Place and Power: A History of Maternity Service Provision in Western Australia, 1829-1950

Briony McKenzie
B.A. History, Hons.

This thesis is presented for the degree of Doctor of Philosophy of Murdoch University 2015.
Declaration

I declare that this thesis is my own account of my research and contains as its main content work which has not previously been submitted for a degree at any tertiary education institution.

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Candidate
Abstract

The nature and provision of maternity services is shaped by many different factors including location and time period. This thesis is a historical study of Western Australia’s maternity services during the period 1829 to 1950. It examines the influence of the medical profession, the state, midwives and women themselves in bringing about important changes to the provision of these services. The study adopts a post-revisionist feminist approach which prioritises the voices of women both as mothers and as midwives. In doing so, it questions established traditional understandings of the quality of the midwifery services offered in WA during the pioneering period and highlights the ways in which medical practitioners and governments undermined empirically-trained midwives and brought about greater state control of their activities. In this analysis, birth in the past is ‘re-normalised’ through an exploration of what birthing may have been like for everyday women and the home is reimagined as a safe and comfortable birthing place.

This study further explores important themes which have relevance to maternity care in the contemporary context. It investigates the changing location of birth and the power structures that influenced women’s experiences in different birth locations in the past. Women’s ‘choices’ in childbirth are explored with a focus on the extent to which women were limited in their decision-making by their socioeconomic and geographic status. The study questions the extent to which contemporary understandings of the social importance of birthing, including the emphasis placed on ‘choices’ and birthing location, can be applied to women of the past. It is argued that early twentieth century women in Australia had a complex and somewhat ambiguous relationship to birthing which limits the extent to which modern understandings of birth can be transposed into the historical narrative.
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### Acronyms

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<th>Acronym</th>
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<tr>
<td>AMG</td>
<td>Australasian Medical Gazette</td>
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<td>AMJ</td>
<td>Australian Medical Journal</td>
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<tr>
<td>ATNA</td>
<td>Australian Trained Nurses Association</td>
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<tr>
<td>BMA</td>
<td>British Medical Association</td>
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<tr>
<td>KEMH</td>
<td>King Edward Memorial Hospital</td>
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<tr>
<td>MJA</td>
<td>Medical Journal of Australia</td>
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<td>NSW</td>
<td>New South Wales</td>
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<td>NSWMG</td>
<td>New South Wales Medical Gazette</td>
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<td>PODs</td>
<td>Post Office Directories</td>
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<td>WA</td>
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Introduction and Methodology

Many contemporary academic discussions about childbirth examine factors affecting women’s personal experiences of birthing. These debates are concerned with conflicts around medicalised birth and ‘natural’ birth, over home birthing and hospital birthing, or between obstetricians and midwives.¹ Conflicts around decision-making and choice in childbirth are also factors affecting contemporary understandings of birth. Recent research has concluded that having choices and being involved in decision-making leads to better birth outcomes for mothers and most women approach childbirth with the expectation that they will be able to make some choices about their birthing experience.²

Debates of this sort suggest the need for further research into the merits of different birthing systems and different birth attendants.³ Consistent criticism of medical management of childbirth in British, European and American research also demonstrates a growing disconnection between the expectations of mothers and the service provided in maternity hospitals.⁴ Indeed, many Australian state and Federal government reviews regularly advocate a decrease in interventionist medical care during childbirth. As researcher Alphia Passamai-Inesedy has noted, the 1999 Australian Senate Community Affairs References Committee’s Inquiry into Childbirth Procedures and the World Health Organisation’s Principles of Perinatal Care report of 2001 both suggest that with regard to childbirth in Western nations:

unnecessary medical intervention and overuse of technology during perinatal care continue to be practiced widely despite the acceptance of evidence-based principles and care. Of the various points

Despite this increasing criticism, the medical model of childbirth has retained its near complete dominance in Australia and the Western world for over ninety years. Even where deviation from the medical approach is supported by research evidence, individual medical practitioners, backed up by their professional organisations, continue to insist that any deviation from the medical model of birth is inherently dangerous.  

Historical discourses on childbirth have much in common with these modern conversations on ‘childbirth politics’. From the 1970s, revisionist historians began questioning the established narratives of traditional medical history which today underpin the power of modern obstetrics. While reflecting this revisionist approach to childbirth history, this study of childbirth in Western Australia (hereafter WA) questions the revisionist narrative by highlighting the important role of women in the continued medicalisation of birthing. As such, this research contributes to the post-revisionist literature on childbirth history. Through a focus on a wide range of primary sources, the thesis provides an historical picture of WA’s maternity services prior to 1950 and focuses on the role of the state, the medical profession, midwives and women themselves in bringing about important changes to the provision of these services. In doing so, this research questions established traditional understandings of the quality of the midwifery services offered in WA during the pioneering period and highlights the ways in which medical practitioners and governments sought to undermine empirically-trained midwives and bring about greater state control of their activities.

This research focuses primarily on the experiences of European women in WA and as such the practices of Indigenous women, their roles as both providers of care and as mothers, is beyond the scope of this thesis. Writing on the health of Australian Indigenous women,
particularly in relation to childbirth, is generally focused on current efforts to improve childbirth outcomes at a clinical level.\(^8\) The history of Indigenous birthing practices in Australia has been, comparatively speaking, neglected by researchers in recent times.\(^9\) The existence of this gap in understanding highlights the significant amount of work still to be done in childbirth history research.

Through an in-depth empirical analysis of WA’s maternity services, this thesis addresses some of the ideas familiar to established narratives of childbirth history. Drawing on this research, the thesis explores a number of supplementary themes related to the study of maternity service provision generally. The modern recognition of the importance of women having choices in relation to childbirth, along with the role of specific birthing spaces in facilitating those choices is applied here through a study of WA’s shifting birthing locations over the period between 1829 and 1950. Unlike some revisionist pieces, this study is not primarily a comparison of different maternity service providers themselves, but an analysis of the location of birth and the power structures that influence women’s experiences in different birth locations. Women’s ‘choices’ in childbirth have always been heavily influenced by the location in which birth takes place. Through an analysis of the birthing spaces of the past, women’s specific experiences of birthing in different locations becomes clearer.

A focus on the dual themes of birthing location and choice in childbirth, factors which are so relevant to the contemporary landscape of maternity service provision, illustrates some of the challenges of feminist history writing. While attempting to establish the experiences of WA women who gave birth in previous generations, this study also acknowledges the inherent challenges of accurately representing or fully understanding these experiences. An important facet of this challenge is the tendency, present in all historical writing, to interpret the past


through the lens of contemporary understanding. Indeed, one of the criticisms of feminist methodological approaches is the way in which ‘women’s issues’ can sometimes be represented as a single cohesive concept across time and space, ‘as if “women” were a unified category of being throughout history and all over the world’. This research does much to highlight the various ways in which past women’s experiences of and attitudes towards childbirth do not conform to contemporary understandings of the inherent value of the childbirth event. While it is impossible to completely remove the present from our representations of the past, in the context of this history it became important to highlight the notable points of divergence between the ideas, attitudes and experiences of women today and those of past generations. The concept of ‘choice’ in childbirth is one such area of divergence which I have chosen to explore through this thesis. In doing so, I highlight some of the problems of transposing modern understandings of choice in childbirth into the historical narrative and attempt to demonstrate the ways in which women’s childbirth choices in the past were defined by their class status and geographic location.

Finally, through an analysis of women’s experiences in different birthing spaces and with different service providers, this thesis provides an alternative representation of birth in the past. Modern conceptualisations of childbirth in the nineteenth and early twentieth century position women in childbirth as victims of a universalised ignorance which rendered the childbirth process inherently unsafe. This vision of past childbirth experiences has been perpetuated by traditional historians who have often characterised midwives, mothers’ traditional birth attendants, as ignorant and dangerous. As feminist sociologist Jo Murphy-Lawless has noted, while the contribution of midwives to the historical and cultural story of childbirth is evidently important, in obstetric circles this story is represented as a set of ‘superstitious beliefs that contribute nothing intrinsically helpful to a woman giving birth’. Indeed, this profoundly negative representation of midwifery in the past is necessary in order to justify the contemporary focus on medicalised, technologically-driven and interventionist approaches to birthing. By highlighting the positive work of midwives as childbirth attendants in women’s homes and by refocusing on the voices of women as mothers and midwives, this study emphasises the ‘normal’ aspects of social domestic birthing in the

11 Within the context of this thesis, ‘choice’ is a problematic term. However, as it is used regularly throughout, I will no longer emphasise this limitation.
past. While we rarely see the uneventful birth in historical representations of the past, it was nevertheless a regular feature of everyday life for women and their families.

