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DISCUSSION

An Australian history of the subordination of midwifery☆

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Summary This paper analyses the history of the subordination of midwifery to medicine and nursing. With the important exception of Evan Willis' work on medical dominance and Annette Summers' work on the takeover of midwifery by nursing, other histories of Australian midwifery have taken a neutral approach to issue of power and control. The aim of analysing this period is to identify the strategies of power that were used to subordinate midwifery. With increased consciousness of how power has operated in the past, midwives and woman of today can be more empowered when seeking to promote normal birth and midwifery models of care.

Concepts of 'power', 'the state' and midwife are defined and discussed. A summary of the decline of midwifery and the rise of obstetrics in Europe and the United Kingdom (UK) gives a background against which to understand the Australian experience. The historical account given here draws to a climax by focussing on the period 1886—1928. It was during this time that medicine forged an alliance with nursing and achieved both legal and disciplinary control of midwifery. Knowing how this was done is important because it helps us to recognise the power strategies that are currently being used by medicine. This is helpful when planning how these strategies might be matched or countered by contemporary woman and midwives when seeking to promote normal birth and midwifery models of care.

This paper analyses the history of the subordination of midwifery to medicine and nursing. The process began shortly after the first fleet landed but occurred primarily during 1886—1928.[1,2] With the important exception of Willis[1] and Summers[2], other histories of Australian midwifery have taken a neutral approach to issue of power and control.[3,4] The aim of analysing this period is to identify the strategies of power that were used by nursing and medicine in their successful bid to subordinate midwifery. With increased consciousness of how power has operated in the past midwives and woman of today can be more empowered when seeking to promote normal birth and midwifery models of care.

The concept of 'midwife' changed substantially during the period of review. Midwife means 'with woman'. Until the early to mid 1900s the term was used to denote a woman who had learned midwifery from experience; sometimes called empirical midwife or vocational midwife.[5] Currently, the vast majority of midwives in Australia are professionally educated. They are state registered nurses and then, after

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additional education, they became registered midwives. Recently with the introduction of Bachelor of Midwifery there are a growing number of registered, professional midwives who are not nurses.

The way that the concept of power is used in this paper is ethically neutral. This is consistent with Foucault's notion of power which he argued was productive; not necessarily oppressive.[6] 'Power' can be usefully thought of as an energy which enables individuals and groups to be able to do or obtain what they want. Power can also be used to prevent someone else from doing what one does not want.[7,8] Foucault differentiates between 'legal power' such as used by the police and courts and 'disciplinary power' which can be used subtly and manipulatively to get others to voluntarily submit to one's wishes.[9,10] Disciplinary power can operate even against the best interests of those subjected to power and even against their resistance.[6] Willis[1] argues that historically medical power was strong and ultimately prevailed over midwifery because of educational, economic, class and gender relations favoured medicine. This paper argues that subtle and coercive power was used by medicine and nursing during the subordination of midwifery. Whether this use of disciplinary power was ethically justified is a value judgement that the reader can make for themselves. Ultimately, because of their influence with the government, medicine was able to convert much of their disciplinary power to legal power to control nursing, midwifery and childbirth.

Following Willis, the concept of 'the state' is used to mean the government. In the case of Australia this means both state and federal governments.[1] Willis' scholarly and critical account of the takeover of midwifery was based primarily on his reading of what happened in Victoria however similar events happened in New South Wales at around the same time.[3]

The paper begins with a summary of the decline of midwifery and the rise of obstetrics in Europe and the United Kingdom (UK). This provides the context for understanding the subordination of midwifery in Australia. The expansion of medicine within Australia, with particular emphasis on the impact that this had on midwifery and childbirth, is then presented. The historical account I am presenting draws to a climax by focussing on the period 1886—1928. It was during this time that medicine forged an alliance nursing and achieved both legal and disciplinary control of midwifery. This paper then specifies the strategies that medicine used and identifies the key sources of support for medical power. Examining the contextual similarities and difference between now and then is the main focus of the discussion section of the paper. This knowledge helps us to recognise the power strategies that are currently being used by medicine. Such knowledge is necessary in planning how these strategies might be matched or countered by contemporary woman and midwives when seeking to promote normal birth and midwifery models of care.

