 250	40.82	16.06
1874	155 103	6 383	2 794	41.15	18.01
1875	172 402	6 706	4 104	38.89	23.80
1876	184 194	6 903	3 467	37.48	18.82
1877	195 092	7 169	3 373	36.74	20.41
1878	206 797	7 397	4 220	35.77	20.41
1879	214 180	7 870	3 207	36.74	14.97
1880	221 964	8 196	3 017	36.92	13.59
1881	221 011	8 220	4 220	37.19	15.02
1882	237 611	8 518	4 274	35.85	17.99
1883	267 865	9 890	5 041	36.92	18.82
1884	298 694	10 679	6 861	35.75	22.97
1885	318 415	11 672	6 235	36.66	19.58
1886	332 510	12 582	5 575	37.84	16.77
1887	354 777	13 513	5 166	38.09	14.56
1888	377 201	14 247	5 529	37.77	14.66
1889	397 061	14 401	5 529	37.77	14.66
1890	414 716	15 407	5 638	37.15	13.59
1891	404 772	14 715	5 170	36.35	12.77
1892	415 813	14 903	5 266	35.84	12.66
1893	426 798	14 384	5 695	33.73	13.34
1894	438 727	13 977	5 2 98	31.86	12.08
1895	452 852	14 874	5 152	32.85	11.38
1896	466 364	14 017	5 645	30.06	12.10
1897	478 444	14 313	5 423	29.92	11.33
1898	492 602	13 933	6 243	28.28	12.67
1899	508 864	13 899	6 144	27.31	12.07
1900	490 325	14 801	5 747	30.19	11.72
1901	505 695	14 303	6 007	28.28	11.88
1902	513 612	14 216	6 204	27.68	12.08
1903	512 690	12 621	6 346	24.62	12.38
1904	519 178	14 082	5 250	27.12	10.11
1905	525 728	13 626	5 503	25.92	10.47
1906	532 783	14 019	5 095	26.31	9.56
1907	541 204	14 542	5 599	26.87	10.35
1908	555 171	14 828	5 680	26.71	10.23
1909	571 044	15 554	5 530	27.24	9.68
1900	592 201	16 173	5 745	27.31	9.70
1911	614 352	16 991	6 544	27.66	10.65
1912	631 577	18 758	6 921	29.70	10.96

Source: Statistics for the State of Queensland for the year 1920 Compiled from Official Records in the Registrar-General's Office, (Brisbane: Anthony James Cumming, 1921), p.17H.

APPENDIX FIVE

APPENDIX FIVE

MATERNAL INQUESTS 1859 - 1912

NAME	PLACE	DATE	CAUSE OF DEATH	LOCATION NUMBER
Adam, Annie	Brisbane	22.12.1901	1. Extrauterine pregnancy 2. Rupture of cyst 3. Haemorrhage syncope	JUS/N302 37/1902
Ah Hee, Mary Roda	Pentland	05.12.1912	Delivering a stillborn premature child	JUS/N513 694/1912
Bachmann, Augusta	-----	24.07.1882	Died in childbed from exhaustion	JUS/N85 82/236 Z3436
Bade, Johanna	Marburg	28.01.1892	Confinement	JUS/N197 48/1892
Bartlett, Johanna	Woogaroo Asylum, Oxley	20.05.1894	Puerperal mania	JUS/N223 181/1894
Baumgarten, Margaret	Charters Towers	13.04.1893	Exhaustion through premature birth	JUS/N213 251/1893
Beck, Mary Ann	Christmas Creek	03.02.1887	Giving birth to a child	JUS/N140 62/1887
Beckett, Ann	Paris St, Brisbane	17.02.1885	Puerperal Fever	JUS/N117 85/175
Berndt, Caroline,	-----	19.01.1882	Exhaustion from childbirth	JUS/N88 82/391
Bidgood, alias Ross, Mary	Reception House Rockhampton	12.11.1873	Puerperal Mania	JUS/N38 73/228
Birkbeck, Annie wife of Charles	South Brisbane	01.10.1897	Puerperal melancholia	JUS/N256 433/1897
Bowers, Mary	Dalby	17.10.1884	Childbirth (through neglect)	JUS/N109 84/455
Bridges, Sarah	Oakey Creek, Toowoomba	07.05.1868	Exhaustion, while in child bed	JUS/N19 68/105
Brooks, Catherine Mary	Roma Gaol, Roma	03.01.1898	Puerperal insanity	JUS/N259 7/1898
Brown, Elizabeth	Aramac	23.06.1878	Exhaustion following childbirth	JUS/N58 78/171
Budda, Sarah	Rockhampton	21.08.1897	Haemorrhage after childbirth	JUS/N254 349/1897
Buttune	Yeppoon Sugar Plantation, Rockhampton	23.10.1895	Confinement	JUS/N179 334/1895
Byrne, Mary Ann	Palm Creek, Logan	30.07.1890	Exhaustion after confinement	JUS/N179 333/1890

NAME	PLACE	DATE	CAUSE OF DEATH	LOCATION NUMBER
Casey, Julia	Townsville	27.11.1871	Childbed	JUS/N31 71/178
Corcoran, Mary	Tambourine, Logan	07.08.1888	Exhaustion after confinement	JUS/N157 325/1888
Cull, Mary	Reception House, Brisbane	09.04.1873	Puerperal fever	JUS/N36 73/74
Cullinan, Bridget	Barcaldine	25.04.1895	Shock and exhaustion after childbirth	JUS/N233 158/1895
Creevey, Esther	Monal, Eidsvold	19.11.1899	Natural causes after childbirth	JUS/N279 497/1899
Dennis, Mary Ann Elizabeth	Lunatic Reception House, Brisbane	21.01.1886	Puerperal mania	JUS/N129 80/109
Deut, Sarah	Mount Cannindal, Eidsvold	14.08.1899	Childbirth	JUS/N376 361/1899
Dietz, Anna	Brisbane	31.08.1880	Puerperal convulsions eclampsia	JUS/N70 80/198
“Dinah”	Pentland	08.08.1906	Veneral disease	JUS/N361 420/1906
Doothoo, Mahan	Brisbane	01.05.1900	Eclampsia while bathing	JUS/N284 199/1900
Dove, Luisa	Cecil Plains Station	15.12.1869	Died after giving birth to a dead baby, with another one to come	JUS/N23 69/A56
Downes, Mary	Brisbane	07.04.1875	Haemorrhage from inversion of the womb after childbirth	JUS/N44 75/153
Evans, Ellen	Upper Caboolture	11.02.1888	Exhaustion after birth brought on by weakness	JUS/N152 74/1888
Fox, Florence Hannah	Brisbane	30.11.1906	Childbirth and peritonitis	JUS/N369 551/1906
Fraser, Muriel May	Nambour	21.11.1911	Antepartum haemorrhage Placenta praevia	JUS/N482 540/1911
Fritsch, Wilhelmina	German Station	18.12.1867	Excessive haemorrhage after childbirth	JUS/N17 67/230
Gallagher, Agnes	Dyarina, Rockhampton	Between 21. And 22 Oct. 1898	Supposed blood poisoning after childbirth	JUS/N268 468/1898
Gambling, Elizabeth, Mrs.	Waterfiled, Ipswich	22.08.1871	Haemorrhage subsequent to labour	JUS/N30 71/131
Garvey, Katie	Cunnamulla	22.06.1908	Eclampsia and coma	JUS/N400 325/1908
Glenwright, Mabel Victoria (married woman)	Charters Towers	23.06.1910	Postpartum haemorrhage	JUS/450 386/1910

NAME	PLACE	DATE	CAUSE OF DEATH	LOCATION NUMBER
Goan, Hanah	Dugandan	29.01.1893	Cramps after childbirth	JUS/N209 57/1893
Godfrey, Matilda	Mount Carbine, Mareeba, Atherton	23.07.1901	Childbirth septicaemial infection Exhaustion	JUS/N484 586/1901
Gorman, Mary Ann	North Brisbane	01.06.1860	Exhaustion after childbirth	JUS/N1 60/24
Granke, Caroline A. H. (and baby)	Esk	05.06.1891	Cramps of confinement	JUS/N190 223/1891
Guse, Hohanna	Highfields	21.05.1895	Childbirth	JUS/N233 164/1895
Hahn, Ottilie Johanna	Gatton	09.04.1907	Difficult childbirth	JUS/N374 243/1907
Hammer, Wilhelmina Fredrike	-----	17.07.1885	Cold after childbirth	JUS/N121 85/377
Holz, Elizabeth	Eidsvold	05.02.1892	Confinement	JUS/N198 56/1892
Hopkins, Helen	Woodhill, Logan	23.05.1890	Childbirth	JUS/N176 228/1890
Hutton, Violet Emily Ethel	South Brisbane	16.02.1903	Puerperal fever	JUS/N312 98/1903
Jorgenson, Anna Maria	Brisbane	04.09.1874	Haemorrhage after childbirth	JUS/N42 74/364
Kennedy, Ellen	Gympie	20.04.1909	Puerperal septicaemia Gastritis (acute) : Shock	JUS/N419 225/1909
Klumpp, Sybella	Brisbane	19.09.1877	Puerperal convulsions	JUS/N54 77/231
Last, Catherine	North Brisbane	16.12.1861	Neglect and injudicious treatment from confinement	JUS/N3 61/96
Leschke, Albertine Caroline	Marburg	11.03.1884	Spasms after childbirth	JUS/N102 84/130
Litfur, Rosalea	Gatton	15.05.1904	Haemorrhage after giving birth to a child	JUS/N321 162/1904
Litzour, Wilhelmina Louisa Sophia	Lowood	08.05.1906	Death in confinement	JUS/N353 212/1906
Lonergan, Annie	Mackay	22.12.1881	Puerperal fever	JUS/N79 81/350
Madsen, Hansine Maria (and baby)	Brisbane	15.11.1876	Mother: thrombosis of the heart. Baby:accidental suffocation	JUS/N51 76/302

NAME	PLACE	DATE	CAUSE OF DEATH	LOCATION NUMBER
Mallicole, Lena	Nambour	14.08.1900	Premature childbirth	JUS/N288 367/1900
McLennan, Ann Sommers, Mrs.	Brisbane	10.04.1875	Exhaustion from prolonged labour	JUS/N44 75/154
Morris, Alice Roberts	Brisbane	08.10.1881	Puerperal peritonitis	JUS/N78 81/277
Neal, Caroline	Mount Gemmel	05.05.1885	Exhaustion from childbirth	JUS/N118 85/236
Newton, Eliza	Lunatic Reception House, Brisbane	05.03.1877	Puerperal fever complicated with mania	JUS/N53 77/132
Pansy "A"	Mount Garnet, Herberton	05.09.1899	Childbirth	JUS/N277 396/1899
Pattison, Mary Ann	Samford	04.04.1880	Died in her confinement	JUS/N68 80/82
Rees, Sarah	Rockhampton	16.02.1860	Childbirth	JUS/N1 60/4A
Ridgway, Alice Matilda	Toowoomba	16.03.1908	Puerperal septicaemia	JUS/N396 202/1908
Robinson, Alice	Croydon	28.11.1887	Sudden access of puerperal mania arising from an attach of Milk Fever and the absence of any Medical care during the attack, arising out of the ignorance of her attendants	JUS/N149 548/1887
Scott, Mrs.	Brisbane	25.05.1870	Loss of blood after childbirth	JUS/N25 70/100
Sherrington, Mary	Landsborough Caboolture	12.07.1890	Died in confinement	JUS/N178 306/1890
Short, Sarah Ann	Moggill	05.11.1877	Haemorrhage from labour	JUS/N54 77/238
Simpson, Rose Ann	Delany's Creek	16.09.1886	Retention of the afterbirth	JUS/N135 410/1886
Smith, Bridget Teresa	Toowoomba	26.06.1908	Septicaemia (puerperal)	JUS/N392 103/1908
Smith, Honora	Skeleton Creek and Blackall	27.09.1889	Syncope probably caused by neglect on the part of midwife during the confinement of the deceased	JUS/N169 436/1889
Sommer, Hilda	Beenleigh	13.02.1885	Exhaustion from childbirth	JUS/N115 85/79