**Midwives, mothers and medicalisation in WA**

This history of maternity service provision fills existing gaps in the historical literature relating to childbirth in Australia by exploring, as much as possible, the Western Australian experience. In this historical study, I will draw attention to the power structures at play in different WA birth locations, with a particular focus on the roles of midwives and mothers themselves. In twenty-first century society, the location of birth and the potential choices which a woman may have in relation to the birth of her baby within that location are linked to the history of childbirth medicalisation and the competing roles of the midwife and the obstetrician. Understanding this history within specific geophysical spaces is important for any analysis of modern birthing practices. The situation that exists now, for midwives, obstetricians and child-bearing women, is in part dictated by what has gone before.

While generally speaking the practices of European women, midwives and doctors in this part of Australia were not dramatically different from those in the eastern colonies (later states), the development of maternity services in WA had its own unique outcomes. WA’s geographic isolation from other colonies, its significant size, its history as a free settlement, its comparative poverty compared to other colonies, along with its distinctive frontier ethos all resulted in delayed state intervention in medical and health matters, particularly in relation to institutionalised maternity care. These factors also meant that WA often had a limited role in national conversations related to health generally and maternity services specifically. For example, for the period prior to 1930, the *Australian Medical Journal* rarely contained articles written by Western Australian doctors; nor did it reference the Western Australian experience to any great extent. WA was one of the last states in Australia to have a medical school. In fact WA’s first dedicated maternity hospital, King Edward Memorial Hospital (hereafter KEMH), predates the establishment of medical training in the state. Despite being

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13 There are competing definitions of what can be considered ‘normal’ in childbirth. In this study, I use ‘normal’ more generally to refer to uneventful, successful birthing in which both mother and baby survive the birth without significant intervention. This was the most usual outcome of childbirth in the past and it should, therefore, be identified as normal.
one of the first jurisdictions to regulate midwifery practice, WA was the last state to completely subsume the profession of midwifery into nursing.

Yet even with these unique features, the WA experience is an exemplar of the by now well-understood story of childbirth medicalisation. In WA, as in most other Western societies, shifts in social, political and cultural attitudes towards child-bearing, midwives and medicine saw the gradual ‘take over’ of childbirth, first by medical-men as individuals and then by the medical profession as a whole in tandem with the state legislative apparatus. Child-bearing women in WA also played an integral role in campaigning for increased access to medicalised birthing, specifically through their push for the establishment of a maternity hospital. Empirically-trained midwives in WA were denied a voice in these transitions and their skills as birth attendants, along with their important roles in pioneer communities, have subsequently been downplayed or ignored. This thesis therefore reframes current historical debates, putting midwives and childbearing-women at the centre, and emphasising, where possible, their roles in the changing landscape of maternity service provision in WA.

Seeing choices in the past

This thesis investigates Western Australian women’s choices in childbirth in the past while acknowledging the inherent challenges in doing so. Exploring ideas surrounding choice in historical writing is fraught with difficulty. In the case of the history of maternity service provision, a discussion of choice, specifically the choices of child-bearing women, is relevant because these ideas are so important to the modern realm of childbirth politics. In contemporary life, a woman’s childbirth choices are a key focus of the provision of her maternity care and the notion of being able to choose, along with the circumstances in which these choices are denied women, forms the discourse in which much of the modern-day literature on childbirth exists. It therefore makes sense to explore this aspect of women’s

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experiences of childbirth in the past: perhaps with a view to comparing past with present, or in the case of this thesis, to shed further light on women’s own encounters with the childbirth process prior to 1950.

Although choice is no doubt important to historical discussions of women’s experiences of childbirth, the concept of choice itself creates problems for, as feminist researcher Mary Caprioli notes, ‘choice cannot adequately be measured’.15 This problem is even more pronounced when seeking to understand choices from an historical perspective. In the past, women’s childbirth choices, their decisions about the location of birth, the birth attendant and the use of anaesthesia for instance, were so profoundly affected by class, social, gender and economic factors that it becomes difficult to see them as choices at all. Women’s individual circumstances along with the constraints of their particular social conditions so heavily influenced their choices in relation to childbirth that it is impossible to establish a rule or pattern which would define their behaviours, particularly from an historical distance. Perhaps what is more important, though, is the relationship that women of the past themselves had to these supposed choices. What this analysis of childbirth in Western Australia suggests is that modern notions of choice and ‘decision making’ in childbirth did not mean the same thing to women of the early twentieth century as they do to modern-day consumers of maternity care. Being ‘in control’ of the birth, feeling personally empowered and having choices during the childbirth process were not necessarily concepts which early twentieth century women prioritised or even recognised as relevant.

While choices in childbirth certainly did exist for individual women in the past, they remain difficult or sometimes impossible for the historian to see, given the lack of any direct evidence which shows that a choice was even made. Contemporary philosophical and economic understandings of ‘choice theory’ may be relevant here too and highlight the various ways in which choice is dictated to individuals from the outside, despite appearances to the contrary.16 Indeed, Robbie E. Davis-Floyd and Carolyn F. Sargent have noted the


important ideological role of Western medicine in determining women’s choices in relation to childbirth in the modern era:

[w]omen must construct their choices in relation to and often in terms of the hegemonic ideology and ethos of Western biomedicine, which leaves little cultural space for alternative conceptions, thus calling into question the notion of "choice" in relation to culture.\(^1^7\)

The underlying idea of choice itself is highly problematic in this sphere; yet it cannot be dismissed as meaningless given its importance to modern day understandings of women’s experiences during childbirth.

Given the complexities surrounding notions of choice, particularly from the historical perspective, it is useful to examine women’s expectations and desires in relation to childbirth, as these are more clearly visible in the available material. Women of all classes have, over time, clearly and publicly expressed their expectations and desires in relation to the management of childbirth and maternity service provision. In Australia and internationally, child-bearing women have been involved in many of the fundamental changes and shifts in the provision of maternity services. Some historians have highlighted the various ways in which, prior to 1950, women themselves supported and promoted the further medicalisation of childbirth.\(^1^8\) This can be seen in women’s campaigning for the establishment of maternity hospitals like KEMH in WA, in their involvement in the setting up of charity lying-in homes such as Perth’s Home of Mercy and in their enthusiasm for and promotion of the use of anaesthetics in labour.

These factors confuse the revisionist narrative which often seeks to highlight the oppressive and patriarchal role of the medical profession in the further medicalisation of childbirth. Revisionist writers, legitimately and rightly, establish the many failings of the early maternity hospital system in Australia and internationally, highlighting the ways in which empirically-trained midwives were devalued and deskilled by the workings of the medical profession.\(^1^9\)


\(^{19}\) See for example Selby, Motherhood in Labor’s Queensland, p.195; Reiger, *Our bodies, our babies*, pp.17-18; Kathleen Fahy, “An Australian History of the Subordination of Midwifery”, *Women and Birth*, Vol.20, 2007,
However, a vacuum remains in fully understanding women’s own attitudes and ideas in relation to these transitions, and certainly, the public actions of many women’s organisations – such as the support for and promotion of maternity institutions like KEMH – suggest that in this earlier period, mothers did not have the same values, and did not see childbirth in the same way, as modern-day women. As historian Anne Misson discovered while interviewing women who had given birth during the 1930s and 40s:

The tendency of the women at the time was to discount the importance of the actual birth as though it was of little concern in a lifetime of experiences, something to be got over as easily as possible for an important and always inevitable end.20

Misson goes on to shed light on the challenges this poses for contemporary writers on childbirth politics.

The most important casualty of the clash between my naivety and the view of reality presented by my interviewees was the assumptions I shared with Ann Oakley, Sheila Kitzinger and the other birth reformers of the last twenty-five years, that the moment of giving birth, the experience of childbirth generally, is of a deep and incontrovertible significance.21

What this suggests is that contemporary understandings of what childbirth means to mothers cannot easily be injected into the stories of the past. It is therefore incumbent on the historian to seek to understand early twentieth century women’s own ideas and values in relation to childbirth and to avoid, as best one can, transposing contemporary attitudes to choice and control into the historical narrative.

Sanctums, surveillance rooms and total institutions

In this analysis of childbirth and maternity service provision in WA, the location of birth is the thematic feature which allows for the development of an understanding of what women’s personal childbirth experiences may have been like. This study follows other works in highlighting the important role of the home in facilitating women’s access to safe midwifery care and contrasts this with women’s experiences of lying-in homes and the maternity hospital. However as a post revisionist text, this study also draws attention to the complexity


21 Misson, “Mentioning the Unmentionable”, p.139.
of women’s own interactions with the location of birth and demonstrates some of the ways in which women shaped and understood their own experiences within certain birthing spaces.