The decline of midwifery and the rise of medicine in Europe

Australia was founded as a British penal settlement in 1788 which was 70 years before the first medical Act was promulgated in 1858.[11,12] It is important to set the subordination of midwives in Australia within the broader context of what had occurred or was occurring in Europe in the 18th and 19th century. Briefly, the exclusive role of midwives as childbirth accoucheur came under increasing medical challenge during those years. Midwifery was an important occupation for many women in terms of income and local authority. Most midwives were trained by apprenticeship with an experienced midwife although many urban midwives in Europe received some form of training from local colleges of surgeons or obstetricians.[13]

Obstetric practitioners of the 18th century described female anatomy, the process of parturition and recommended techniques to improve birth outcomes. The most formidable instruments of the male accoucheur were the obstetric forceps. During the 18th century, lying-in hospitals were established throughout Europe. William Smellie set up a school in London in 1740.[14] These hospitals had a dual aim; to deliver poor women free of charge and to provide access for male accoucheurs and midwives to large numbers of deliveries. Foucault, understood how the hospitals were central to medical power when wrote about the inextricable concept of power/knowledge.[15] Major outbreaks of puerperal sepsis were closely linked to the practice of male-midwives in lying-in hospitals.[16]

A key power achievement for medicine was the UK medical Act of 1858 (a similar Act was duplicated shortly after in Australia).[1] The medical Act gave medicine autonomy; that is the right to define and control medical practice and limit other workers from practising medicine.[11] The medical Act brought together three groups: physicians, barber surgeons and apothecaries. Physicians were the smallest and the highest status group. They came from the aristocracy and had a university education.[1] Physicians only provided their services to the wealthy upper class who could afford to pay. Surgeons came from the middle classes of society and were trained under an apprenticeship system. They had slowly emerged from the barber surgeons over about 200 years.[17] The apothecaries were most numerous and in the lowest tier in the medical hierarchy in terms of class and income. Apothecaries had originally been grocers but during the 17th and 18th century they narrowed their focus to drugs and expanded their occupational territory to include giving medical advice. The apothecaries were the original general practitioners who provided low-cost service to the bulk of the population.[1] Differences between these three groups are important because the lower status occupations gained power from their amalgamation with the physicians.

In Britain, in the early to mid 19th century, there was a rapid increase in the number of GPs. They were being recruited from the burgeoning capitalist class that had been spurned by the industrial revolution. The increase in GP numbers meant that they were finding it difficult to establish a practice. Medicine as a discipline was in a pre-scientific era; the causes of mostly disease were unknown, medical treatments were based on unproven theories and were not very effective.[1] In the absence of scientific evidence, GPs had no strong claim to expert knowledge. They had difficulty in gaining a competitive advantage against the low paid vocational health care providers such as homeopaths, herbalists, bone-setters and midwives. The rising numbers of GPs also created competition between doctors. Some, who could not

establish a practice in England, decided to immigrate to Australia.

The decline of midwifery and the rise of medicine in Australia

In the early years of Australia settlement, the emigrating GPs found that there was less medical competition. The first areas of competition occurred in the wealthier parts of major cities. As the numbers of GPs increased, however, competition between GPs became a problem and they moved out of the city and infiltrated rural areas. In the rural area the focus of competition became the unregulated health workers, including midwives.[11]

An important matter that was contextual to the struggle for control of birth was Australia's low population and need for economic development. Only 6% of Australia's convicts were ever kept behind bars; free convict labour played a crucial role in the development of Australia. When the last of the convict ships landed in 1868, the plentiful source of free labor dried up. This led to widespread anxiety about the future development of the country.[12] By the turn of the century the Anglo-Saxon population was about 4 million (the indigenous people were not counted). This low number of white people, compared with the vastness of the land created fear for governments about the national security and the economy.[1]

Since the beginning of white colonisation empirical midwives had provided the vast majority of maternity care. Many midwives set up private lying-in cottage type homes or hospitals during the pioneering era of 1820—1880.[3,4] The midwife's control over care for childbearing women continued largely unchallenged in Australia until the mid to late 1880s.[3,4]

As the number of GPs expanded midwives were increasingly seen as a problem. Writing in the *Australian Medical Journal*, doctors informed each other that the fastest way to build up a general practice was to establish a relationship with the women during pregnancy; build up her trust and then become the doctor for the whole family; thus the midwife stood in the way of medical income and status.[1] In order to wrest the childbearing women away from the midwives GPs had to find a way to justify their involvement in all labours and births, not just the complicated ones. They used the same strategies that were used in Europe i.e. they claimed that midwives were dangerous and the cause of maternal deaths due to sepsis.[1,18,19] At the time, hand washing to reduce sepsis, advocated by Semmelweiss in the 17th century was not yet commonly taught to doctors and, of course, antibiotics had not yet been developed.[1] Thus, as in Europe, rather than the midwives being the cause of puerperal sepsis, it is more plausible that doctors carried the infection from women to women. Notions of cleanliness and dirtiness, however, were strongly class-based which made the midwives vulnerable to being stigmatised.[16]