NAME	PLACE	DATE	CAUSE OF DEATH	LOCATION NUMBER
Spendlove, Anne	Brisbane	02.04.1872	Culpable neglect on part of husband previous to and after confinement.	JUS/N33 72/67
Stringer, Martha	Milbong Harrisville	08.05.1892	Flooding after confinement	JUS/N200 181/1892
Sullivan, Edith Emily	Sapphire	08.06.1907	Death after childbirth	JUS/N376 317/1907
Taylor, Anne (and her infant child)	Felton	22.12.1864	Natural causes to wit from puerperal convulsions	JUS/N9 65/31
Tesch, Albertina Henrietta	Logan Reserve and Beenleigh	15.12.1888	Exhaustion from postpartum haemorrhage	JUS/N162 568/1888
Todd, Caroline Jane	Woombye	14.02.1891	Childbirth	JUS/N186 46/1891
Trueman, Emmistine, Mrs.	Tiaro, Maryborough	16.11.1874	Exhaustion from prolonged labour	JUS/N42 74/321 Z3390
Vistarini, Mary	Newinga Station Goondiwindi	07.06.1890	Inflammation of bowels after childbirth	JUS/N177 267/1890
Warner, Ann	Lunatic Reception House, Brisbane	22.03.1884	Puerperal mania complicated with fever	JUS/N104 84/247
Whitting, Eliza	Oxley	16.08.1891	Exhaustion through childbirth	JUS/N192 315/1891
Willert, Frederick Hannah	Beenleigh	28.05.1894	Exhaustion from haemorrhage after childbirth	JUS/N224 206/1894
Williams, Isabella	Dalby	17.08.1876	Puerperal convulsions during labour	JUS/N49 76/196
Williams, Mary Ann	Herberton	06.04.1891	Flooding after confinement	JUS/N188 147/1891
Williams, Mary Ann	Augathella	30.10.1910	Childbirth Heart failure	JUS/N460 633/1910
Wilson, Bertie, T.	Brisbane	24.07.1899	Septicaemia Eclampsia	JUS/N276 335/1899
Wilson, Mary Ann and female unnamed	Brisbane	29.06.1878	Thrombosis	JUS/N59 78/202
Young, Sarah, Mrs.	Ellangowan Farm, Leyburn	29.10.1875	Puerperal haemorrhage	JUS/N46 75/383
Young, Helen	Beenleigh	20.05.1891	Neglect during childbirth	JUS/N193 351/1891

Source: QSA, Justice Department, Index to Inquests 1859-1886, 1887-1897, 1898-1914.

A P P E N D I X S I X

APPENDIX SIX

JUSTICE DEPARTMENT
INFANT INQUESTS 1859 – 1886

NAME	PLACE	DATE	CAUSE OF DEATH	LOCATION NUMBER
Albert, (illegitimate child)	Maryborough	21.01.1885	Convulsions	JUS/N127 86/22
Albrecht (unnamed infant)	Not recorded	16.04.1883	Unknown	JUS N/58 83/126
Anderson, William Goulson (infant)	Townsville	03.04.1878	Death supposed to have been caused by hand feeding	JUS/N58 78/110
Athrelpho (male infant unnamed six days old)	Sydney Street, Mackay	25.04.1875	Inflammation	JUS/N44 75/183
Baner, Otto (infant)	-----	10.03.1885	Diptheric Croup	JUS/N116 85/129
Barlow, James (illegitimate infant of Evelyn Frances	Maryborough	21.10.1870	Prematurely born	JUS/N27 70/173
Bason, George (infant)	Mary River	27.01.1883	Drowning or apnoea followed by asphyxia	JUS/N90 83/29
Baxter,Ernest (3 months)	Toowoomba	28.12.1869	Suffocation	JUS/N22 69/135
Bell, Esther (infant)	Lawson Vale, 27 miles from Brisbane	25.04.1883	Convulsions caused by teething	JUS/N92 83/132
Bennett, Robert (2 months)	Gabbinban, near Toowoomba	27.07.1872	Congestion of the brain	JUS/N34 72/145
Bishop, J. (infant)	Allora, Warwick	30.01.1874	Convulsions	JUS/N39 74/26
Blackburn (infant of one Louisa Blackburn)	Clare Cottage, Turbot Street, Brisbane	16.11.1885	Want of proper attendance at birth	JUS/N125 85/587
Brannelly, Eva B. (infant)	Brisbane	9-10-11-June 1879	Starvation	JUS/N63 79/149
Brenton, Mary Anna (infant)	Copperfield	27.06.1876	Asphyxia	JUST/N49 76/162
Brisbane (unknown child)	-----	05.05.1864	Found, dead appeared to be stillborn	JUS/N7 64/64
Brisbane (male infant)	Found in Brisbane River, under the paddle wheels of the 'Bremer Steamer'	30.08.1864	-----	JUS/N8 64/118

NAME	PLACE	DATE	CAUSE OF DEATH	LOCATION NUMBER
Brisbane (female infant)	Found in the Brisbane River by the Edward Street Ferryman	31.08.1864	-----	JUS/N8 64/119
Brisbane (name unknown)	Found in a waterhole in Queen Street	14.03.1865	Stillborn	JUS/N9 65/86
Brisbane (unknown female infant)	Found in a waterhole on Key's Allotment in Adelaide Street	19.06.1866	-----	JUS/N13 66/103
Brisbane (unknown female infant)	Found exposed to the weather in Victoria Park, died later in hospital	22.06.1866	-----	JUS/N13 66/104
Brisbane (unknown newborn male)	Market Wharf in river	25.04.1867	Suffocation, caused by a stocking tied over mouth and nose	JUS/N15 67/91
Brisbane, (unknown newly born female infant)	Found in paddock of W.T. Blackeney, South Brisbane	17.08.1867	-----	JUS/N16 67/144
Brisbane, (name unknown newly born male child)	Brisbane	05.06.1877	Suffocation	JUS/N53 77/143
Brisbane, (name unknown - infant)	Brisbane	15.09.1877	From exposure to night air	JUS/N54 77/201
Brisbane (newly born male infant - unknown)	Brisbane	08.04.1878	Not known	JUS/N58 78/123
Brisbane, (bones of a newly born infant)	Brisbane	06.03.1879	No return	JUS/N62 79/211
Brisbane (unknown infant)	-----	6-9-10 Sept. 1879	By violence	JUS/N65 79/211
Brisbane (newly born female infant - unknown)	Found in Brisbane River at 17 Mile Rock	19.08.1868	-----	JUS/N19 68/160
Brisbane (unknown female infant)	Found buried in Catholic portion of cemetery	10.10.1869	Stillborn	JUS/N21 69/81
Brisbane (unknown newly born child)	In the river near Kangaroo Point	22.09.1870	-----	JUS/N27 70/163
Brisbane River (unknown female infant)	Brisbane River	Found on 10.10.1875	Strangulation	JUS/N46 75/395
Brisbane River (unknown newly born female)	Near Milton	23.09.1875	Died in delivery	JUS/N47 75/426

NAME	PLACE	DATE	CAUSE OF DEATH	LOCATION NUMBER
Brophy (newly born infant of Mary Ann Brophy)	Mackay	Supposed 02.09.1875	Neglect during confinement	JUS/N46 75/327
Brophy, Joseph (infant)	Sandy Creek, in bed, dead	-----	Intracranial haemorrhage	JUSA/N124 85/533
Brown, Jane (infant)	In an old shaft, Gympie	02.01.1873	Drowned	JUS/N36 73/3
Bruner, Barbara (infant)	Toowoomba	15.02.1872	Drowned in a boiler	JUS/N32 72/34
Bryan, Ellen (4 months. Her parents late of Crocodile Diggings)	On board the 'Clarence' steamer at anchor in Hervey's Bay. Inquest in Brisbane	04.07.1867	Atrophy	JUS/N61 67/126
Bunkum, William Ernest (infant)	Brisbane	20.05.1881	Drowning (Accidental)	JUSA/N75 81/133
Burns, Thomas Henry (2 weeks)	Rockhampton	19.05.1868	Asphyxia by being overlaid in bed	JUS/N19 68/130
Byrne, Josephine (2 months)	-----	25.05.1885	Diarrhoea	JUS/N119 85/271
Cade, Precilla (infant)	Geraldine	07.03.1885	Fever	JUS/N117 85/158
Cain, William James (infant)	Veranda of house	13.04.1885	Chest injury	JUS/N118 85/204
Care, John (infant)	In the Mary River	13.12.1884	Accidental drowning	JUS/N112 84/578
Carroll, Charles (infant)	Summerbe	04.02.1878	Weakness brought on by excessive purging	JUS/61 78/319
Carter, Elizabeth (infant)	Brisbane	20.05.1868	Natural causes	JUS/19 68/110
Caudihy, Patrick (9 months)	Toowoomba	13.11.1868	Accidental drowning in a tub	JUS/N20 68/216
Chapman, (female child of Eliza)	St. Lawrence	30.07.1868	Exhaustion and asphyxia, no person in attendance when she was born	JUS/N19 68/163
Chapple, James (infant)	Rockhampton	02.01.1874	Dysentery and convulsions	JUS/39 74/2
Clack, Alice Maud (infant)	Brisbane	28.08.1877	From Coma	JUS/N53 77/185
Clarke, Peter (infant)	Townsville	31.12.1878	Shock whilst being seized by a devil fish whilst bathing	JUS/N61 78/341

NAME	PLACE	DATE	CAUSE OF DEATH	LOCATION NUMBER
Cockerill, John Alfred (2 months)	Nerang	14.02.1875	Suffocation by accident in the night	JUS/N43 75/51
Coghlan, Edward James (7 months)	Brisbane	07.11.1867	Atrophy	JUS/N16 67/176
Coling, (infant to Charles and Eliza)	Taroom	27.08.1874	Stillborn	JUS/N41 74/246
Coling, Charles (infant)	Taroom	07.03.1877	-----	JUS/N52 77/62
Colston, Edward Coper (3 months)	Maryborough	04.04.1862	Convulsions	JUS/N4 62/178
Cook, Herbert (infant)	Brisbane	27.12.1873	Inanition	JUS/N40 74/151
Cooper, George Alexander (infant)	Laidley, Gatton	30.08.1878	Fracture of the skull caused by a veranda post falling on him accidentally	JUS/N59 78/222
Corbett, Catherine Ellen (6 months)	Norman	30.06.1871	Maternal nourishment, mother dying when babe was 12 days old	JUS/N30 71/117
Cottier, Emily (5 months)	Rockhampton	06.05.1865	Natural causes	JUS/N10 65/166
Crawley, Felise Edward (infant)	Brisbane	01.05.1877	Convulsions	JUS/N53 77/134
Crawford, (infant, 10 hours)	Gympie	29.07.1873	-----	JUS/N37 73/154
No name (infant)	Dalby	23.08.1877	Stillborn	JUS/N53 77/177
Dalton, John Joseph Patrick (infant)	Proserpine Station, Bowen	07.09.1877	Burns accidentally received	JUS/N53 77/200
Daly, (male child)	Ipswich	13.06.1870	Stillborn	JUS/N26 70/112
Darwent, Moses (infant)	Rockhampton	05.12.1885	Congestion of lung	JUS/N126 85/604
Davis, Florence (10 months)	Spring Hill, Brisbane	27.06.1871	Suffocation by drowning in tub	JUS/N30 71/119
Davis, Thomas (infant)	Dalby	09.09.1872	Inanition	JUS/N34 72/192
Desley, William (infant)	Millchester	05.01.1878	Diarrhoea and vomiting	JUS/N57 78/8
Delpratt, Paul (infant)	Logan	10.03.1886	Teething	JUS/N129 86/126
Dempsey, Margaret (infant)	Ipswich	14.02.1886	Diarrhoea	JUS/N129 86/128