Since the 1970s, the location of birth has formed a significant part of the contemporary discourse surrounding the ‘right’ way for childbirth to proceed. These modern understandings of the importance of specific birthing spaces can be useful when investigating births in the past. For example, Kathleen Fahy and Jenny Parratt’s dualistic concepts ‘sanctum’ and ‘surveillance room’ provide powerful and evocative language in which to describe women’s potential experiences of birth in different locations. According to Fahy and Parratt, a ‘sanctum’ is a birthing space which is designed to optimise women’s comfort through the creation of a homely atmosphere. Sanctums are well ventilated, provide easy access to different types of furniture as well as the outdoors, and provide privacy from the outside world. In contrast, a ‘surveillance room’ is a clinical environment which seeks to optimise the convenience of birth attendants and facilitates the consistent surveillance of the birthing woman. In a ‘surveillance room’ the bed dominates the space and the door of the room has been removed to facilitate easy viewing of the woman by attendants. Access to the outdoors, toilet facilities or showers is restricted. These opposing concepts illustrate the ways in which contemporary theorists imagine and recreate the location of birth and reiterate its importance to child-bearing women. Thus Fahy and Parratt claim that ‘the more a birth room deviates from a “sanctum”, the more likely it is that the woman will feel fear…reduced emotional wellbeing and possibly emotional distress’.

An older but related concept expounded by author Erving Goffman is also instructive when seeking to understand women’s experiences of certain birth locations in the past. Goffman’s ‘total institution’ theory was a response to institutionalised approaches to mental health during the 1950s and 60s. He describes the total institution as a place where all aspects of life – sleep, work and play for example – are conducted in the same general space and under the

24 Fahy and Parratt, “Birth Territory”, p.46.
same authority. In such places, the activities of individuals are conducted in the company of
many others. All are treated alike and expected to do the same things. Daily events are
scheduled and this program is imposed from above by a body of officials.\textsuperscript{26} In these types of
institutions there is a small supervisory staff who manage a large body of ‘inmates’. Inmates’
access to the outside world is restricted and they live their lives within the body of the
institution. Staff on the other hand are socially integrated into the outside world.\textsuperscript{27}
Information is restricted in total institutions so that those living on the inside are excluded
from decision making. Management’s plans for inmates are not communicated to the inmates
themselves and this gives the staff a basis for maintaining distance from and control over
those living within the institution.\textsuperscript{28} In this way, the existence of a collection of individuals is
controlled by a group of officials, bureaucrats and staff who dictate almost every aspect of
life. Inmates are denied any agency and have very little control over their daily activities.

The images of ‘sanctum’, ‘surveillance room’ and ‘total institution’ are useful and powerful
tools for communicating the overall flavour of a particular birthing environment. As
highlighted by Steven Zweig and Deborah Parker Oliver, the ‘total institution’ model in
patient management was a feature of many hospitals until the 1970s and 80s, both in the
context of childbirth and other medically managed events.\textsuperscript{29} Perth’s early Home of Mercy had
many facets of the ‘total institution’, while the labour ward of the early KEMH could
accurately be described as a ‘surveillance room’. Similarly, it is easy to imagine the home of
a nineteenth century wealthy Perth woman being her ‘sanctum’ during childbirth.

Yet, women’s own reactions and responses to these spaces were often more complex than
these simple images would suggest, again highlighting how the contemporary focus on
childbirth location may not easily translate into the historical narrative.
In the past as much as now, women’s access to friends, husbands and partners, their ability to
maintain their personal privacy along with their access to anaesthesia, refreshment and basic
personal items during childbirth were all dependent on birth location. However for most
women historically, the physical space of the birthing place was dictated to them by their

\textsuperscript{26} Erving Goffman, \textit{Asylums: Essays on the Social Situation of Mental Patients and other Inmates}, 1961, this
\textsuperscript{27} Goffman, \textit{Asylums}, p.18.
\textsuperscript{28} Goffman, \textit{Asylums}, pp.18-19.
\textsuperscript{29} Steven C. Zweig and Debra Parker Oliver, “Returning from the Total Institution to a Home Environment: A
class status, their geographic location and their adherence to socially normative behavior in relation to child bearing. Consequently, not all women responded to different birth locations in ways which modern consumers of maternity care would necessarily accept or understand. Indeed, most women passively accepted the ‘surveillance rooms’ of the maternity hospital and some eagerly embraced the highly-medicalised and often impersonal care they received there.

Challenges in the sources: feminist methods and women’s voices

Finding women’s voices in the history of maternity care in WA is a methodological cornerstone of this thesis. In the past forty years, revisionist historians of childbirth have identified that women collectively and as individuals embody both the biological and social aspects of childbirth. While birthing is necessarily a ‘natural’ biological event, it is also an event of deep cultural and social significance in which women as mothers are the central figures. For this reason it is imperative that the insights and experiences of women themselves become the primary building blocks of broader understandings of birthing. Such an approach is necessarily embedded in feminist methodology which remains highly relevant to this area of historical research. One of the aims of any feminist project is to explore the unique experiences of women themselves, to ‘give insights into gendered social existence that would otherwise not exist’. Yet it is also the case that a focus on the voices of women can directly challenge existing ideas and understandings. As historians Kathryn Anderson, Susan Armitage, Dana Jack and Judith Wittner have noted in their work recording women’s oral histories:

> When women speak for themselves, they reveal hidden realities: new experiences and new perspectives emerge that challenge the “truths” of official accounts and cast doubt upon established theories.

For these reasons, feminist methods which prioritise women’s voices are an integral part of revisionist and post revisionist histories of childbirth. In this context, source material which focuses on women themselves or gives an insight into women’s personal experiences is difficult to find and much sought after. Research into women’s childbirth experiences in the

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31 Ramazanoğlu and Holland, *Feminist Methodology*, p.147.
past therefore becomes an exercise in bringing together a wide range of sources and attempting to read into the silences in the primary material.

In conducting research for this project, I have sought to access primary material from a number of different sources including existing oral histories, government documents, hospital records, newspapers, statistical data, journal articles, diaries and books which all shed light on women’s experiences of childbirth in this state. While material which shines a light on the roles of governments and institutions in the management of maternity care is relatively easy to access, efforts to establish what childbirth was like for Western Australian women in the past suffer significantly from a lack of primary sources. In the modern tradition of ‘birth stories’ women’s own private experiences of childbirth are highly prized, but these personal stories were not considered relevant or even interesting in past generations.33 Most women who gave birth to children before 1950 would now be very elderly or deceased and consequently their personal accounts may be lost to history. Even for early researchers recording oral histories in the 1980s, women’s own reluctance to talk about matters relating to sexuality and reproduction has hampered their investigations.34 In interviews conducted by Anne Misson and historian Beth Robertson, the kinds of details about childbirth which are now of interest to authors are often brushed over by interviewees, who lived in a time when the primary focus was on motherhood itself, not on the process which makes it possible. Women giving birth during the period before 1960 knew very little about childbirth and were often at a loss to describe their experience in any detail. As a participant in Anne Misson’s research project of 1985, Mrs. M had this to say of her experiences during the 1940s and 50s:

I knew nothing about contractions and dilation and crowning and the whole minute to minute physical progression that my daughter and daughter-in-law are familiar with. My generation just went to the hospital when the ‘pains’ started, lay on the labour table and pushed when instructed.35

Given the limitations of such descriptions of the actual childbirth event, it is difficult ever to fully understand what childbirth was really ‘like’ for women of this generation. This remains one of the fundamental challenges in investigating and analysing women’s relationship to childbirth in the past and reinforces the ways in which modern ideas and expectations about birthing do not easily translate into the historical narrative.

33 Misson, “Mentioning the Unmentionable”, p.134.
34 Misson, “Mentioning the Unmentionable”, p.135.
35 Misson, “Mentioning the Unmentionable”, p.137.
Even at a quantitative level, the role of women – as professionals, but even as mothers – in the story of childbirth, is sometimes difficult to see in the historical material. Medical sociologist Evan Willis has noted that the lack of published historical material concerning midwives in Australia is a source of great complexity for modern-day historians of childbirth and this is borne out in the Western Australian material. For example, while the number of men employed in various occupations is recorded in early WA censuses, women’s employment is not documented. The Blue Books, the earliest sources of quantitative data available for the colony, also do not list employment details for women. This is one of the main reasons why it is difficult to assess the numbers of, or the qualifications of, midwives working in the Swan River colony prior to the establishment of the first register of midwives in 1913. Similarly, early material on births and deaths in the colony does not always indicate causes of death, so it remains difficult to accurately assess the number of women or children who died during childbirth, particularly in the early years.