Midwives were working class women and most were not formally educated.[3,13] Being unable to read and write created a huge power differential when it came to challenging medicine's claims that they were safer practitioners than midwives. This lack of education was related to being female as much as to being working class. It has been convincingly argued that the takeover of midwifery by medicine was an example of gender-based oppression; an oppression from which women and midwives are still suffering.[18—21]

In spite of educational, economic, class and gender disadvantage midwives for many years provided stiff competition for doctors. This was particularly so in the rural areas where midwives set up many private maternity homes.[3,4] Midwives were known within the community and were generally held in high regard. They charged much lower fees than doctors.[2,4] The community generally thought midwives were as effective as medicine or even more so. One doctor wrote that after his arrival in town he tried to raise funds from the local community to build a maternity hospital. When a public meeting was called he found out that the people resisted him taking over from the midwife because, they said 'what about the poor midwife being done out of a living and she being an old resident working in the village before this young doctor was born'.[1] Given the cost advantage that midwives had plus community support medicine needed could not overthrow midwifery. They turned to nursing for a strategic alliance.

The role of nursing in the subordination of midwifery

Nursing emerged as an occupational group from the Crimean war (1854—1856) where Florence Nightingale and her nurses provided care for wounded soldiers. In designing nursing to fit with medicine, Nightingale was influenced by the way the military operated and made sure that nurses were formally subordinate to medicine. From the beginning nurses were taught to follow 'doctors orders'.[22]

Over the first 30 years of the 19th century the Australian Trained Nurses Association, (ATNA) used medicine as a model of how to professionalise. ATNA set up a register, started a professional journal, formed a professional society, advocated standards for nursing training and sought legal support for the registration of nurses.[2] Observing nursing's attempts to professionalise medicine saw a strategic opportunity to get rid of independent midwives. Medicine and nursing formed an alliance that served the interests of both parties because nursing wanted to claim an occupational territory that included the whole life cycle.[2]

Willis' account of the subordination of midwifery critically deconstructs what occurred in Victoria and, in the absence of other critical accounts my history of the takeover of midwifery follows Willis.[1] I note in passing that the very first School of Midwifery was at the Benevolent Hospital in Sydney commencing in 1877.[3] The Women's hospital in Melbourne commenced midwifery training in 1888. This was in response to government and community pressure to try to improve birth outcomes for women and babies.[1] Both medicine and nursing opposed the training of independent midwives. These two groups used their power to ensure that the Diploma of Midwifery could be taken only by women who had completed their general nursing training.[1,2]

By the early 1900s, the federal government decided that it needed to do something about the low population base.[1] Following a Royal Commission into the declining birth rate (1904) the government introduced a baby bonus of 5 pounds in 1912.[1] I offer a personal note here to link my history to that of Australia. My grand mothers, on both sides of my family,

were having babies at this time. Both grandmothers had 11 children. They had all their babies at home with a midwife in attendance. I know from my parents' stories that financially times were tough for them and I deduce that at least in part, my grand-parents were motivated to have a lot of children because of the baby bonus. Australia has again introduced a baby bonus and the birth rate is going up.

During the first two decades of the 20th century the state strongly supported the need for midwives, mainly because of unmet needs in rural areas. Although it was resisted by both medicine and nursing, a Midwives Registration Bill was passed by parliament in 1915.[1] This bill ensured the establishment of a Midwives Board to govern practice and to register midwives. Both vocational midwives and nurses with formal midwifery qualifications were entered on the register. Vocational midwives needed the endorsement of doctors as to the safety and fitness to practice.[3,4] This is an example of how medical disciplinary power was converted to legal power.

Although the Victorian government continually pressured the Women's Hospital to provide some training to currently practising vocational midwives both medicine and nursing resisted. These power plays were occurring within a context of there not being enough midwives, or doctors for birth, particularly for the poorer parts of town and in the rural areas. Medical and Nursing refusal to train vocational midwives adds weight to the idea that their real concern was to eliminate the midwife as a source of occupational competition rather than any real concern for the welfare of childbearing women or babies.[1]

In 1916 a government inquiry, recommended that only a trained and medically supervised nurse or midwife be allowed to give care during the lying-in period.[1] This decision was the death knell for independent midwifery. Although I have no evidence it seems likely that then, as now, such an inquiry would be chaired by a doctor and composed primarily of doctors.