NAME	PLACE	DATE	CAUSE OF DEATH	LOCATION NUMBER
Dennis, Albert (infant)	Slacks Creek	17.07.1883	General debility	JUS/N94 83/214
Dew, Walter Henry Richard (infant)	Charters Towers	06.06.1876	Suffocation caused by being accidentally overlain by his mother	JUS/N49 76/134
Dickson, Mary (infant, (few days old)	Townsville	30.08.1876	Asphyxia	JUS/N50 76/208
Dodds, Grace (1 week)	Pimpama	31.05.1867	Suffocation through her mother lying upon her	JUS/N16 67/107
Dora, (Polynesian infant)	Logan	31.01.1884	Weakness	JUS/N101 84/80
Dunn, John (9 months)	Spring Hollow, Brisbane	11.10.1866	Congestion of the brain	JUS/N13 66/160
Eageley, James (infant)	Clermont	15.01.1875	Accidentally poisoned by strychnine	JUS/N43 75/49
Eawes, Mary Anne (7 months)	Railway train near Toowoomba	12.01.1874	Destitution and diarrhoea	JUS/N39 74/4
Elger,	Rockhampton	14.02.1874	Overlain in bed	JUS/N39 74/74
Everist, William Charles (infant)	Maryborough	10.09.1883	Drowning	JUS/N95 83/275
Ewers, Susan (3 weeks old)	Toowoomba	11.10.1874	General debility	JUS/N41 74/267
Ewing, Mary (infant)	Brisbane	06.07.1878	Cyanosis	JUS/N58 78/190
Fisher, (unnamed infant 5 days old)	Gympie	30.08.1869	Convulsions	JUS/N21 69/64
Fitzgerald, Sarah (infant)	Cooktown	24.10.1876	Neglect of mother	JUS/N50 76/261
Fogg, Louisa (infant)	West Moreton	18.07.1878	Convulsions	JUS/N57 78/31
Fontaine, Emma Elizabeth (infant)	Toowoomba	23.11.1884	Gastric and convulsions	JUS/N111 84/534
Foreman, Harriet Lucy (4 months)	Maryborough	21.07.1865	Convulsions brought on by teething	JUS/N10 65/170
Fouch (infant)	Toowoomba	19.11.1863	Murdered by her mother	JUS/N6 63/137
Franz (infant)	Maryborough	29.11.1867	Suffocation from pressure	JUS/N17 67/214
Gardner, (illegitimate child of Susan)	Dalby	12.02.1873	Died while being born	JUS/N36 73/56

NAME	PLACE	DATE	CAUSE OF DEATH	LOCATION NUMBER
Gardner, Herbert (infant)	Tenningering	19 & 20 Jan.1877	Inflammation of the bowels and spinal irritation	JUS/N52 77/12
Gawey, Ellen (infant)	Gympies	18.10.1870	Enteritis and dysentery	JUS/N27 70/169
Geike, Elizabeth (baby)	-----	25.04.1882	Convulsions	JUS/N83 82/150
Gibson, Kate (infant child)	Grandchester	14.08.1876	Apnoea or suffocation	JUS/N129 76/193
Glass, (newborn infant of Jane)	Fortitude Valley, Brisbane	04.01.1870	Improper treatment after birth	JUS/N2 69/138
Godwin, Frank Henry, (illegitimate child of Elizabeth)	Brisbane	28.05.1880	Starvation	JUS/N53 80/128
Goldup, (infant)	-----	18.10.1883	Premature birth	JUS/N96 83/333
Green, Eliza Ann (3 months)	Fortitude Valley, Windmill Street	17.01.1866	Natural causes or convulsions	JUS/N12 66/21
Greham, (no name, female infant not baptised)	Mrs. Williams, near (?)	03.04.1833	Natural causes	JUS/N92 83/123
Haack, Madeline Marie (infant)	Logan Reserve near Waterford	31.12.1881	Debility from birth	JUS/N79 81/346
Hamilton, Thomas (infant)	-----	15.02.1883	Whooping cough, relaxed bowels and general debility	JUS/N91 83/54
Hark, James (infant)	-----	Birthday of January 1884	Convulsions	JUS/N100 84/9
Harris, Elizabeth (5 months)	Bowen Hill, Brisbane	15.07.1871	Suffocation, while in bed with others	JUS/N30 71/123
Harris, Henry (infant)	Leyburn	14.04.1873	Croup	JUS/N36 75/205
Hawkins, Francis (infant)	Ingham, Cardwell	11.02.1881	Want of nourishment and proper treatment	JUS/N73 81/41
Hay, (stillborn female child of Mary)	Grey Street, Warwick	11.05.1875	Born dead	JUS/N45 75/205
Heaball, (newly born of Susan)	Brisbane	24.04.1868	Natural causes	JUS/N18 68/100
Heal, Harriet (infant) Norah	Lutwyche, Brisbane	10.06.1882	Asphyxia by drowning – accidental	JUS/N84 82/184

NAME	PLACE	DATE	CAUSE OF DEATH	LOCATION NUMBER
Healey, James (10 weeks)	Toowoomba	15.10.1874	Inflammation of the lungs	JUS/N41 74/280
Heeck, Lena Mary (infant)	-----	11.12.1883	Convulsions	JUS/N99 831/475
Henry, Albert (2 months)	South Brisbane	01.08.1867	Congestion of lungs, caused by Whooping Cough	JUS/N16 67/135
Henry, Elizabeth Florence (infant)	-----	22.02.1883	Teething with measles	JUS/N91 83/55
Hine, Inke ? Margaret (infant)	Toowoomba	07.11.1876	Disease of the lungs	JUS/N50 76/273
Hiscock, Bridget (infant)	-----	26.09.1882	Convulsions	JUS/N86 82/308
Hoffman, Elizabeth (infant)	Gympie	11.09.1872	Natural causes	JUS/N34 72/185
Holland, Ian (infant)	Mackay	27 & 28 Oct. 1878	Not known	JUS/N55 78/272
Homann, Ernst (infant)	Brisbane	02.05.1886	Paralysis of the heart	JUS/N130 86/194
Horne, (male infant of Charles Horne – 13 days old)	Ipswich	14.05.1865	Thrown out of a cart, which cart was running away	JUS/N10 65/137
Howard, Henry William (infant)	-----	17.06.1882	Drowning	JUS/N84 82/197
Howden, Sarah Jane (3 months)	Roger Street, Brisbane	22.05.1867	Congestion of the brain	JUS/N16 67/103
Hudson, Martha Maria (ca 6 weeks)	Fortitude Valley	22.12.1862	Suffocation caused by her mother lying on her	JUS/N5 63/1 Z2839
Hume, George (10 months)	Tiaro, Maryborough	02.07.1874	Inflammation of the duodenum	JUS/N40 74/183
Infant child, male	-----	14.10.1884	Drowning	JUS/N109 84/582
Infant (unbaptised male)	-----	29.01.1885	Natural causes	JUS/N115 85/57
Ingram, John Henry (1 year)	Redbank, Ipswich	16.01.1866	Scalded by boiling water	JUS/N12 66/17
Ipswich, (male infant – unknown)	-----	15 & 17 May 1877	Asphyxia from drowning	JUS/N53 77/119
Ipswich, (female infant - parents unknown)	-----	22.08.1877	Immersion in water	JUS/N53 77/182

NAME	PLACE	DATE	CAUSE OF DEATH	LOCATION NUMBER
Ipswich, (name unknown – newborn female)	-----	13.11.1877	Strangulation by umbilical cord at birth	JUS/N55 77/270
Ipswich, (name unknown - a newborn child)	-----	07.01.1878 & 05.02.1878	Injuries to the skull	JUS/N57 78/30
Jarvis, Charles (infant)	Toowoomba	30.10.1876	Natural causes	JUS/N50 76/272
Johns, Matilda (infant)	Qualtrough Street, Wooloongabba	16.02. 1885	Meningitis probably from exposure in the sun	JUS/12O 85/338
Johnston, (male infant son of Wilhemma)	Ipswich	14.05.1860	No evidence whether natural causes or otherwise	JUS/N1 60/22 Z2839
Karse, Donald (infant)	Brisbane	12.07.1877	Convulsions	JUS/N37 73/155
Kerby, Johanna (infant)	-----	22.02.1883	Drowning	JUS/N91 83/91
Keown, Samuel Joseph (infant)	Townsville	12.10.1883	Suffocation by being overlaid	JUS/N87 82/348
Kerr, John (4 months)	Anderson Street, Fortitude Valley, Brisbane	31.05.1867	Drowned in a cess-pool, accidentally	JUS/N15 67/100
Lade, James Maxted (infant)	Samford Road Brisbane	28.01.1883	Drowning	JUS/N90 83/19
LaFontaine, Elise Mathilde (infant)	West Coast Gully, Gympie	17.12.1869	Drowned	JUS/N22 69/131
Lang, Rachel Cecilia	Ipswich	08.02.1863	Suffocation: mother lay on her	JUS/N5 63/25
Langenbach, Mary (female infant)	Goondiwindi	29.01.1881	Infanticide	JUS/N74 81/91
Larkins, (male infant son of John Larkins	Bundamba	18.06.1860	Natural Causes	JUS/N1 60/25
Lashatell, Louis Henry (infant)	-----	-----	Teething with measles	JUS/N91 83/55
Lawrence, Mary Anne (4 weeks)	North Brisbane	15.07.1872	Affection of the lungs by cold	JUS/N34 72/127
Lawson, James (infant)	Ingham	06.02.1883	Accidental drowning	JUS/N91 83/60
Learmouth, James Seaton (infant)	-----	30.06.1882	Convulsions arising from cold	JUS/N85 82/220
Leibrintz, Louisa (infant)	Branch Creek, Dalby	25.06.1871	Convulsions	JUS/N31 71/160

NAME	PLACE	DATE	CAUSE OF DEATH	LOCATION NUMBER
Leips, Macpherson Laurie (infant)	Bundaberg	21.05.1883	-----	JUS/N93 83/155
Liddy, Mary Julia (infant)	Boundary Street, Brisbane	09.12.1882	Death was due to brain mischief probably convulsions	JUS/N89 82/415
Livingstone, Agnes (infant)	Brisbane	14.08. 1878	Rupture of a blood vessel in the chest caused by a cart passing over deceased	JUS/N59 78/217
Long, Albert (infant)	Gympie	10.10.1871	Fractured skull caused by being thrown out of a cart	JUS/N31 71/156
Long, George Evans (infant)	Neweum, Wide Bay	23.07.1877	Accidentally upsetting of a bullock dray	JUS/N53 77/161
Longso, (infant – south sea Islander	Bundaberg	23.01.1886	Debility	JUS/N127 86/31
Lotz, John (infant)	Waterford, Logan	03.03.1885	Prematurely born	JUS/N116 85/106
Low, Georgina (infant)	Waterford	19.10.1884	Diarrhoea	JUS/N109 84/475
Luake, Fredrick William	Price Mountain, Nerang	06.06.1885	Bite of a death adder	JUS/N119 85/286
Lyons, (Bridget – female infant of)	Brisbane	07.02.1881	Injuries to the skull and scalp	JUS/N74 81/84
Macauliffe (infant)	Copperfield	-----	-----	JUS/N69 80/106
McCarthy, Andrew (infant)	Bundaberg	15.05.1883	Convulsions from teething	JUS/N93 83/156
McCarthy, John (infant)	Dalby	17.10.1872	Natural Causes	JUS/N34 72/198
McDonald, William (infant)	Sheriff Street, Petrie Terrace, Brisbane	16.11.1882	Suffocation from being overlain	JUS/N88 82/380
McEighran, Jane	Southport	29.01.1883	Diarrhoea, consequential to teething	JUS/N90 83/27
Mackavanah, John Henry (infant)	Dalby	13.10.1877	Lost in the bush (starvation)	JUS/N54 77/225
Mackay, (unknown infant)		23 & 24 Nov.1881	Unknown	JUS/N79 81/310
McLennan (infant son not named of John and Mary)	Brisbane	27.10.1876	Congestion of the brain from injuries received at birth	JUS/N50 76/270 Z