For later periods, WA hospital records provide some insight into women’s experiences, but these are very limited and a majority are not accessible to researchers. Hillcrest Hospital, for example, a charity lying-in facility run by the Salvation Army which operated in Fremantle during the early decades of the twentieth century, holds records relating to hundreds of births. However, only a small proportion of these records relate to the period before 1950 and of those, none are accessible to researchers.37 One of the primary concerns of the institution during its time as a charity lying-in hospital was that the young, often single women who gave birth there should not be identified.38 Many babies born at Hillcrest were later adopted and information relating to births is only available to those wanting to trace their own origins.39 For other institutions like Woodside Maternity Hospital, primary material relating to the running of the facility before 1953 has been lost.40 Even for institutions where material is available to researchers such as the House of Mercy and KEMH, the records of births and 

36 Evan Willis, Medical Dominance, 1989, Allen & Unwin, North Sydney, p.94.
38 Patients at Hillcrest wore veils to obscure their identity when they were nursed by students of the Fremantle Midwifery School during the period 1909-1916. See Central Board of Health, Files – General, 1899-1987, State Records Office of Western Australia, Item no.1910/0158, Cons.1003.
39 WADCD, “Roads”, p.16.
40 WADCD, “Roads”, p.68.
the limited notes of attending midwives or doctors do not shed much light on the experiences of individual women. This material is often generic and contains limited reference to specific birth events. The recording of mothers’ own reactions or feelings is certainly beyond the scope of these documents, again demonstrating the way the childbirth event itself was de-emphasised in the minds of both mothers and their attendants.

Other factors also influence the lack of primary sources available to historians of childbirth. WA’s remoteness from the rest of Australia led to the colony’s exclusion from much of the national discourse around obstetrics and midwifery which appeared in the *Australian Medical Journal* and similar publications. The personal experiences of individual doctors, which often included comprehensive descriptions of midwifery cases, appeared in the journal over many decades, but these rarely came from WA-based medical-men. Nor did hospital statistics, a common feature of the journal, relate to WA hospitals. Thus the voices of WA-based medical practitioners remain mostly silent in the journals during the period prior to 1930.

Despite a lack of material directly relevant to the Western Australian experience, medical publications and the contributions of individual doctors do shed considerable light on the practice of obstetrics and midwifery in Australia throughout the nineteenth and early twentieth centuries. However the use of such material brings its own challenges, because it highlights the underlying gender prejudice of the majority of material available to researchers in this area. The gender bias of statistical documents such as early WA censuses and the Blue Books demonstrates one of the ways in which the voices of women are silenced in the primary material. The anecdotes, statistics and commentary provided in publications such as the *Australian Medical Journal* and other journals during the period before 1950, work to limit the voices of women in other ways, specifically through the perpetuation of gendered understandings of women’s right and ability to comment on matters relating to their own bodies. From the 1870s and 80s, medical-men in Australia were in a powerful position which allowed them to define both acceptable standards of practice in midwifery as well as the expected behaviours of mothers and midwives within that context. As Lisa Featherstone has argued, during this period:

> the medical profession became authorities in the construction of the female body: doctors were able to define and articulate the physical and mental capacities of the woman. Through medical discourse and clinical practice, the woman became irretrievably linked to her reproductive organs, in ways that men were not. Based on the intense study of this body, doctors became the chief purveyors of social and
medical authority over women and mothers.\textsuperscript{41}

For the period in question, commentary in the \textit{Australian Medical Journal} and similar publications reflects this gendered understanding of midwifery practice and works to reinforce male medical expectations of the behaviours of mothers and the abilities of midwives. This material also reflects a class bias, as the contributors to such publications were necessarily practising medical-men who, during the late nineteenth and early twentieth centuries, established both an economic and political influence in broader society. The ability of medicine to establish itself as a profession and the very publication of a professional journal, all speak to the superior class status of the male medical doctor during this period.

As a result of these limitations, reliance on much of the available material for historical study into childbirth is somewhat problematic. Oral histories and letters remain two of the few sources which directly reference women’s attitudes, desires and expectations in relation to childbirth but these are severely limited by women’s own inability or unwillingness to discuss matters related to reproduction. Other sources like newspaper articles can give some insight, but the majority of the material is hampered by a lack of focus on the childbirth event itself as well as a blindness to the role of the mother in that process. It therefore remains difficult to accurately communicate the history of women and childbirth. Women’s perspectives have been so comprehensively silenced in much of the source material that what remains is only a shadow of women’s full experience. Nevertheless, this study seeks to tell that story by drawing on a broad array of sources and reading into the many silences which such sources present.

\textbf{Organisation of the thesis}

Like other revisionist and post revisionist histories of childbirth, this study questions some of the underlying assumptions which give modern obstetrics its power, and is therefore inherently linked to contemporary discussions focusing on the historical roots of ‘childbirth politics’. The first part of the thesis examines some of the common themes emerging from this discourse and aims to provide a broader context to the Western Australian material discussed in the main part of the text. Chapter One is a literature review which concentrates

on the writing of revisionist historians and historians of Australian and Western Australian childbirth. Some of the primary themes of this thesis are highlighted through an analysis of the existing work in this area.

Part two comprises five chapters which utilise both primary and secondary source material directly related to the history of maternity service provision in Western Australia for the period 1829 to 1950. Chapters Two, Four and Six rely mainly on primary material and are focused on women’s specific experiences in different WA birthing locations. Chapters Three and Five are shorter chapters that serve as contextual interludes. These sections separate the longer, more focused chapters and provide important and relevant contextual information which assists in understanding the broader implications of changes to maternity services in Western Australia. Chapter Two focuses on the colonial era, addressing both medical and midwifery attendance at childbirth. In this chapter, I establish the position of the home as a ‘sanctum’ for women during childbirth and emphasise the important role of the midwife as a provider of care in the home environment. Chapter Three sheds light on the negative representations of midwives perpetuated by medical practitioners in Australia from the 1880s and highlights the beginnings of the suppression of independent midwifery practice in Western Australia. The ‘Golden Age’ of medicine, so important to understanding how medical approaches to childbirth came to dominate the maternity sphere, is also discussed in its Western Australian context. Chapter Four follows this theme through an analysis of early twentieth century state legislation designed to regulate and manage maternity services in WA. The continuation of midwifery practice through the establishment of lying-in homes is discussed with a particular emphasis on the ability of women to access these homes.

Chapter Five examines important social changes which had a bearing on maternity service provision in Australia from the turn of the century. After the damning findings of the 1903 Royal Commission into the Decline of the Birth-Rate and on the Mortality of Infants in New South Wales, greater emphasis was put on the importance of motherhood and maternity services generally. Midwives came in for increasing criticism as infant mortality statistics highlighted the poor state of infant health across Australia. This chapter addresses the impacts of these developments on midwives and emphasises the role of state and federal governments in the increasing provision of maternity services through the establishment of maternity hospitals and the launch of the Maternity Allowance.
These changes provide the backdrop to the issues discussed in Chapter Six which primarily focuses on the establishment of WA’s first dedicated maternity hospital, King Edward Memorial Hospital. The setting up of this institution was the final result of many years of campaigning by Perth’s women’s groups who highlighted the need for low-cost institutionalised maternity care in WA. Using material from oral history projects undertaken in the 1980s, this chapter looks into women’s experiences of institutionalised care with a particular focus on the use of anaesthesia during childbirth. This material demonstrates the often ambiguous nature of women’s relationships to the maternity hospital experience during the 1920s, 30s and 40s and reinforces the challenges of interpreting past events through the modern lens.