In 1923 nurses got their own Act and were specifically excluded them from providing care in childbirth unless also registered as a midwife.[8] In 1928, a further Nurse's Act was passed which formally abolished the Midwives Board and brought midwifery under the control of nursing.[8] Nurse-midwives were restricted to the practice of midwifery to rural areas where there was a shortage of doctors wishing to provide obstetric care. This is support for the notion that medicine's real interest in controlling midwives was protecting the financial interests of their members. Nursing was already subordinated to medicine thus the Nurses Act of 1928 effectively ended midwifery as an independent occupation.

In the decade following the introduction of the baby bonus the proportion of births attended by midwives halved as the five pound allowed women to select a doctor to attend them.[1] In Victoria the baby bonus eventually became contingent upon having a medically supervised birth. These social and economic factors, coupled with the dominance of the medically asserted belief that midwives were the chief cause of puerperal sepsis, created the last nail in the lid of the coffin of independent midwifery.[1]

By the late 1920s medical dominance in the care of childbearing women was firmly established.[1,3] There was no decrease in infant mortality, however under medical care. Further, even though medicine was firmly in charge of births across Australia, the death rate from puerperal sepsis did not decrease until the 1930s and 1940s when antibiotics became widely available.[1,3] The involvement with medicine was not benign. With medical attendance at what would have been normal births, the use of anaesthesia and forceps became much more common. This resulted in a proliferation of birth injuries to both mothers and infants; this was no doubt a major factor in doctors being unable to lower the mortality and morbidity during this time.[1] One doctor, writing in the *Medical Journal of Australia* in 1929, boasted that he used forceps for every one of his 768 deliveries as a way of preventing complications.[1]

Conclusion

Medicine in the 19th and early 20th century was composed almost entirely of men who shared the same power base as other dominant males; they were white, well educated and from economically richer families. It was these males who owned or managed every institution of society; the army, the church, the law, the newspapers, the government, etc. These privileges, combined with a brotherhood of other dominant males, formed a powerful base for the success of the medical strategies to subordinate midwifery.

Legal and disciplinary power are the two major types of social power that have been used in this historical account.[9] Disciplinary power requies the use of ongoing effort. A long campaign of disciplinary power was used when stigmatising midwives as unsafe practitioners. Medical networks with each other and with other dominant white males were used to propagate this belief. With the support of governments disciplinary power was eventually converted into legal power. The Medical Registration Act formed the foundation for medicine to be able to claim an ever increasing occupational territory and the domination of other health disciplines.[1] Other laws that converted medical disciplinary power to legal power included the Nurses Registration Acts, the Private Hospitals Acts (which were proclaimed in different states on different dates in the 1920s). Doctors chaired the Nurses Registration Boards in all states until the second half of the 20th century. The Private Hospitals Act gave the department of health (and the doctors who advised the department) power to regulate and accredit the lying-in cottages run by midwives and therefore indirect power over their occupational competitors.[3,4] Legal power allowed doctors to reduce the amount of effort they had to put into disciplinary power aimed at subordination.

Speaking generally, medicine has changed and so has the broader society. Free higher education has seen a much more diverse range of doctors who now come from both sexes, all classes and all races. Women are now better educated and more powerful than they were. Nurses and midwives all now university educated and much more engaged in public debate about health care. Midwives and women are actively challenging anti-midwife ideology by countering with research evidence via our professional journals. Midwives and women are asking for woman centred birthing and they are being heard on radio, television and read in the newspapers. They are being consulted by governments; something that was unheard of in the 1880s. These social factors have increased power for women and midwives and led diminution of dominant white male privilege that supported medicine in the past.

The social and educational advances of women and midwives have levelled the occupational playing field to some

extent. Today, in the context of an Australia-wide shortage of obstetricians and GP obstetricians, governments are motivated to provide maternity services close to where the voters live. Thus there is a synergy of interests between maternity consumers, midwives and government. For example, in the state of New South Wales, the government is extending midwifery-led models of care; including free standing birthing centres and publicly funded homebirth. This is an example of midwives and women building networks, finding support and using power to bring about desired changes to maternity services.

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