NAME	PLACE	DATE	CAUSE OF DEATH	LOCATION NUMBER
McLeod (newly born infant of Isabella - illegitimate)	Palmer Street, Palmerville	15.09.1874	Protracted labour	JUS/N41 74/259
McManus, John Charles, (female infant child of)	Townsville	24.04.1878	Convulsions	JUS/N58 78/113
McNamara, Thomas (infant)	Warwick	23.01.1874	Chronic diarrhoea and whooping cough	JUS/N39 74/16
McPhillip, James (11 months)	Mundubbermere, Darling Downs	10.01.1868	Accidentally eating strychnine	JUS/N18 68/44
Madsen, Hansine Maria, (infant of)	Brisbane	15.11.1876	Accidental suffocation	JUS/N51 76/302 Z
Maher, Mary (male infant unnamed child of)	Ipswich	26.05.1879	Asphyxia by drowning	JUS/N63 79/130
Male infant – stillborn	Brisbane	14.05.1883	Unknown	JUS/N93 83/180
Male infant (unnamed son of Kate Sheehan)	Blackall	25.04.1883	During or immediately after birth from natural causes	JUS/N19 85/275
Manson, (premature infant of Robina Manson, single)	Celbridge, Brisbane	24.12.1871	Born dead	JUS/N31 71/200
Martin, Charles (infant)	Broadwater Street, Ruth, Dalby	23.02.1872	Natural causes	JUS/N33 72/59
Maryborough, (name unknown - female infant)	-----	31.07.1879	Not known	JUS/N65 79/177
Maryborough, (unknown male infant)	Opposite the Union Saw Mills, Mary River	-----	-----	JUS/N46 75/312
Maryborough, (unknown newly born male infant)	Found in a ditch near Richmond Street	27.06.1865	-----	JUS/N10 65/173
Mary River , (unknown male infant)	Nr. Dundathu, Maryborough		Improper tying of naval cord	JUS/N37 73/142
Mein, Ernest Julius (infant)	In a creek near Mr. Priddy's Farm at the foot of Bazaar Street, Maryborough	27.04.1871	Drowned	JUS/N29 71/63
Mewing, Anna Louisa (infant)	Pimpama Island, Logan	09.08.1833	Thirst	JUS/N94 83/233
Mogg, Charlotte (infant)	Ipswich	25.07.1884	Asphyxia	JUS/N106 84/340

NAME	PLACE	DATE	CAUSE OF DEATH	LOCATION NUMBER
Moore, Jane (infant)	Brisbane	25.03.1884	Drowning	JUS/N103 84/161
Moran, Alace (infant)	On road to Ruby Creek, nr. Stanthorpe	23.04.1873	Fell off a dray	JUS/N36 73/78
Morris, Richard Moreton (infant)	In a lagoon at back of father's house, Townsville	21.09.1873	Drowned	JUS/N38 73/209
Moreton, Mary Jane (infant)	Newton, Etheridge	09.06.1875	Convulsions	JUS/N45 75/263
Mulhollan, Margaret Ann (infant)	Ipswich	11.03.1873	Convulsions	JUS/N36 73/47
Mundy, Alfred George (infant)	Rockhampton	10.04.1869	Asphyxia	JUS/N23 69/a81
Murphy, Ethella Mary (infant)	Drayton Inn, Dalby	06.02.1872	Debility	JUS/N33 72/54
Murray, George (infant)	Rockhampton	09.07.1870	Asphyxia from drowning	JUS/N26 70/129
Napier, Allan (infant)	Mackay	31.10.1885	Gun shot wound accidental	JUS/N125 85/579
Neale, Elizabeth Ann (1 month)	Warwick	15.01.1864	Convulsions	JUS/N7 64/5
Nicholes, Eliza (infant)	Cairns	04.01.1878	Poisoned	JUS/N57 78/6
Norwood, Henry (infant)	Gympie	06.07.1874	Asphyxiated convulsions	JUS/N41 74/204
Nutley, Mary Jane (infant son of)	Harrisville, Ipswich	29.04.1880	Natural causes	JUS/N68 80/84
O'Brien, John (5 months)	Warwick	06.07.1874	Congestion of the lungs	JUS/N38 73/217
O'Keeffe, Mary (infant)	Dalby	25.04.1875	Poisoned by taking spirits	JUS/75/184
O'Leary, Emily (illegitimate)	Maryborough	05.11.1872	Natural causes	JUS/N35 72/220
O'Rafferty (infant 2 days old)	Rockhampton	23.06.1868	Congestion of the lungs	JUS/N62 79/87
O'Sullivan, Alice Maud (infant)	Charters Towers	29.03.1879	Overdose of narcotic called 'Infant's Preservative' given in ignorance	JUS/N62 79/87
Otte, Carl Heinrick Wilhelm (infant)	Beenleigh	04.12.1877	Natural causes	JUS/N55 77/272

NAME	PLACE	DATE	CAUSE OF DEATH	LOCATION NUMBER
Palmer, Emma Mary (8 months)	Roma	03.12.1866	Convulsions brought on by teething	JUS/N15 67/6
Panzram, Appolonia (infant)	Yatala, Logan	31.01.1883	Congestion of the lungs	JUS/N90 83/39
Petty, (infant girl)	Pimpama	16.06.1868	Cold, from want of attention	JUS/N19 68/132
Pillows, (newborn infant)	Roma	21.08.1868	Natural causes few hours after birth	JUS/N19 68/170
Polley, Julius Wilhelm Albert (infant)	Brisbane	22.04.1883	Diarrhoea and dysentery during teething	JUS/N92 83/128
Potts, Ellen (7 months)	Brisbane	21.12.1864	Natural causes	JUS/N9 65/8
Power, Charlotte Eleanor Elizabeth (infant)	Gympie	29.03.1875	General debility	JUS/N44 75/195
Quelch (5 weeks)	Toowoomba	13.01.1886	Accidentally smothered when mother lay upon him	JUS/N12 66/64
Rawcliffe	Toowoomba	18.12.1876	Stillborn	JUS/N51 76/336
Reid, Matthew (infant)	Charters Towers	06.06.1878	Accidentally falling down a shaft	JUS/N57 78/147
Robb, Willie (infant)	Beenleigh	29.12.1882	Congestion of the lungs	JUS/N89 82/427
Rook, Joel (infant)	Tears	20.12.1882	Drowned	JUS/N108 82/434
Ryan, Johanna	Brisbane	23.02.1880	Newly born – loss of blood and exposure	JUS/N68 80/56
Ryrie (child)	Tenningering	07.04.1882	Stillborn	JUS/N83 82/116
Salter, James (infant)	Stanthorpe	-----	Asphyxia by drowning	JUS/N62 79/92
Sam (female infant)	Brisbane	14.11.1877	Asphyxia from suffocation	JUS/N55 77/256
Sargent, Elizabeth (9 months)	Maryborough	22.04.1879	Drowned	JUS/N62 79/112
Schmidt, Christian Frederick William (infant)	Beenleigh	29.09.1882	Convulsions	JUS/N87 82/337
Schumuck, Helena (infant)	Ipswich	25.08.1883	Natural causes	JUS/N95 83/263
Secret, (infant)	St. Lawrence	16.03.1874	Death at birth	JUS/N41 74/257

NAME	PLACE	DATE	CAUSE OF DEATH	LOCATION NUMBER
Selby, John (2 weeks)	Stanthorpe	16.03.1874	Dislocation of the neck	JUS/N39 74/54
Shearer, William	Goodna	07.12.1872	Drowned	JUS/N35 72/243
Shulz, Bertha (infant)	Toowoomba	15.03.1877	Dysentery	JUS/N52 77/61
Sleip, (infant)	Dalby	26.09.1871	Not known	JUS/N31 71/158
Smith, Caroline (infant child)	Brisbane	20.08.1860	Blow from stick while playing	JUS/N2 60/77
Smith, Catherine	Townsville	17.10.1884	Exhaustion	JUS/N109 84/494
Smith, Henry (3 weeks old	Maryborough	19.11.1864	Accidentally smothered	JUS/N9 71/25
Smith, Robert (infant)	Fort Cooper	08.10.1878	Want of food	JUS/N60 78/260
Sommers, Anne	Logan River	28.06.1883	Convulsions	JUS/N94 83/208
Unknown (infant bones)	Stanthorpe	11.04.1876	-----	JUS/N48 76/99
Stapleton, Mary	Dalby	18.04.1870	Suffocation from drowning	JUS/N25 70/76
Stapleton, William (infant)	Toowoomba	08.04.1881	Diarrhoea	JUS/N74 81/97
Stokes, Henry	Ipswich	31.05.1878	Haemorrhage	JUS/N58 78/139
Stokke, Charlotte Octavia	Brisbane	26.03.1885	Teething	JUS/N120 85/319
Stunden, Louisa Robina	Brisbane	04.01.1883	Congestion of the lungs	Jus/n90 83/1
Suki, Mary (infant)	St. George	06.08.1878	Unknown	JUS/N59 78/214
Sullivan, Jeremiah (1 week old)	Darling Downs	31.08.1868	Croup	Jus/n9 68/191
Sutton, Henry Charles (infant)	Slacks Creek	17.05.1883	Croup	JUS/N93 83/153
Tage, Otto	Beenleigh	01.02.1886	Accidental drowning	JUS/N129 86/102
Taylor, Anne and her infant child	Felton	22.12.1864	Natural causes to wit from puerperal convulsions	JUS/N9 65/31 Z2863

NAME	PLACE	DATE	CAUSE OF DEATH	LOCATION NUMBER
Teitzel, Augusta Philip (infant)	Condamine, nr. Warwick	05.06.1874	Drowning	JUS/N40 74/156
Thiedecke, Carl F.W.	Pimpama Island, Logan	10.12.1883	Consumption and inflammation of the brain	JUS/N98 83/429
Thomas, Harry Elton	Bowen	06.05.1878	Natural causes, probably acute inflammation of the bowels	JUS/N58 78/114
Thompson, (infant not christened)	Cairns	29.10.1885	Suffocation	JUS/N124 85/543
Thwaite, James Arthur (3 months)	Gppdma	12.08.1874	Natural causes	JUS/N41 74/222
Thwaites, Richard	Logan	27.10.1884	Convulsion fits	JUS/N109 84/474
Tighe, Lilly	Commera, Logan	23.02.1883	Convulsions	JUS/N91 83/74
Tilley, Daniel	Logan	06.03.1883	Scalded badly on chest	JUS/N91 83/82
Toll, (infant)	Clermont	23.06.1872	Smothered: no evidence to show how	JUS/N34 72/137
Toowoomba (name unknown – infant)		15.11.1876	Supposed to be stillborn	JUS/N50 76/275
Totten, William John	In a shaft, One Mile, Gympie	21.05.1871	Dislocation of vertebra of neck	JUS/N29 71/74
Towoah, (Polynesian infant son of Tewah, Iven-vah)	Woffanbah, Coomera River	19.02.1884	Malnutrition at birth	JUS/N100 84/90
Trines, George Frederick, (infant)	Loganholme	30.04.1883	Cause unknown	JUS/N92 83/137
Twaddle, Kate (7 months)	Toowoomba	30.11.1874	Want of proper food and of necessary care while teething	JUS/N42 74/308
Unknown (infant, female)	-----	-----	Murdered by drowning by person or persons unknown	JUS/N123 85/454
Unknown (female child)	Kangaroo Point	12.08.1884	Not ascertained but probably neglect at birth	JUS/N108 84/402
Unknown (infant)	Brisbane	April 1886	Strangulation	JUS/N131 86/211
Unnamed (female infant of Thomas and Jemina Learmouth)	Beenleigh	16.07.1883	Convulsions	JUS/N94 83/209
Unnamed (infant child of Jan Stoltznow)	Beenleigh	21.01.1886	Alleged to be born dead	JUS/N86 86/86