The final part of the thesis contains a concluding chapter which brings together the arguments and ideas of the text as a whole. This chapter is an in-depth exploration of the supplementary themes of the thesis which have emerged through the empirical analysis of WA’s maternity services. I discuss the extent to which different childbirth locations can be seen to impact on women’s own experiences of childbirth in the past with a focus on the dualistic concepts of ‘sanctum’ and ‘surveillance room’, along with Goffman’s ‘total institution’ model. The challenges of transposing modern understandings of ‘choice in childbirth’ into the historical narrative are explored and the notion of choice is further problematised. The challenges of historical writing, including the specific challenges of revisionist approaches are examined with a focus on the application of contemporary ideas to historical understandings. By exploring these contemporary themes in this historical narrative of childbirth, it is possible to highlight important links between our understandings of childbirth in the past and in the present.
Chapter 1

Literature Review

Literature relating to the history of childbirth in the Western world is rich and varied, ranging from histories of famous obstetricians and well known maternity hospitals through contemporary accounts of highly skilled midwives to revisionist and post-revisionist approaches which challenge the traditional medical histories of the early and mid twentieth century. Australian authors, along with their international counterparts, provide competing representations of birth in the past as they seek to explore the narrative of childbirth medicalisation. These debates focus on the role and expertise of the traditional midwife and how these may have differed from those of the medical-man. Competing discourses which seek to explore notions of control and power in maternity care, as well as important concepts like ‘risk’ and ‘safety’ in childbirth, also predominate here. This extensive body of historical work is influential on the modern day experience of women and mothers in that it reflects contemporary debates in the sphere of ‘childbirth politics’. Historians working in this field often seek to make a point about the present state of maternity service provision in Western nations, making contemporary childbirth history writing important to the formation of modern day women’s health services. This thesis makes a contribution to this body of work by exploring the unique and so-far unrecorded story of Western Australian mothers and midwives before 1950. Their experiences, along with their active work in the maternity service area, bring fresh insights to this broad historical field and demonstrate the great variety in women’s responses to care models in the past.

Representations of the medicalisation of childbirth: midwives against doctors

Many writers in the field of the history of childbirth criticise the increasing presence of medical thinking and practice in modern birthing.¹ These authors often note the way that

medical discourses of childbirth centering on perceptions of ‘risk’ and ‘safety’ have come to dominate the field of maternity care, highlighting the way these ideas have worked to alienate women from childbirth and increase their fear of the birthing process. Writers who enter this contemporary realm of ‘childbirth politics’ are necessarily engaged in an historical discussion too, concerning the rise of obstetrics and the subsequent subjugation of female midwifery. The roots of the arguments about modern maternity care and childbirth management can be found in seventeenth century Europe when medical-men first began to challenge female midwives for the right to control childbirth cases. Much of the writing on childbirth history often seeks to explain past and current trends by highlighting this conflict. How this story of medicalisation is represented by different authors is a reflection of their particular biases and attitudes. It is either a medical success story which emphasises the horrors of childbirth in the past and compares this to the low maternal and infant mortality rates of today; or it is a story of the exploitation and manipulation of child-bearing women and midwives by a patriarchal industry which saw itself as the only rightful controller of childbirth care.

Charles Singer (1928) provides a classic example of the former view when he writes:

\[t\]he midwives were for the most part ignorant, dirty, unskillful and superstitious, and the loss of life and health that resulted from their mishandling was enormous. The objection to the ‘man midwife’ was only gradually overcome, though his advent was unquestionably attended by a fall in the mortality.

In contrast, Barbara Katz Rothman (1984) questions why medical involvement in childbirth occurred at the expense of the midwife, and why, given the lack of evidence, it has generally been believed that medical management is safer for women and children.

\[I\]t is not at all clear that the surgeons were providing better services [than midwives], in spite of the surgical and instrumental techniques. Not all physicians who practiced the new obstetrics were trained in its use. The iatrogenic results of the new obstetrics may have outweighed its benefits, particularly for normal and healthy births.

By referencing past history and the conflict between medical-men and midwives, both these authors seek to make a point about the present. Singer reiterates the common theme of medical history writing, suggesting, as feminist historian Lesley Barclay puts it, that

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3 Charles Singer, A Short History of Medicine, 1928, this edition 1944, Oxford University Press, London, pp.163-64.

‘medicine is progressing along a continuum from darkness into light, with ever increasing specialisation’. This notion of medical progress remains a powerful and influential one, which is born out in the enthusiasm with which childbearing women of today have embraced medicalised birth. Rothman seeks to question this assumption when she notes that the impacts of medical management on mothers in the past were often negative, or ‘iatrogenic’. She goes on to reflect on the harmful effects of medicalised birth on child-bearing women in modern North America, and in so doing, explains her own choice to have her baby at home.

This tactic of representing past aspects of maternity care as influential on the state of present-day maternity services is challenging but legitimate. It is a hallmark of the revisionist approach to childbirth history which underpins this study of maternity services in WA. Revisionist historians first began to question established medical accounts of childbirth history from the 1970s and the ideas put forward by trailblazers like Jean Donnison, Barbara Katz Rothman, Evan Willis and Ann Oakley gained legitimacy and momentum throughout the 1980s and 90s. One of the key facets of these debates centres on differing representations of midwives and their practice in the period prior to the medicalisation of childbirth. Revisionists seek to redress what they perceive as the imbalance evident in early histories of childbirth in which midwives are portrayed as incompetent and dangerous childbirth managers. As Oakley writes:

In such histories, the achievements of male obstetrics over those of female midwifery are rarely argued empirically, but always a priori, from the double premise of male and medical superiority. More recent investigations of this argument reveal a different picture, in which the introduction of men into the business of reproductive management brought special dangers to mother and babies.

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7 Rothman, Giving Birth, pp.11-22.
Murphy-Lawless makes a similar point in relation to the supposed successes of obstetrics over the period of childbirth medicalisation:

[...] the assertion of obstetrics, that it has conquered death, making childbirth safe for women, requires careful examination because the medicalisation of childbirth has not been an unqualified success and has not given women all the benefits it claims to have done.⁹

In this way, researchers like Oakley and Murphy-Lawless question the legitimacy of medicalised approaches to childbirth, both as they were carried out in past and as they occur in the maternity hospital of today. For these writers, obstetric management of childbirth is not a universally positive achievement of modern medicine. Instead, the story of childbirth medicalisation is one of the manipulation of women and misrepresentation of midwives.

Oakley (1994) makes the important point that the history of inter-professional rivalries is written by the victors.¹⁰ This partly explains why, in both WA and Australia broadly, the medical profession became so dominant in the sphere of maternity care, and why common perceptions of childbirth history always favour the doctor over the midwife. Influenced by this victor’s version of history, many historians adopt without question the idea that all or most midwives in the past were incompetent and dangerous. Ruth Teale (1978) takes her lead from traditional medical historians when she suggests that in colonial Australia poor European women were ‘at the mercy of the local mid-wife’.¹¹ According to Teale, traditional midwives working in Australia during colonial times were unclean and caused death and disease.¹² Similarly, Australian medical historian W.F. Shaw (1947) criticises the midwife of the nineteenth century, suggesting that women were inherently incompetent as childbirth attendants:

In difficult labour …[the childbearing woman] was usually butchered to death if attended by a ‘Sairey Gamp’ of the time, or one of the vagabond surgeons…Obstetrics, bound by the customs of many centuries, was enslaved in women’s hands.¹³

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While Shaw does accord ‘vagabond surgeons’ their share of the blame for the ‘butchering’ of women in childbirth, it is clear his anger is directed mainly at midwives. Shaw believes that ‘women’s hands’, not those of men, have ‘enslaved’ obstetrics.

Edward Shorter (1983) similarly promotes the idea that doctors were significantly better than midwives at managing birth in the past. He seeks to debunk what he regards as the revisionist-created myth that medical doctors were overly concerned with intervening in the birth process and suggests that it was in fact the midwives who were highly interventionist.

In contrast to recent “golden age” interpretations, the actual midwives of traditional Europe and England intervened furiously in the natural process of birth. Constantly tugging and hauling at the mother’s birth canal, at the infant’s head, and at the placenta…

John L. Thornton is another author who reflects this view. Writing in 1972, Thornton parrots the attitude of Dr. Percival Willughby who, in his 1863 midwifery text, strongly criticised the midwives of seventeenth century England. According to Thornton:

While deploring the dreadful injuries inflicted on both mothers and children by uneducated, inefficient and often brutal midwives, Willughby set about remedying the situation.

In Thornton’s thinking, it is the noble Willughby, the medical-man and obstetrician who ‘remedies’ the ‘situation’ created by the ill-informed and rough midwives. In all these texts, the ignorance and meddlesome behaviour of the empirically-trained midwife is the chief cause of maternal and infant deaths in childbirth. The medical-man is seen as the solution to this problem, the only person qualified to reduce mortality at childbirth.

Childbirth history revisionism: issues of safety and personnel

While unquestioning support of the medical-man was the hallmark of traditional medical histories of midwifery, most historians working in this field over the last 40 years take a revisionist approach. Authors such as Jean Donnison, Sheila Kitzinger, Ann Oakley, Lesley Barclay and Kathleen Fahy have all been highly influential in developing alternative understandings of childbirth history within the British and Australian context. These authors

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– whose work has been influential on this study – highlight the inequities inherent in established representations of traditional midwifery and question conventional ideas about the quality of midwifery services offered in the past. For example, Donnison (1977) suggests that while traditional midwifery practice was fraught with problems, the introduction of medically-trained practitioners made little difference to childbirth outcomes. There was:

no guarantee that any man setting up as a man-midwife, whether medically qualified or not, really understood his business, any more than there was for the women in this work. Without doubt male practice at its worst was as bad as that of the most ignorant midwife. 16

This more nuanced view is supported by other authors. For example, Roy Porter (1988) writes:

Men’s claim that only their skills could safely deliver infants was contradicted by centuries of safe deliveries by midwives. If anatomical expertise were vital, that was an argument not for supplanting midwives but for educating them. 17

Similarly, Australian writer T.S. Pensabene (1980) explains that alternative childbirth attendants – like the midwives working in colonial Victoria – offered a ‘similar, if not better, service to that of the qualified physician’. 18 In addition, Pensabene notes that the inadequacy of the medical doctor’s training meant that ‘they possessed little theoretical or practical advantage over midwives’. 19

Other authors such as Margaret Versluysen question the quality of obstetric training in the past. Versluysen (1981) notes that female midwives invariably had more direct experience of childbirth than medical-men, pointing out that in England, medical training in obstetrics remained limited for much of the nineteenth century. 20 As Porter (1997) suggests, in Britain:

[the art of obstetrics languished because, although it was a specialized skill, none of the authorized bodies wished to shoulder responsibility for it…] Even after the Medical Act of 1858, students could

qualify without any obstetrical training – a disgrace which lasted until 1886. Even then instruction was often perfunctory… 21

This lack of expertise often translated into a reluctance to act. As Pat Jalland (1986) notes, even by the mid 1800s when medical practitioners had been involved in childbirth management in England for well over a century, medical-men generally still had a limited knowledge of childbirth processes and ‘could only play a limited role in the delivery room’. 22

Certainly, the medical profession did not enjoy unmitigated success in the new business of obstetrics. Claims of a dramatic reduction in maternal and infant mortality after the introduction of medically-managed birth have never been tested and are strongly rejected by many commentators and historians. Donnison observes how as early as the 1800s, claims for a fall in maternal mortality rates were being made by male practitioners in London, even though there was no way to make an accurate assessment of the outcomes of male and female practice. 23 The claims of medical practitioners did not recede with the passing of time however. Writing in 1978, obstetrician and historian Peter Huntingford notes how in 1944, the Royal College of Obstetricians and Gynaecologists made the assertion that ‘the incidence of maternal mortality and morbidity is primarily a matter of obstetric personnel’. 24 He questions this understanding:

\[ \text{[t]} \text{he decline in maternal mortality is often and all too easily accounted for by the shift from domiciliary to hospital confinement, by advances in obstetric technology, and by the displacement of midwives and GPs by specialists.} 25 \]

Huntingford implies that other arguments for reductions in maternal mortality, like those relating to the introduction of sulphonamides and penicillin and reductions in instrumental interference in childbirth, have been ignored. 26

Similarly, Pat Jalland (1986) explains that during the Edwardian and Victorian eras, mortality rates for childbearing women – not including deaths from stillbirths or miscarriages – stood at

22 Pat Jalland, Women from Birth to Death: The Female Life Cycle in Britain 1830-1914, 1986, The Harvester Press, Sussex, p.120.
23 Donnison, Midwives and Medical Men, p.60.
around 5 in every 1000 children born alive. These figures did not improve until the 1930s, well after the introduction of medical management of childbirth. Medical Sociologist Evan Willis defends the legacy of midwives in relation to puerperal fever deaths noting that in Australia it was the affluent and middle-class women who employed doctors for their confinements who ran the greatest risk of infection. Medical historian Milton Lewis (1992) points out that in New South Wales as medically-managed childbirth increased and midwife management decreased over the early twentieth century, there was no decline in maternal mortality. According to Lewis, contemporary commentators acknowledged that doctors should shoulder a significant part of the blame for the excessively high maternal mortality rates occurring at this time. Ann Oakley highlights a similar situation in New York City during the early twentieth century. In 1913 midwives attended 40 percent of the childbirth cases but had only 22 percent of the maternal deaths from sepsis. In comparison, doctors, with 60 percent of the births, had 69 percent of the sepsis deaths. This leads Oakley to conclude that ‘illiterate midwives are likely to have spread a good deal less infection than doctors’.

Another claim made by obstetricians and medical historians in the past was that childbirth was always safer in hospital than in the home. This is demonstrateably untrue according to Australian historians Kay Saunders and Katie Spearritt. Writing in 1996, Saunders and Spearritt used statistics from colonial Queensland to illustrate how, as hospitalisation rates increased during the turn of the nineteenth century, so did maternal deaths from puerperal fever. Authors like Lewis, Fahy, Saunders and Spearritt suggest that the significant factor in reducing maternal mortality from puerperal fever and other infections was the introduction of sulphur drugs in the 1930s and 40s.

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31 Kay Saunders and Katie Spearritt, “Hazardous beginnings: childbirth practices in frontier tropical Australia”, *Queensland Review*, Vol.3, Iss.2, 1996, p.2. Puerperal fever was a severe disease common in child-bearing women internationally prior to the 1930s. It was caused by bacteria passed from attendant to mother via the genital tract and often resulted in death.
women by medically trained men, or the shifting of birth from the home to the hospital, did not in themselves have any positive effect on the mortality rate.

Revisionist historians also make important points about the complex competition which emerged between midwifery and obstetrics during the period of childbirth medicalisation. Through analyses of various historical material, the legitimacy of the medical profession’s current dominance of maternity care and the ethics of the manner in which this near monopoly was first attained and is today maintained is questioned by some writers. Versluysen demonstrates that there is a vast amount of material from this period that shows that both midwives and medical-men sought to discredit each other in an effort to retain and gain clients.\textsuperscript{33} However, there is a sense that much of the bad press was specifically directed towards midwives who were constantly hounded by accusations of illiteracy, uncleanness and bad practice. As Carol Thorogood (2001) writes, the medical profession claimed that:

midwives were ignorant, meddlesome and dangerous and therefore not fit to birth babies without medical supervision…[Medicine] mounted a public campaign, which portrayed [midwives] as dirty, illiterate and unskilled practitioners…\textsuperscript{34}

In a similar way, Rothman claims that midwives felt that the growing popularity of male practitioners was due to their ability to convince women about the dangers of childbirth and the apparent incompetence of midwives.\textsuperscript{35} These ideas are reflected by Oakley (1994) who uses the work of American obstetrician Henry Garrigues (1902) to demonstrate how midwifery was misrepresented during the early years of the twentieth century. According to Oakley, writing such as that produced by Garrigues contains some specific critical suppositions that demonstrate the professional and gender divide within maternity care at the turn of the century. Oakley lists these assumptions as follows:

1. Midwives are ignorant and dirty, therefore their practice is dangerous.
2. Even trained midwives are incompetent.
3. Midwives are especially unscientific because they care for women…
4. Men know more about obstetrics than women.
5. Doctors know more about obstetrics than anyone else.
6. Obstetrics is a science.\textsuperscript{36}

\textsuperscript{33} Versluysen, “Midwives, medical men and ‘poor women labouring of child’”, p.27.
\textsuperscript{34} Thorogood, Politics and the Professions, p.30.
\textsuperscript{35} Rothman, Giving Birth, p.53.
\textsuperscript{36} Oakley, Essays, p.66.
According to Oakley, these assumptions, presented as facts, were very powerful in influencing the public perception of midwives.\textsuperscript{37} She goes on to explain how important these arguments against midwifery were to the rise of obstetrics, and questions the positioning of the new obstetrics as a science:

Dr Garrigues and others like him had to argue that the practice of female midwives was dangerous and unscientific, and that the status of midwives in society was low. They had to do this in order to get people to accept obstetricians. Naturally, they equated obstetrics with science, but what is striking…is that the discreditation of midwifery as unscientific sufficed \textit{instead of} proving the scientific credentials of the new medical discipline. The obstetricians’ attack on midwives was a substitute for any sustained defence of their own case.\textsuperscript{38}

For writers like Oakley, Thorogood and Rothman, it is clear that medical-men in the past were trying to manipulate women into believing untruths about midwives and down-playing their capabilities as birth attendants. They did this in order to legitimately challenge for the control of an ever-increasing section of the midwifery market, into which convention and social taboos had so far made it difficult for them to enter.

Richard and Dorothy Wertz (1977) note that as male-midwives began to increase in popularity, their initial claims that they knew more about the mechanics of birth than midwives were expanded to include the suggestion that they knew how to prevent problems from emerging and that they could remedy any problems that did arise.