NAME	PLACE	DATE	CAUSE OF DEATH	LOCATION NUMBER
Unnamed (child of Mary Keneally)	Townsville	09.01.1886	Not given	JUS/N130 86/171
Unnamed (male child of one Johanna Koklar)	Maryborough	02.07.1886	Asphyxia	JUS/N132 86/285
Unnamed (infant female)	Stanthorpe	-----	-----	JUS/
Walkinson, Alice (infant)	Warwick	13.11.1876	Convulsions produced by dentition	JUS/N50 76/285
Walleck, (infant boy, 10 weeks)	Dalby	04.06.1866	Suffocation: jammed between bed and wall	JUS/N12 66/94
Walsh, (newborn infant, male, of Mary)	Brisbane	16.12.1866	Fracture of skull, accidentally occasioned through sudden delivery of the mother in an erect posture	JUS/N14 66/210
Walter, Fredrick William	Maryborough	29.08.1872	Injuries from burns	JUS/N34 72/179
Welsh, Alexander (2 weeks)	Bowen Brodge, Brisbane	20.09.1865	Smothered by mother accidentally	JUS/N10 65/123
White, Elizabeth	One Mile, Gympie	28.02.1874	Chronic diarrhoea	JUS/N39 74/55
White, Jane	In a 10 gal. Tub of water, Copperfield	01.02.1874	Drowning	JUS/N39 74/38
White, John (11 months)	Toowoomba	10.07.1869	Convulsions	JUS/N21 69/39
White, Margaret (3 months)	Warwick	19.12.1866	Suffocation, by being overlaid	JUS/N14 66/209
Wildermuth, Mary Catherine (infant)	Nudgee Road, Brisbane	05.0401883	Asphyxia by drowning	JUS/N92 83/116
Wilson, Alfred Ness	-----	15.03.1885	Convulsions from teething	JUS/N116 85/134
Wilson, Mary Ann and female unnamed	Brisbane	29.06.1878	Thrombosis	JUS/N59 78/202
Wooff, Elizabeth	Maryborough	23.07.1877	Natural causes	JUS/N53 77/149
Wraight, (infant daught of William and Eliza; 3/52	Immigration Depot, Ispwich	03.10.1873	Inanitism	JUS/N37 73/200
Yontee, John Henry	Laidley Creek	30.03.1882	Drowning	JUS/N82 82/87
Young, Samuel (5 months)	Killarney, Warwick	10.01.1875	Congestion of the brain, caused by exposure to the sun	JUS/N43 75/9
Yule, John	Ross Creek, Townsville	13.12.1882	Accidentally drowned	JUS/N89 82/417
Zinke, Charles Arthur	Branch Creek, Dalby	26.04.1871	Convulsions	JUS/N29 71/79

JUSTICE DEPARTMENT
INFANT INQUESTS 1887 – 1897

NAME	PLACE	DATE	CAUSE OF DEATH	LOCATION NUMBER
Baker, Mary	Deep Creek Moutain, Brisbane	26.10.1890	Infantile debility	JUS/N182 489/1890
Besgrove, James	Ipswich	17.08.1890	Prematurely born	JUS/N179 374/1890
Bonka Bonka, Tom	Geraldton	06.06.1891	Asphyxia caused by its mother overlying it	JUS/N191 271/1891
Bray, Nellie	Mount Morgan, Rockhampton	16.06.1895	Premature birth	JUS/N233 193/1895
Bull, Catherine	Rockhampton	28.03.1893	Asphyxia at birth: probably accidental	JUS/N212 228/1893
Cavanagh, Donald James (infant)	Eisvold	25.09.1897	Accidentally drowned	JUS/N256 434/1897
Dagg, infant of Amy Jane Dagg	Oakley Flat Caboolutre	25.06.1895	Natural causes	JUS/N234 201/1895
Unnamed (infant daughter of John and Jane Davidson)	South Brisbane	14.10.1889	Neglect at birth	JUS/N170 465/1889
Dugdale, George	Grantham, Gatton	21.08.1887	Premature birth	JUS/N146 363/1887
Dunglison, Alice Lily	Brisbane	05.01.1889	Suffocation by another child	JUS/N164 396/1889
Dunn, Hannah Eileen Salisbury (infant)	Brisbane	28.10.1897	Malnutrition	JUS/N257 455/1897
Eblo, S.S. Islander	Beenleigh	14.05.1888	Prematurely born	JUS/155 241/1888
Female infant of Sally S.S. Islander	Boconnick Plantation near Bundaberg	03.06.1887	Asphyxia caused by overlaying by the mother accidentally	JUS/N144 252/1887
Female infant (name unknown)	Rockhampton	Unknown	Not stated	JUS/N134 368/1886
Female infant (found in Fitzroy River 12.10.1886)	Rockhampton	Unknown	Not stated	JUS/N135 447/1886
Foss, (no Christian name)	Rockhampton	07.04.1889	Accidental suffocation. overlaid in bed	JUS/N165 151/1889
Granke, Emil	Esk	05.06.1891	Through mother straining herself before confinement	JUS/N190 224/1891
Gray (infant child of Richard and Anne)	South Brisbane	16.05.1896	Premature birth	JUS/N242 227/1896

NAME	PLACE	DATE	CAUSE OF DEATH	LOCATION NUMBER
Gray (Baptised) Mat	Helidon, Gatton	07.02.1891	Weakness	JUS/186 61/1891
Halfcastle, (infant)	Landsborough, Caboolture	09.07.1890	Exhaustion from bleeding	JUS/N178 314/90
Halfcastle, (infant – Aboriginal)	Mackay	27.04.1895	Strangulation	Jus/n233 176/1895
Harris, James	Beeneligh	15.08.1893	Exhaustion through exposure at birth	JUS/N216 428/1893
Newly born (infant child of Johanna Hazeldun)	Nerang	28.03.1887	Naval string twisted round its neck at time of birth which caused suffocation	JUS/N142 159/1887
Hembrook, Oliver	Rockhampton	16.01.1891	Premature birth	JUS/N185 23/1891
Holzberger, Barbara Louise	South Brisbane	01.02.1895	Jaundice consequent on premature birth	JUS/N230 29/1895
Infant (name unknown)	Brisbane	13.02.1889	Debility caused by premature birth	JUS/165 78/1889
Infant (name unknown)	Brisbane	22.08.1890	Unknown	JUS/180 414/1890
Infant (male, Name unknown)	Mackay	06.06.1886	Not specified	JUS/132 298/1886
Infant (child of one Mary Jane Bruton otherwise known as Polly Bruton)	Charleville, Morven	08.06.1891	Bleeding, the navel cord not having been tied or through protracted confinement causing exhaustion	JUS/191 257/1891
Infant (male child of one Lucy Isabel Else)	Brisbane	24.10.1886	Convulsions	JUS/N137 502/86
Infant (child of one Louisa Hopkins)	Brisbane	31.10.1886	Weakness	JUS/N137 515/1886
Infant (son of John McLauchlan	Murphy's Creek	25.02.1889	Heat apoplexy	JUS/N165 70/1889
Infant unnamed of E.H. Palmer	Home Creek Station And Blackall	25.09.1894	Injuries at birth Convulsions	JUS/N221 83/1894
Johnson, Annie Augusta (infant)	Brisbane	28.07.1897	Injury to head from log of wood causing fracture of the skull	JUS/N254 318/1897
Johnston, Harry	Brisbane	09.06.1891	Strangulation by navel cord and weakness	JUS/N190 23/1891
Kingston, (female infant of Annie Knack)	Abington Maryborough	24.08.1889	Stillborn	JUS/N169 378/1889
Knack (female infant)	Toowoomba	23.02.1888	Fracture of the skull Laceration of substance of brain	JUS/N153 101/1888

NAME	PLACE	DATE	CAUSE OF DEATH	LOCATION NUMBER
Kucks, (infant of Julia Degen and Rudolph Kucks	North Brook Creek Sandy Creek Esk	21.07.1895	Bladder on the navel string	JUS/N234 235/1895
Lawson, Edward Thomas	Dungeness Ingham	08.09.1886	Suffocation caused by overlying	JUS/N135 426/1886
Lee, Yee (infant)	Cairns	27.03.1891	Suffocation	JUS/N189 160/1891
McFadyean (infant child)	Brisbane	18.06.1889	Infantile malnutrition	JUS/N168 297/1889
McGrath, Mary Margaret	Townsville	04.05.1888	Overlaying	JUS/N155 229/1888
McGuirk, Patrick (infant child)	Helidon	26.04.1888	Injuries received during pregnancy	JUS/N154 180/1888
McLean, John	South Brisbane	02.06.1893	Weakness consequent on premature birth	JUS/N214 329/1893
Marshall, Mary Palmer	Warwick	24.03.1888	Asphyxia from suffocation during suckling	JUS/N153 149/1888
Mills, Arthur James (infant)	Bribie Caboolture	29.05.1890	Accidental drowning	JUS/N176 237/1890
Morgan, Mary Ann (infant)	East Bundaberg	10.07.1886	Drowning	JUS/N133 303/1886
O'Brien, Thomas John (infant unregistered 1 month 4 days old)	Arcturn Downs Springsure	22.08.1897	Convulsions	JUS/N255 374/1897
O'Drane, Catherine Florence	Brisbane	13.05.1894	Suffocation Supposed to have been lain on during the night accidentally	JUS/N223 193/1894
O'Neill, Florence M	Rockie	01.07.1891	Overlain by the mother	JUS/N191 279/1897
Pollard, William (infant 2 years and 9 months)	Croydon	27.08.1897	Accidentally burnt	JUS/N255 370/1897
Poole (infant)	Charters Towers	21.07.1890	Accidentally suffocated	JUS/N179 359/1890
Price, Kate	Ipswich	17.12.1892	Premature birth	JUS/N206 500/1892
Price, William George	Oxley	02.08.1896	Teething	JUS/N145 339/1887
Schubel (infant of Mrs. Schubel)	Marburg	24.08.1896	Bleeding	JUS/N245 386/1896
Sherrin, (male child 3 weeks old not named son of John and Janet Sherrin)	Mount Mosgrove	03.04.1887	Unknown	JUS/N142 171/87

NAME	PLACE	DATE	CAUSE OF DEATH	LOCATION NUMBER
Smith, George Joseph	South Brisbane	16.05.1894	Cause incidental to birth	JUS.N223 198/1894
Soapy, Bartholemew	Port Kennedy	29.08.1891	Haemorrhage of the navel cord	JUS/N193 365/1891
Sothmann, David (infant)	Bingera Plantation Bundaberg	02.12.1887	Whooping cough	JUS/N149 529/1887
Stillborn male	Mackay	07.07.1886	Unknown	JUS/N133 302/1886
Teves, Amelia L.	Rosewood	07.01.1893	Convulsions caused by teething	JUS/N208 2/1893
Tidswell, Alice G.	Charters Towers	05.03.1893	Weakness through premature birth	JUS/N211 161/1893
Unknown male (infant)	Charters Towers	28.08.1892	Unknown	JUS/N203 345/1892
Unknown (supposed illegitimate child of one Adelaide O'Connor)	Hughenden	23.05.1887	Not stated	JUS/N143 231/1887
Unknown (child female)	South Brisbane	Unknown	Probably drowning If drowning probably a case of murder	JUS/N204 385/1892
Unknown (child found in Brisbane River)	South Brisbane	Unknown	Unknown	JUS/N219 569/1893
Unknown (child of Rachel McCann)	Southport	23.09.1892	Suffocation by being smothered in sawdust	JUS/N204 375/1892
Unnamed (infant of Eliza McLean)	Barcaldine	12.01.1889	Inflammation of stomach	JUS/N164 18/1889
Unnamed (infant female)	Beenleigh	02.11.1897	Reported to police as stillborn by Henrietta von Senden – midwife	JUS/N256 436/1897
Unnamed (male child of Elizabeth Wilkins	Clifton Creek Tiaro	29.01.1889	Convulsions and premature birth	JUS/N164 64/1889
Unnamed (male child of Kate Gray)	Helidon	17.08.1892	Weakness	JUS/N203 313/1892
Unnamed (female infant of Rolfe)	Rockhampton	28.08.1891	Suffocation consequent upon neglect at birth	JUS/N192 339/1891
Unnamed (female child of Mary Ferney)	Rockhampton	22.10.1892	Supposed stillborn	JUS/205 416/1892
Unnamed (female child)	Rockhampton	23.04.1893	Neglect at birth	JUS/N213 296/1893
Female (infant child of one Ellen Vincent)	Tent Hill Gatton	11.03.1888	Suffocation	JUS/N153 118/1888
Wardrope, Albert	Ipswich	09.07.1892	Premature birth	JUS/N202 268/1892
Wilson, Mary (infant)	Brisbane	07.06.1890	Premature birth and haemorrhage from umbilical cord	JUS/N177 270/1890