The doctors were claiming that their moral therapy – a vast amount of culturally influenced, scientifically unsubstantiated, and essentially speculative knowledge – would ensure a woman’s having healthy reproductive organs, less painful and unsafe births, and a generally happier, more fulfilling life.\textsuperscript{39}

These ideas, coupled with the ever-present pressure for motherhood, led women to better accept medical-men as childbirth managers. By suggesting that a safe delivery was at risk without male medical supervision and advice, medical professionals sought to position themselves as providing much needed comfort to women during a difficult time. Their future as mothers became a ‘threatened destiny’ which only medical attendance could safely bring to a happy conclusion.\textsuperscript{40}

\textsuperscript{37} Oakley, \textit{Essays}, p.66.
\textsuperscript{38} Oakley, \textit{Essays}, p.68.
\textsuperscript{39} Wertz and Wertz, \textit{Lying-In}, p.93.
\textsuperscript{40} Wertz and Wertz, \textit{Lying-In}, p.93.
For Evan Willis, the subordination of midwifery to medicine which gradually took place over the early decades of the twentieth century is linked to the social division of labour, gender and the production of the labour force. Arguing against technological-determinist theories which emphasise doctors’ better access to training and new birth techniques, Willis suggests that midwives were the victims of ‘male medical imperialism’.41

The health division of labour came to replicate the sexual division of labour in the domestic context with the male-husband-father-doctor directing and controlling the female-wife-mother-nurse in the interests of the child-patient.42

In addition to this, Willis argues that the transition to medical dominance was also a class transformation which affected other professions beside midwifery, specifically ‘quack’ doctors who also suffered a decline during medicine’s Golden Age. The medical takeover of midwifery therefore took place within the context of the social relations of production because it was primarily concerned with class and gender relationships which are themselves relationships of domination and subordination.43

Findings such as these illustrate how important revisionist approaches to this field of study are. Culturally dominant ideas about the quality of services offered by empirically-trained midwives are shown, at least in certain contexts, to be inaccurate, and this in turn casts doubt on the subsequent adoption of policies which brought midwifery and childbearing under medical control in a hospital setting. What revisionist historians highlight is that there is simply not enough evidence to suggest that the medicalised approaches of the past were safer or more successful than those of traditional midwifery, even though this is the assumption made by traditional historians of childbirth. Through these historical misrepresentations and assumptions, obstetrics has maintained an unquestioned dominance in both modern maternity care and in the shaping of common understandings about childbirth history.44

41 Willis, Medical Dominance, pp.122-23.
42 Willis, Medical Dominance, p.123.
43 Willis, Medical Dominance, p.123.
The development of the maternity hospital: discourses in risk and control

One of the most complex aspects of the debates around childbirth in the past centres on the development and growth of maternity hospitals. Revisionist historians have written about the hospital as a source of power for medical-men and as the vehicle through which midwifery became permanently subjugated to medicine. Versluysen’s 1981 article ‘Midwives, medical-men and 'poor women labouring of child': lying-in hospitals in eighteenth-century London’, one of the best-known texts in this field, analyses the beginnings of hospitalisation for childbearing women in Georgian England. Versluysen notes that broader community concern over the quality of midwifery practice during the eighteenth century, coupled with anxiety about high infant mortality rates and depopulation, created a context in which male-midwives could push for the establishment of maternity hospitals. These first institutions were a way to better establish male involvement in parturition and to normalise medical participation in what had been until recently, an all-female domain.

The establishment of hospitals for the purpose of managing maternity patients is commonly represented as one of the success stories of modern obstetrics. However, Versluysen suggests that the reality of the beginnings of hospitalisation for childbirth is somewhat more confusing and complicated than it first seems. In the context of an existing hospital system which was only for the acutely ill and dying, Versluysen asks why this new form of institutional supervision was deemed necessary for young, healthy, pregnant women. Childbirth was not considered to be a disease during this period. Before 1900 childbirth advice manuals for women typically represented pregnancy and childbirth as natural normal states. Nor was it the case that maternity care in hospitals was set up to accommodate women with some form of obstetric risk, for as Versluysen points out:

hospital records for the period plainly show that patients suffering from any recognisable complicating conditions, especially infection, were refused admission...it might be assumed that patients in lying-in hospitals were selected according to some identification of specific obstetric risk. But systematic antenatal care was non-existent in the eighteenth century and the selection of high-risk cases would therefore have been difficult, if not impossible.

45 Versluysen, “Midwives, medical men and ‘poor women labouring of child’”, p.36.
46 Versluysen, “Midwives, medical men and ‘poor women labouring of child’”, p.20.
47 Oakley, The Captured Womb, p.12.
48 Versluysen, “Midwives, medical men and ‘poor women labouring of child’”, p.21
Nor was it the case that some new midwifery technology or medical therapy required an institutionalised approach for its use to be effected. Versluysen notes that the strict rules surrounding which women could use the facilities of the hospital belie the suggestion that maternity hospitals were developed to assist all women during their childbearing. Only certain types of women – married, poor, and with the support of a subscriber – were allowed entry to these institutions. According to Versluysen, the answer to the question of why these institutions were established lies firmly with the ‘desire to establish male control’ of midwifery practice.49

Examinations of the hospital as the site of the medical training of midwives has also been of interest to historians writing about childbirth history. Shorter, for instance, suggests that the creation of midwifery training sites in hospitals throughout continental Europe demonstrates the willingness of medicine to pass on its scientific perspective on childbirth and thereby better equip midwives for their role as the primary childbirth attendant.

Contrary to a popularly accepted myth, the “male medical doctors” did not attempt to keep scientific knowledge out of the midwives’ hands. In fact, the doctors desperately tried to persuade them to acquire it.50

In a break with other revisionist historians, Donnison supports Shorter’s point when she suggests that maternity hospitals played an important part in the future of midwifery because they provided a forum for midwives to gain a basic medical understanding of childbirth.51 Yet according to Versluysen, training also had its down sides because midwives were limited in their ability to practise their midwifery techniques while undergoing training. The institutionalised hierarchies of the hospital meant that midwives were positioned as subordinate to doctors, so although midwives might hope to improve their knowledge through hospital-based training, they were rarely allowed to actually practise their midwifery skills in the hospital. The role of primary carer during childbirth was reserved for the doctor, with midwives being expected to act only as a nurse to the patient.52

49 Versluysen, “Midwives, medical men and ‘poor women labouring of child’”, pp.21-22.
50 Shorter, A History of Women’s Bodies, p.42.
51 Donnison, Midwives and Medical Men, p.27.
52 Versluysen, “Midwives, medical men and ‘poor women labouring of child’”, pp.38, 32.
Most revisionist historians project a negative view of the maternity hospitals of eighteenth century Europe and point out that these early institutions were also very unsafe for women and babies. However, more recent post-revisionist work seeks to redress common representations of early maternity hospitals as inhumane and unsafe places to give birth. Lisa Forman Cody (2004), makes the point that while maternal mortality rates in nineteenth century hospitals were generally high, it remains in contention as to whether eighteenth century hospitals were equally dangerous as places to give birth. This idea echoes the earlier work of Margaret DeLacy (1989) who notes that in eighteenth century Britain, epidemics of puerperal fever were actually rare events and did not cause a significant number of deaths. Eighteenth century maternal mortality rates at these early institutions are generally thought to have been significantly higher than the mortality in home births during the same period. However, Cody questions this revisionist-inspired idea, suggesting that hospital birth in London during the eighteenth century was no more dangerous than births at home during specific periods.

Cody completes her revision of this component of childbirth history by examining the extent to which medical-men were able to operate in these early hospitals, calling into question Versluysen’s analysis of the reasons behind their creation. In her examination of previously untapped archival material from the British Lying-in Hospital, Cody found that women mostly ran the hospital.

The British Lying-in Hospital rarely relied upon its doctors to deliver infants, nor did it ever admit a male student before 1830 – making the presumed connection between the rising power of eighteenth-century men-midwives and the establishment of lying-in hospitals more nuanced than generally assumed.

Like Shorter and Donnison, Cody questions the extent to which the hospital environment marginalised midwives and sought to deskill them, as has been claimed by other historians.