JUSTICE DEPARTMENT
INFANT INQUESTS 1898 – 1912

NAME	PLACE	DATE	CAUSE OF DEATH	LOCATION NUMBER
Adam, John (infant)	Brisbane	24.03.1909	Gastro-enteritis	JUS/N417 152/1909
Annan, Elizabeth (infant)	Townsville	24.02.1909	Acute gastro-enteritis	JUS/N415 116/1909
Armanasco, Ellen (infant)	Gympie	16.12.1908	Infantile convulsions	JUS/N413 51/1909
Ashwood, May (infant)	Brisbane	24.02.1909	Acute gastro-enteritis	JUS/N416 135/1909
Ashwood, Roy (infant)	Brisbane	24.02.1909	Acute gastro-enteritis	JUS/N416 135/1909
Austen, Ronald Allen	Noralvera, St. George	04.11.1912	Convulsions, teething	JUS/N511 649/1912
Azar, Pearl (infant)	Brisbane	17.08.1910	Fracture of the skull Knocked down by a horse and cart	JUS/N452 429/1910
Baker, John (infant)	Townsville	29.03.1910	Malnutrition	JUS/N443 216/1910
Balkin, Yashy (infant)	Tiaro	09.06.1909	Died 18 hours after birth Sickly, delicate when born	JUS/N421 268/1909
Banaghan, Kathleen	Brisbane	19.12.1908	Diarrhoea Thrush	JUS/N411 25/1909
Bannister (infant)	Surat	16.03.1912	Premature birth	JUS/N493 187/1912
Bartells, Margareta (infant)	Townsville	02.05.1909	Gastro-enteritis and Exhaustion	JUS/N420 229/1909
Bartley, Grace (infant)	Croydon	Circa 26.01.1898	Starvation	JUS/N260 74/1898
Basile, Agnes Cecilia M. (infant)	Brisbane	19.12.1908	Gastro-enteritis	JUS/N409 546/1908
Beattie, Gertrude May (infant)		14.03.1909	Gastro-enteritis	JUS/N417 153/1909
Bell, (infant daughter of Katie Bell)	Sandgate	24.02.1906	Suffocation: compression of the windpipe	JUS/N348 93/1906
Benstead, Esther Ida	Beaudesert	02.10.1911	Convulsions brought on by teething	JUS/N479 470/1911

NAME	PLACE	DATE	CAUSE OF DEATH	LOCATION NUMBER
Bird, Norman Frank (infant)	Biggenden	15.05.1910	Pneumonia accentuated by the actions of ascetic acid	JUS/N446 281/1910
Body, Norman	Richmond	03.06.1907	Premature Natural causes	JUS/N377 327/1907
Boles, Evelyn Margaret (infant)	Gladstone	09.06.1910	Heart failure	JUS/N447 319/1910
Bourne, William Eric (infant)	Jacksons, Yeulba	20.08.1909	Convulsions	JUS/N428 437/1909
Brenan, Thomas (infant)	Charleston	25.10.1909	Unknown	JUST/N433 575/1909
Brennan (infant child of Margaret)	South Brisbane	21.04.1904	Asphyxia (accident)	JUS/N335 179/1905
Brown, Jno William	Wallumbilla	22.05.1908	Convulsions while teething	JUS/N397 238/1908
Bruce, Doris Evelyn (infant)	Caboolture	06.06.1910	Burns and shock	JUS/N448 350/1910
Buchhols, Jno (infant)	Brisbane	02.07.1909	Convulsions	JUS/N424 333/1909
Buckley, Catherine (infant)	Brisbane	09.07.1910	Gastro-enteritis	JUS/N449 363/1910
Bull, Edna May (infant)	Brisbane	02.11.1910	Gastro-enteritis	JUS/N456 549/1910
Buller, Albert Joseph	Brisbane	17.03.1907	Teething	JUS/373 179/1907
Burgess (illegitimate child of Emily Ellen Burgess)	South Brisbane	14.09.1902	Asphyxia and want of assistance at confinement	JUST/N308 294/1902
Burley, Richard	Brisbane	25.01.1907	Icterus neonatorum	JUS/N371 102/1907
Busby, Dorothy	South Brisbane	26.10.1904	Congenital syphilis	JUS/N325 324/1904
Cameron, George	Charleville	22.11.1908	Premature birth Exhaustion	JUS/N408 523/1908
Carson, Robert (male infant of Hugh and Elizabeth)	Harrisville	02.02.1898	Unknown	JUS/N260 69/1898
Carson, Heather	Townsville	17.11.1909	Teething and diarrhoea	JUS/N433 555/1909
Chick, Vera (infant)	Brisbane	02.12.1910	Gastro-enteritis	JUS/N460 637/1910
Christian, William	Goodniwindi	16.06.1901	Gastro-enteritis Convulsions from teething	JUS/N297 258/1901

NAME	PLACE	DATE	CAUSE OF DEATH	LOCATION NUMBER
Conway, Jno H. Theo (infant)	Brisbane	12.12.1908	Malnutrition and Gastro-enteritis	JUS/N409 544/1908
Cox, Alice May (infant)	Brisbane	03.12.1908	Gastro-enteritis	JUS/N412 27/1909
Craig, Charles John (infant)	Rockhampton	08.03.1911	Gastro-enteritis Intestinal catarrh	JUS/N467 163/1911
Crane, Grace Maria (infant)	Burketown	18.11.1910	Exposure (lost in bush)	JUS/N460 650/1910
Curry, Vera May B. (infant)	Brisbane	28.09.1909	Artificial feeding Marasmus	JUS/N429 455/1909
Daker, (unnamed infant of Mary Ann)	Ayr	03.01.1907	Unknown: supposed to be premature born	JUS/N371 138/1907
Daly, John (infant)	Croydon	01.01.1898	Bright's Disease	JUS/N259 19/1898
Damro, Rosie Alice (infant)	Kingaroy	11.12.1910	Convulsions through teething	JUS/460 629/1910
Dauth, Erace Evelyn (infant)	Beaudesert	08.02.1910	Asphyxia from overlaying	JUS/N439 104/1910
Davis, Jessie (infant)	North Pine	20.06.1910	Premature birth: unable to take nourishment	JUS/N474 333/1910
Davis, Leonard Clive	Brisbane	07.10.1907	Want of breast milk Bronchitis	JUS/N382 477/1907
Dearing, Dorothy Ward (infant)	Brisbane	04.07.1910	Gastro-enteritis	JUS/N449 365/1910
Dingwall, James	Charters Towers	18.11.1906	Premature birth Asthemia	JUS/N369 62/1907
Dionysius, Anna (infant)	Gatton	27.07.1898	Asphyxia	JUS/N266 377/1898
Discher (unnamed child of Annie Discher)	Geraldton	08.01.1906	Stillborn	JUS/N346 44/1906
Dosetto, Eileen Emily (infant)	Brisbane	06.12.1908	Gastro-enteritis	JUS/N409 542/1908
Dumphy, Edna Ellen (infant)	Ipswich	27.04.1911	Burns, shock (accident)	JUS/N470 232/1911
Dyer, (male infant)	Townsville	27.10.1907	Asphyxia	JUS/N384 547/1907
Dyer, Elizabeth Mary (infant)	Miles	18.01.1911	Convulsions	JUS/N463 63/1911
Edgeworth, William H	Toowoomba	19.12.1901	Convulsions brought on by teething and excessive heat of weather	JUS/N303 681/1902
Eising, Henrietta (infant)	Toowoomba	29.01.1910	Gastro-enteritis	JUS/N437 65/1910

NAME	PLACE	DATE	CAUSE OF DEATH	LOCATION NUMBER
Ellingham, Gladys May	Brisbane	19.12.1906	Asphyxia (overlain)	JUS/N369 65/1907
Elliot, Cyril (infant)	St. George	15.02.1911	Whooping cough and cutting his eye teeth	JUS/N466 132/1911
Ellis, Pearl (infant)	Longreach	17.11.1900	Shock, effect of burning	JUS/N291 507/1900
Eugland, Elsie	Brisbane	21.04.1907	Premature birth and masasmus	JUS/N374 247/1907
Euglauder, Robert Reid (infant)	Brisbane	09.04.1911	Gastro-enteritis	JUS/N469 206/1911
Erckenloff, Alexander John (infant)	Brisbane	19.01.1911	Gastro-enteritis	JUS/N462 47/1911
Female infant (unknown found in Brisbane River)	Brisbane	About 08.03. 1902	Premature birth	JUS/N305 188/1902
Finch, (infant child of Mrs. Finch)	Brisbane	17.11.1904	Child was stillborn	JUS/N326 334/1904
Finding of a six month old foetus of an infant	Warwick	Found 22.05.1907	Premature	JUS/N376 324/1907
Fitzgerald, leslie	Roma	08.12.1907	Infantile cholera	JUS/N384 590/1907
Flanagan, Kevin	Brisbane	21.12.1906	Enteritis (artificial feeding	JUS/N368 42/1907
Flannery, Albert	Chillagoe	01.09.1912	Bled to death through negligence of nurse in not securely tying the umbilical cord	JUS/N506 508/1912
Fletcher, Andrew Thomas	Rockhampton	14.10.1906	Asphyxia (overlain)	JUS/N364 480/1906
Foster, William Hy (infant)	Charters Towers	05.12.1908	Gastro-enteritis	JUS/N417 159/1909
Fraser, Lucy Mary Catherine (infant)	Mackay	18.03.1911	Compound fracture of vault of skull Laceration of cortex	JUS/N468 196/1911
Freshwater, Edith J.	Nanango	13.11.1902	Convulsions from teething	JUS/N310 373/1902
Geigor, Kathleen, H.	Brisbane	29.10.1907	Premature birth Gastro-enteritis, etc.	JUS/N384 532/1907
Goodfellow (infant of Ellen)	Ipswich	13.07.1908	Stillborn	JUS/N402 354/1908
Gordon, Frank (infant)	Brisbane	05.01.1910	Gastro-enteritis	JUS/N436 29/1910

NAME	PLACE	DATE	CAUSE OF DEATH	LOCATION NUMBER
Gray, William (infant)	Brisbane	27.03.1909	Gastro-enteritis Exhaustion	JUS/N417 170/1909
Greensill	North Pine, Brisbane	27.07.1911	Remains of infant but too putrid to certify as to age sex whether full time or born alive	JUS.N477 423/1911
Grienke, Max, J.	Mount Beppo, Esk, Brisbane	18.01.1902	Convulsions, teething	JUS/N303 78/1902
Griffin, Hilda Ethel (infant)	Brisbane	15.03.1911	Gastro-enteritis	JUS/N467 170/1911
Haild, Arthur G.	Gympie	24.11.1908	Dentition gastro-enteritis	JUS/N408 516/1908
Hansen, (infant male child)	Isisford	22.03.1898	Murder	JUS/N262 153/1898
Harding, Maud (infant)	Townsville	04.10.1909	Whooping cough	JUS/N429 475/1909
Hardy, Lillian Sarah (infant)	Landsborough, Caboolture	17.06.1898	Natural causes	JUS/N264 258/1898
Hardy, Reginald Leslie	Kingaroy	08.10.1912	Premature birth	JUS/N508 562/1912
Haritage, (innamed infant of Rosey)	Rockhampton	18.09.1908	Asphyxia	JUS/N405 445/1908
Hay, Gordon Bennett (infant)	Biggenden	18.03.1910	Broken neck - accident	JUS/N442 197/1910
Hill, Kate	Binnedah, Stonehenge	23.01.1908	Convulsions caused by teething	JUS/N393 137/1908
Hines, Alice Maud (infant)	Townsville	02.03.1910	Teething Gastro-enteritis	JUS/N440 145/1910
Hoffman, (infant child of Mrs. G.M. Hoffman	Toowoomba	08.11.1904	Prematurely born Debility from birth	JUS/N326 342/1904
Holledge, George (infant)	Roma	16.03.1909	Premature birth	JUS/N417 162/1909
Hollingsworth, Mertal	Brisbane	31.10.1909	Premature birth	JUS/N432 528/1909
Hunt, Ivy	Brisbane	14.08.1906	Debility from birth	JUS/N359 355/1906
Hunter, Robert Elver	Gympie, Eel Creek	27.02.1912	Premature birth and weakness	JUS/N489 118/1912
Infant (premature birth) of Agnes Mengel	Gin Gin	02.02.1910	Premature birth	JUS/N442 190/1910
Infant (of May Egan)	Roma	11.02.1910	Suffocation	JUS/N440 141/1910
Infant (no name of Violet May Lenwood)	Toowoomba	03.07.1909	Asphyxia Inhalation sawdust	JUS/425 353/1909

NAME	PLACE	DATE	CAUSE OF DEATH	LOCATION NUMBER
Imbour, James (infant)	Brisbane	03.03.1911	Gastro-enteritis	JUS/N465 118/1911
Jones, Gladys Josephine	Longreach	05.08.1911	Premature birth Bronchitis Syncope	JUS/N475 373/1911
Kenafacke, Hannah	Amby	07.01.1908	Premature birth Icterus neonatorum Asthemia	JUS/N390 62/1908
Kenaly, Elizabeth (infant)	Brisbane	24.02.1910	Gastro-enteritis	JUS/N440 137/1910
Kendall, Thomas P.	Cunnamulla	11.06.1900	Premature birth	JUS/N286 265/1900
King, Gladys Ivy (infant)	Brisbane	16.08.1910	Gastro-enteritis Whooping cough	JUS/N455 513/1910
King, (infant son of Henry Thomas)	South Brisbane	21.11.1898	Premature birth	JUS/N268 498/1898
Korn, Arthur Allen	Biggenden, Mount Shamrock	08.10.1912	Infantile diarrhoea	JUS/N507 545/1912
Lanzius, George Thomas Rupert (infant)	Brisbane	20.10.1910	Premature birth	JUS/N456 546/1910
Latcham, Arthur	Nanango	04.06.1902	Convulsions from premature birth and bleeding from navel	JUS/N305 189/1902
Livermore, Charles (infant)	Landsborough	10.03.1910	Teething and general debility	JUS/N442 188/1910
Logan, Daucas	Roma	21.08.1909	Premature birth	JUS/N431 504/1909
Lynch, newlyborn male of Bridget Lynch	Emerald	11.05.1901	Not proved that the child ever breathed	JUS/N296 225/1901
McDonal, Daisy (an illegitimate infant)	Longreach	04.03.1898	Overdose of Royal Infant Preservative	JUS/N261 114/1898
McDonald, Clarice (infant)	Rockie	30.12.1910	Gastro-enteritis	JUS/N462 34/1910
MacGregor, Edith		17.03.1911	Gastro-enteritis	JUS/N467 175/1911
McHugh, Maria (infant)	Rockhampton	26.02.1909	Gastro-enteritis	JUS/N418 185/1909
McKenna (premature baby)	Warkon Woolshed, Surat	11.09.1912	Premature birth	JUS/N505 506/1912
McKeon, Caroline	Mount Bismark	01.01.1907	Premature birth	JUS/N368 37/1907
McLennan, Catherine	Toowoomba	06.09.1903	Convulsions due to teething	JUS/N316 295/1903
McLeod, Noreen	Brisbane	22.12.1909	Teething	JUS/N435 4/1910

NAME	PLACE	DATE	CAUSE OF DEATH	LOCATION NUMBER
McManus, Catherine	Brisbane	09.12.1907	Debility from birth	JUS/N388 6/1908
McNab, Lily (infant)	Caboolture	12.03.1909	Not stated (six hours after birth)	JUS/N416 144/1909
Maddock (unnamed)	Landsborough	20.06.1910	Premature birth	JUS/N450 379/1910
Mahoney, Johanna (infant)	Longreach	21.04.1909	Asphyxia	JUS/N420 238/1909
Male infant child of Carl August and Alice Jonsson	Cairns	04.03.1903	Haemorrhage from umbilical cord	JUS/N288 367/1903
MaQuire, Mary Agnes (infant)	Gatton	07 – 10. 02.1910	Fracture of skull caused by fall from a spring cart	JUS/N438 96/1910
Markham (infant)	Brisbane	01.01.1910	Gastro-enteritis	JUS/N435 21/1910
Marshall, Catherine	Nanango	28.07.1902	Premature birth	JUS/N306 241/1902
Martin, Agnes Mary Jessie (infant)	Ilfracombe	24.10.1910	Snake bite	JUS/N456 531/1910
Mercia, Stewart (infant)	Brisbane	11.01.1910	Gastro-enteritis	JUS/N436 43/1910
Mickelmore, Rose	Gilberton	18.08.1911	Weakness and due to injuries received by its mother through a kick from a horse before birth of the deceased.	JUS/N522 213/1913
Morgan, Charlotte		24.06.1905	Premature birth Syncope	JUS/N341 314/1905
Mullins, Michael William (infant)	Ravenswood Junction	07.02.1910	Drowning	JUS/N440 129/1910
Mullins, Richard	Charters Towers	23.07.1910	Gastro-enteritis Heart failure	JUS/N451 407/1910
Mullins, William	Brisbane	24.12.1909	Gastro-enteritis	JUS/N436 36/1909
Murray, (unnamed child of Annie)	Bolton	19.09.1906	Natural death	JUS/N350 150/1906
Noble, (child of Anne Noble)	Cooroy	28.10.1909	Suffocation shortly after birth (the child was deformed)	JUS/N432 529/1909
O'Brien, Elizabeth Ann (infant)	Gayndah	29.01.1911	Gastro-enteritis	JUS/N464 89/1911
Ohl, James Rossiter (infant)	Brisbane	08.10.1909	Gastro-enteritis	JUS/N429 475/1909
Palin, Frederick William (infant)	Caboolture	03.07.1910	Premature birth	JUS/N455 505/1910

NAME	PLACE	DATE	CAUSE OF DEATH	LOCATION NUMBER
Pery, Francis (infant)	Brisbane	10.12.1909	Gastro-enteritis	JUS/N433 570/1909
Pfitzner, William (infant)	Croydon	03.06.1898	Accidental drowning	JUS/N263 249/1898
Power, Mary Ellen (infant)	Toowoomba	15.06.1909	Convulsions	JUS/N422 282/1909
Probst, Frederick Carl (infant)	Gayndah	18.07.1910	Diarrhoea	JUS/N450 397/1910
Raynbird, Alma (infant)	Brisbane	02.08.1910	Gastro-enteritis Whooping cough	JUS/N452 431/1910
Redrick, Doris M. (infant)	Townsville	16.10.1909	Marasmus and Exhaustion	JUS/N430 487/1909
Reibelt, Edna May (infant)	Bodumba Station, Inglewood	13.08.1910	Accidental poisoning	JUS/N451 425/1910
Reimers, Albert Alex	Texas	13.01.1907	Premature birth	JUS/N371 111/1907
Reiner, Mary Elizabeth (infant)	Childers	27.03.1909	Influenza followed by pneumonia	JUS/N419 205/1909
Reufrey, Claude Raymond	Torrens Creek	22.09.1908	Infant convulsions	JUS/N404 414/1908
Richards, infant female child of Mrs. Richards	Mount Morgan	20.11.1904	Asphyxia	JUS/N326 343/1904
Roberts, Arthur Leslie	Brisbane	05.09.1906	Premature birth Asthemia	JUS/N359 365/1906
Roche, William David (aged 3½ months)	South Brisbane	07.02.1898	Diarrhoea Exhaustion	JUS/N260 78/1898
Roseberry, Edward John (infant)	Beenleigh	02.10.1910	Superficial burns (scalding accidental	JUS/N456 529/1910
Ross, Catherine (infant	Inglewood	01. 03. 1898	Inward convulsions	JUS/N261 104/1898
Ross, Harriet (infant)	Inglewood	02.03.1898	Inward convulsions	JUS/N261 104/1898
Ryan, Mary Agnes	Rockhampton	22.12.1908	Prematurity – non-viable	JUS/N393 150/1908
Schulte, Carl (infant)	Gayndah	09.11.1910	Prematurity	JUS/N459 612/1910
Schulte, Herman	Gayndah	09.11.1910	Prematurity	JUS/459 611/1910
Shakleford, Jno (infant)	Brisbane	21.03.1909	Gastro-enteritis Bronchial pneumonia	JUS/N417 173/1909

NAME	PLACE	DATE	CAUSE OF DEATH	LOCATION NUMBER
Shaw, Patrick Joseph (infant)	Brisbane	16.04.1909	Gastro-enteritis	JUS/N418 199/1909
Smith, Frederick William	Brisbane	12.02.1907	Asphyxia (overlain)	JUS/N371 114/1907
Solomon, Keith James (infant)	Toowoomba	01.01.1909	Cerebral congestion Convulsions	JUS/N411 22/1909
Stewart, Mercia (infant)	Brisbane	11.01.1910	Gastro-enteritis	JUS/N436 43/1910
Steiger, Roland Denis (infant)	Toowoomba	13.03.1911	Ricketts	JUS/N467 173/1911
Storey, Audrey Maud (infant)	Brisbane	01.12.1910	Consumption of lungs and bowels	JUS/N460 636/1910
Sweetman, Michael John	Rockhampton	01.10.1912	Premature birth	JUS/N509 586/1912
Teague, Eva (infant)	Townsville	14.01.1910	Gastro-enteritis	JUS/N436 40/1910
Thomas, Ernest (infant)	Brisbane	06.07.1910	Premature birth	JUS/N450 384/1910
Towle, William Jno (infant)	Kidston	19.11.1912	Haemorrhage	JUS/N514 25/1913
Tripcony, Thomasina Stella	Brisbane	30.12.1907	Teething: acute congestion of the brain	JUS/N388 16/1907
Turnbull, Argyle Bruce (infant)	Pomona	25.03.1910	Dysentry	JUS/N443 212/1910
Unknown (infant)	Brisbane	03.11.1899 (about)	Premature birth	JUS/N279 475/1899
Unknown (male infant)	Brisbane	12.01.1900	Unknown	JUS/N283 142/1900
Unknown (male infant)	Found at Ascot	-----	Unknown	JUS/N297 284/1901
Unknown (female infant)	Found at Breakfast Creek near Kelvin Grove, Brisbane	Unknown	Unknown	JUS/N301 465/1901
Unknown (male infant)	Brisbane	Unknown	Unknown	JUS/N482 546/1911
Unknown (male infant)	Brisbane	Unknown	Unknown	JUS/N490 148/1912
Unknown (female infant)	Brisbane	30.06.1910	Doubt if born alive	JUS/N450 381/10
Unknown (infant)	Brisbane	About six weeks before 10.03.1911	Unknown	JUS/N467 153/1911

NAME	PLACE	DATE	CAUSE OF DEATH	LOCATION NUMBER
Unknown (infant)	Clermont	23.04.1901	Chronic diarrhoea	JUS/N296 216/1901
Unknown (new born infant)	Mount Morgan	30.01.1911	Shock from exposure Of haemorrhage due to lack of proper attention	JUS/N467 159/1911
Unknown (newly born infant)	Port Douglas	15.03.1906	Evidently exposure	JUS/N350 129/1906
Unknown (male infant)	Rockhampton	27.02.1906	Stillborn	JUS/N349 111/1906
Unknown (male infant)	Sandgate	01.03.1912	Asphyxia by drowning	JUS/N492 168/1912
Unknown (male infant)	South Brisbane	Not given	Wound penetrating scalp	JUS/285 217/1900
Unknown (male infant)	South Brisbane	Unknown	Unknown	JUS/N289 445/1900
Unknown (infant)	Townsville	04.03.1901	Premature birth Stillborn	JUS/N295 162/1901
Unknown (infant)	Townsville	02.01.1907	Body decomposed	JUS/N371 117/1907
Unknown (female child)	Townsville	13.06.1912	Asphyxia due to strangulation	JUS/N504 458/1912
Unnamed (illegitimate daughter of Mary Lederhose)	Brisbane	08.04.1906	Congestion of lungs, etc.	JUS/N351 174/1906
Unnamed (male infant)	Brisbane	06.01.1907	Asphyxia	JUS/N368 48/1907
Unnamed (illegitimate daughter of Sarah Diplock	Cairns	01.04.1906	Suffocation	JUS/N352 179/1906
Unnamed (infant of Nora May McNally)	Gympie	08.12.1909	Stillborn	JUL/N434 592/1909
Unnamed (infant)	Isisford	21.09.1899	Suffocation	JUS/N277 399/1899
Unnamed (illegitimate child of Lilyian)	Kilkivan, Gympie	02.11.1910	Atelectasis – death occurring during or immediately after	JUS/N458 586/1910
Unnamed (newly born)	Mareeba	14.06.1899	Exposure	JUS/N275 256/1899
Unnamed (male child of George and Esther Randall)	Maryborough	09.04.1910	Non-viability	JUS/N444 250/1910
Unnamed (infant Kanaka male)	Mossman	11.03.1902	Weakness and bronchitis	JUS/N304 123/1902
Unnamed (infant sone of Mrs. Beatrice Kulmartin)	Oakey	16.07.1907	Premature birth	JUS/N378 356/1907

NAME	PLACE	DATE	CAUSE OF DEATH	LOCATION NUMBER
Utz, Mary (infant)	Brisbane	29.04.1911	Gastro-enteritis	JUS/N470 227/1911
Vallis (infant unnamed)	Glassford Creek	14.05.1900	Stillborn	JUS/N285 218/1900
Venz, E. E. (infant)	Kingaroy	04.07.1909	Convulsions	JUS/N424 336/1909
Wagner, (infant child of Edith Wagner)	Rockhampton	03.06.1904 (death) 15- 16 June Enquiry date	Asphyxia due to overlying or by the bedclothes falling over the child's face	JUS/N321 177/1904
Walker, Ethel May (infant)	Clermont	03.12.1902	Convulsions	JUS/N310 384/1902
Wall, Ellen Katleen	Cunnamulla	10.07.1909	Teething	JUS/N424 341/1909
Wallace, John (infant)	Mackay	04.08.1909	Broken ribs and internal injuries	JUS/N429 463/1909
Wallin, Gloria Viola (infant)	Gayndah	18.12.1910	Convulsions due to gastro-intestinal irritation	JUS/N464 88/1911
Walmesley (infant)	Toowoomba	04.12.1910	Gastro-enteritis Marasmus	JUS/N459 618/1910
Watson, Pennel Graham (infant)	Brisbane	09.10.1910	Loss of mother's milk from birth – gastro-enteritis	JUS/N455 512/1910
Webber, Eliza May (circa eight months old)	Brisbane	25.01.1898	Convulsions	Jus/n262 178/1898
Weble, Ethel (infant)	Brisbane	08.12.1909	Gastro-enteritis	JUS/N429 569/1909
Wilson, George (infant)	Maryborough	12.04.1911	Tetanus	JUS/N469 220/1911
Woodcraft (unnamed illegitimate infant child of Mabel Woodcraft)	Toowoomba	12.06.1907	Suffocation	JUS/N376 325/1907
Woods, Vera Florence (infant)	Brisbane	09.07.1910	Premature birth	JUS/N450 382/1910

Source: QSA, Justice Department, Index to Inquests 1859-1886, 1887-1897, 1897-1914.

APPENDIX SEVEN

CAUSES OF DEATH OF INFANTS 1859 – 1912

Murder	Still-born	Pre-mature	Suffocation /Asphyxia	Overlaid	Starvation	Convulsions	Gastro Enteritis	Teething	Drowning	Various Medical	At Birth	Natural Causes	Un-Known	Other	Total
-	1	1	2	-	1	3	-		1	3	1	-	2	1	**16**
2	2	-	1	-	-	-	-	-	-	-	-	-	8	1	**14**
1	-	-	-	1	-	-	1	-	5	3	2	1	-	2	**16**
-	2	-	1	-	2	2	1	-	-	2	1	1	2	3	**17**
-	1	-	1	3	1	-	3	1	2	7	-	-	-	-	**19**
1	-	1	2	-	1	6	-		-	3	1	1	-	2	**18**
-	1	-	1	-	1	3	-	-	1	7	-	2	1	1	**18**
1	-	-	-	1	-	1	-	-	4	4	1	2	1	1	**16**
1	-	-	-	2	-	2	-	-	4	3	-	1	1	3	**17**
-	-	1	-	1	-	2	2	-	-	3	2	1	2	2	**16**
0	1	-	2	-	1	-	-	-	3	-	1	2	4	1	**15**
-	-	-	1	-	-	4	-	-	2	3	-	3	-	5	**18**
-	2	-	1	1	-	2	1		3	4	1	2	-	1	**18**
-	-	-	1	-	1	1	1	1	2	6	1	1	3	1	**19**
-	1	-	2	-	-	2	-	1	2	2	1	3	1	2	**17**
2	1	-	2	1	-	1	1	1	1	2	1	-	2	1	**16**
-	-	-	-	1	1	1	-	1	3	2	-	1	-	-	**10**
8	**12**	**3**	**17**	**11**	**9**	**30**	**10**	**5**	**33**	**53**	**13**	**21**	**27**	**29**	**280**

Murder	Still-born	Pre-mature	Suffocation /Asphyxia	Overlaid	Starvation	Convulsions	Gastro Enteritis	Teething	Drowning	Various Medical	At Birth	Natural Causes	Un-Known	Other	Total
0	-	4	2	3	1	-	-	-	1	1	1	1	2	1	**18**
1	-	4	-	-	-	1	-	-	-	4	4	-	2	1	**17**
-	1	1	2	4	1	1	-	-	2	2	1	1	-	1	**17**
1	-	2	2	-	-	1	-	1	-	3	2	-	5	-	**17**
-	2	3	1	-	-		-	-	-	1	2	-	-	-	**9**
-	-	1	1	-	2	3	8		-	1	-	1	-	1	**18**
-	-	2	1	-	-	3	3	2	-	3	1	-	2	1	**18**
-	1	3	2	1	-	1	6		-	2	-	-	-	3	**19**
-	1	3	-	2	-	2	5		-	2	-	-	-	1	**17**
1	1	3	1	-	-	3	3	-	-	1	-	1	1	2	**18**
-	-	10	2	-	-	-	4	1	-	1	-	-	-	-	**18**
-	1	5	1	-	-	1	4	1	-	2	-	-	1	2	**18**
-	-	3	1	-	-	1	7	-	2	1	-	1	-	1	**16**
-	-	5	1	1	-	3	4	-	-	2	-	-	-	2	**18**
-	-	3	-	-	-	1	3	1	-	3	-	-	7	-	**18**
2	3		3	-	-	-	1	-	1	2	-	-	2	2	**17**
-	1	1	-	1	-	3	4	1	-	1	-	1	-	2	**15**
-	-	1	1	-	-	-	1	-	-	1	-	1	-	-	**4**
13	**23**	**57**	**38**	**23**	**13**	**54**	**63**	**13**	**39**	**86**	**24**	**27**	**49**	**51**	**572**

Source: QSA, Justice Department, Index to Inquests 1859-1886, 1887-1897, 1897-1914.

APPENDIX EIGHT

APPENDIX EIGHT

INQUESTS INTO DEATHS OF STILLBIRTHS 1859-1912

NAME	PLACE	DATE	CAUSE OF DEATH	LOCATION NUMBER
Brisbane (unknown child)	-----	05.05.1864	Found, dead appeared to be stillborn	JUS/N7 64/64
Brisbane (name unknown)	Found in a waterhole in Queen Street	14.03.1865	Stillborn	JUS/N9 65/86
Brisbane (unknown female infant)	Found buried in Catholic portion of cemetery	10.10.1869	Stillborn	JUS/N21 69/81
Coling, (infant to Charles and Eliza)	Taroom	27.08.1874	Stillborn	JUS/N41 74/246
No name (infant)	Dalby	23.08.1877	Stillborn	JUS/N53 77/177
Daly, (male child)	Ipswich	13.06.1870	Stillborn	JUS/N26 70/112
Hay, (stillborn female child of Mary)	Grey Street, Warwick	11.05.1875	Born dead	JUS/N45 75/205
Male infant – stillborn	Brisbane	14.05.1883	Unknown	JUS/N93 83/180
Manson, (premature infant of Robina Manson, single)	Celbridge, Brisbane	24.12.1871	Born dead	JUS/N31 71/200
Rawcliffe	Toowoomba	18.12.1876	Stillborn	JUS/N51 76/336
Ryrie (child)	Tenningering	07.04.1882	Stillborn	JUS/N83 82/116
Toowoomba (name unknown – infant)		15.11.1876	Supposed to be stillborn	JUS/N50 76/275

NAME	PLACE	DATE	CAUSE OF DEATH	LOCATION NUMBER
Kingston, (female infant of Annie Knack)	Abington Maryborough	24.08.1889	Stillborn	JUS/N169 378/1889
Stillborn male	Mackay	07.07.1886	Unknown	JUS/N133 302/1886
Unnamed (infant female)	Beenleigh	02.11.1897	Reported to police as stillborn by Henrietta von Senden – midwife	JUS/N256 436/1897
Unnamed (female child of Mary Ferney)	Rockhampton	22.10.1892	Supposed stillborn	JUS/205 416/1892
Discher (unnamed child of Annie Discher)	Geraldton	08.01.1906	Stillborn	JUS/N346 44/1906
Finch, (infant child of Mrs. Finch)	Brisbane	17.11.1904	Child was stillborn	JUS/N326 334/1904
Goodfellow (infant of Ellen)	Ipswich	13.07.1908	Stillborn	JUS/N402 354/1908
Unknown (male infant)	Rockhampton	27.02.1906	Stillborn	JUS/N349 111/1906
Unknown (infant)	Townsville	04.03.1901	Premature birth Stillborn	JUS/N295 162/1901
Unnamed (infant of Nora May McNally)	Gympie	08.12.1909	Stillborn	JUL/N434 592/1909
Vallis (infant unnamed)	Glassford Creek	14.05.1900	Stillborn	JUS/N285 218/1900

Source: QSA, Justice Department, Index to Inquests 1859-1886, 1887-1897, 1897-1914.

APPENDIX NINE

APPENDIX NINE

MATERNAL DEATHS DISCUSSED IN CHAPTER FOUR

1864-1911

NAME	PLACE	DATE	CAUSE OF DEATH	LOCATION NUMBER
Bridges, Sarah	Oakey Creek, Toowoomba	07.05.1868	Exhaustion, while in child bed	JUS/N19 68/105
Cull, Mary	Reception House, Brisbane	09.04.1873	Puerperal fever	JUS/N36 73/74
Fraser, Muriel May	Nambour	21.11.1911	Antepartum haemorrhage Placenta praevia	JUS/N482 540/1911
Glenwright, Mabel Victoria (married woman)	Charters Towers	23.06.1910	Postpartum haemorrhage	JUS/450 386/1910
Lonergan, Annie	Mackay	22.12.1881	Puerperal fever	JUS/N79 81/350
Newton, Eliza	Lunatic Reception House, Brisbane	05.03.1877	Puerperal fever complicated with mania	JUS/N53 77/132
Pattison, Mary Ann	Samford	04.04.1880	Died in her confinement	JUS/N68 80/82
Short, Sarah Ann	Moggill	05.11.1877	Haemorrhage from labour	JUS/N54 77/238
Sullivan, Edith Emily	Sapphire	08.06.1907	Death after childbirth	JUS/N376 317/1907
Taylor, Anne (and her infant child)	Felton	22.12.1864	Natural causes to wit from puerperal convulsions	JUS/N9 65/31

Source: QSA, Justice Department, Index to Inquests 1859-1886, 1887-1897, 1898-1914.

APPENDIX TEN

APPENDIX TEN

DEATHS IN CHILDBIRTH DISCUSSED IN CHAPTER FIVE

1861-1894

NAME	LOCATION	DATE	DIAGNOSIS	ARCHIVAL NUMBER
Bowers, Mary	Dalby	17.10.1884	Childbirth (through neglect)	JUS/N109 84/455
Brophy (newly born infant of Mary Ann Brophy)	Mackay	Supposed 02.09.1875	Neglect during confinement	JUS/N46 75/327
Casey, Julia	Townsville	27.11.1871	Childbed	JUS/N31 71/178
Glass, (newborn infant of Jane)	Fortitude Valley, Brisbane	04.01.1870	Improper treatment after birth	JUS/N2 69/138 Z2839
Klumpp, Sybella	Brisbane	19.09.1877	Puerperal convulsions	JUS/N54 77/231
Last, Catherine	Brisbane (North)	16.12.1861	Neglect and Injudicious Treatment from Confinement	JUS/N3 61/96
Smith, Honora	Blackall	27.07.1889	Syncope Probably Caused by Neglect on the part of the Midwife during the confinement	JUS/N169 436/1889
Spendlove, Anne	Brisbane	02.04.1872	Culpable Neglect on part of Husband Previous to and after confinement	JUS/N33 72/67
Trueman, Emmistine,	Maryborough	16.11.1874	Exhaustion from Prolonger Labour	JUS/N42 74/321
Walsh, (newborn infant, male, of Mary)	Brisbane	16.12.1866	Fracture of skull, accidentally occasioned through sudden delivery of the mother in an erect posture	JUS/N14 66/210
Willert, Frederick Hannah	Beenleigh	28.05.1894	Exhaustion from Haemorrhage after Childbirth	JUS/N224 206/1894

Source: QSA, Justice Department, Index to Inquests 1859-1886, 1887-1897.

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