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56 Historians give a lot of attention to Frank Nicholls’ 1751 pamphlet “The petition of the unborn babes to the censors of the Royal College of Physicians of London” which criticises London’s maternity hospitals and claims that one in fifteen children is born dead at the British Lying-in Hospital. Nicholls also calls into question the treatment of the mothers at these institutions. Using these sorts of sources, historians like Porter and Loudon have condemned eighteenth century maternity hospitals.
The matron’s powerful role and the female midwifery students’ qualifications challenge any sweeping conclusions that this hospital contributed to a professional marginalization of Georgian midwives.59

Cody makes the simple and often forgotten point that the lying-in experience differed across London’s hospitals during the eighteenth century. While there were some hospitals that were run by doctors and could perhaps be seen as institutions designed to allow medical-men access to women’s bodies (Cody identifies the Middlesex Lying-in Ward founded in 1747 as potentially being one such institution) there were clearly others that were not heavily medicalised in their practices and which sought to train midwives not medical-men.60

While the context to the establishment of midwifery training in WA was different to that being explored by authors like Cody, Donnison and Shorter, the primary material used in this study also suggests that midwives working at the state’s first dedicated maternity hospital were relatively independent of medical oversight. Indeed, during the early years of KEMH, the midwives in training conducted the majority of the deliveries on their own and the honorary physicians were rarely called to a case. These findings reflect the great variation in the staffing and management of early maternity hospitals and reinforce the need for further investigation into the running of individual facilities and the experiences of women within them. While some hospitals may have been, as Versluysen suggests, the vehicles for the establishment of male medical control of childbirth, this was clearly not the case for all institutions, some of which were run and managed almost entirely by women.

The importance of early Australian revisionists: critiquing the maternity hospital

The majority of Australian writing on childbirth history was undertaken in the second half of the twentieth century, particularly the three decades from 1970 to 2000.61 During the 1980s and 90s, Australian writers including Milton Lewis, Kay Saunders and Katie Spearritt, participated in some of the international historical debates about childbirth history identified above. In addition, the period of the late 1970s to the late 1990s was a key time for the

61 Traditional medical histories of Australian midwifery were mainly written before this time. Notable among them are Shaw’s “Development of Obstetrics and Gynaecology” (1947) and F.M.C. Forster’s Progress in Obstetrics and Gynaecology in Australia, John Sands, Sydney, 1967.
development of important projects related specifically to Australian childbirth history. The history of women’s birthing experiences began to feature in broader projects about the history of women as pioneers in Australia, in histories of colonial child welfare, and in histories of early medical practice in Australia. An in-depth and well-researched history of Australia’s oldest maternity hospital, the Royal Women’s Hospital Melbourne, was produced by Janet McCalman (1997), and Kerreen Reiger’s important and influential work The Disenchantment of the Home: Modernizing the Australian family 1880-1940 (1985) examined the changes occurring in how birth was understood and managed in the early years of the twentieth century.

In addition to these broader research projects, some very significant historical studies were undertaken during the 1980s and 90s which analysed the provision of maternity services by early twentieth century state governments. The works of Wendy Selby in Queensland, Anne Blood and Beth Robertson in South Australia and Anne Misson and Susan Pyke in Victoria have all been highly influential on this study of Western Australia’s maternity services. The projects produced as a result of this research seek to give voice to women themselves through the use of oral histories and focus on a highly significant period in Australian childbirth history, namely the transition from home to hospital birthing. Like many revisionist authors, Selby (1992) questions the quality of maternity services after the introduction of government-run maternity hospitals. Using oral histories, Selby was able to build up a picture of women’s personal experiences of childbirth in these new institutions. Her findings add weight to the theory that the medicalisation of childbirth had a negative impact on the safety of mothers and babies, and that this was especially the case during the 1920s. Like a number of authors who write about this period of transition from home birthing to hospital birthing, Selby found that many women suffered poor outcomes as a result of their visits to hospitals, and that rates of intervention were significantly higher in maternity wards than they were in home confinements. Hospitals were built and doctors’ control of childbirth was institutionalised before the medical profession could improve the safety of childbirth, and this situation led to greater intervention in childbirth and no reduction in rates of mortality.

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64 Selby, Motherhood in Labor’s Queensland, p.32.
Early projects such as Selby’s also highlight important aspects of hospital life which shed light on women’s own experiences and go some of the way to explaining mothers’ seeming support for increasing medicalisation in childbirth management. Childbearing women had very little control over their hospital experience and found themselves, in many cases, at the mercy of hospital staff. For example Blood (1982) notes that in relation to childbirth:

[t]he relationship between both doctors and midwives and their patients was in most cases, across all strata of society, one in which the doctor was the ultimate authority, omnipotent and vested with complete control of the situation...The midwife was the doctor's first lieutenant and in this role was more intimidating and awe-inspiring than the doctor himself.\(^\text{65}\)

Our understanding of women’s experiences of childbirth during this period is greatly informed by these insights into the hierarchical relationships between patient, midwife and doctor in the hospital setting. In a similar way to the midwives training in Britain’s early maternity hospitals, trained midwives in some Australian hospitals were not independent practitioners in their own right, but assistants to male obstetricians who were expected to obey the doctor’s orders. Mothers, as patients in the maternity hospital, occupied the lowest position in the institutionalised hierarchy. Blood’s research and her use of oral histories taken from women who gave birth in the 1930s illustrates this inequality between patients and their attendants. As one woman testifies, ‘I wasn't so much afraid of pain or anything, but of not knowing what to do right. I wouldn't have done anything to upset her [the nurse]. She hated us asking questions’.\(^\text{66}\)

Susan M. Pyke’s 1986 study of eight women who gave birth in Victorian hospitals during the 1920s and 30s suggests that compliance with and acceptance of medical dictates in the hospital setting was the norm among women during this time. She notes that during the 1920s and 30s ‘the hegemony of the medical elite was portrayed as progress and an obvious choice’.\(^\text{67}\) Through her interviews, Pyke found that women’s understanding of, and expectations of birth were shaped by the philosophies and ideas of the medical elite, who were anxious to reinforce their power base within the lucrative sphere of the hospital.\(^\text{68}\)

Medical and nursing knowledge about childbirth was not questioned, and most women’s

\(^{65}\) Anne Blood, Birth in South Australia in 1938, 1982, Honours Thesis, Flinders University, p.39

\(^{66}\) Blood, Birth in South Australia, p.39.


\(^{68}\) Pyke, “‘but Nothing Interesting Ever Happened to Us’”, p.53.
experiences of the hospital reinforced the notion that mothers should do as the doctors and nurses instructed them. This deference to hospital staff and acceptance of hospital protocols is reflective of the hospital hierarchies identified by Blood and Selby in their oral history projects. Pyke’s interviewees had these same experiences of being at the bottom of the institutionalised pecking order.69

The work of Anne Misson in Victoria shines a light on these important issues by focusing on the role of women in the acceptance and promotion of medicine’s ‘Safety Model’ of childbirth. Misson (1986) points out that in Australia by the 1930s, women’s recognition of childbirth as a family-centred, domestic event had disappeared from the public discourse.70 Women had come to fully accept and endorse what Misson calls the ‘Safety Model’ of childbirth in which birth always took place in a maternity hospital and where both mother and baby were under the complete control of medical professionals. This model reflected the medical focus on the pathology of pregnancy and birthing and emphasised the needs and priorities of obstetricians over the concerns of patients. Within this context, a mother’s emotional or physical needs were seen as superficial and irrelevant to the task at hand.71 The use of anaesthesia was part of the accepted routines of medicalised childbirth because as Misson notes it allowed the doctor:

\[
\text{to remove the problem of a feeling, demanding and anxious patient interrupting what [he] must do for her own good and the good of the baby.72}
\]

Women of the time not only accepted but actively demanded these things, all of which were seen as important facets of the most modern and safest path to motherhood.73

The positive attitudes of early twentieth century mothers to the medicalised model of childbirth perplexed feminist historians of the 1970s.74 Since this time, some writers have sought to explain women’s apparent endorsement of the ‘Safety Model’ in ways which imply that mothers were merely victims of a manipulative and patriarchal profession which sought

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69 For example see Pyke, ‘‘but Nothing Interesting Ever Happened to Us’’, p.60.
71 Misson, Protected and Directed, pp.9-10.
72 Misson, Protected and Directed, p.10.
73 Misson, Protected and Directed, p.10.
to undermine women’s own control over their own bodies. Murphy-Lawless puts forward a version of this idea when she identifies one of the key aspects of medical claims to superiority in the field of obstetrics: the ability to handle death.\textsuperscript{75}

\begin{quote}
[T]he price women paid for this claim to more certain knowledge [of death] was a severe limitation of their agency and an absolute diminution of their own knowledge base and skills.\textsuperscript{76}
\end{quote}

Other authors resist such interpretations. For example Misson writes that theories of this type:

\begin{quote}
fail…to see women as members of a public who, regardless of the eventual drawbacks for them or the self-interest of the other parties involved, accepted the changes in social values which had made their domestic and emotional needs seem of diminishing importance…women as part of the general public welcomed the move as one which offered them a positive improvement in their standard of living.\textsuperscript{77}
\end{quote}

Selby also questions any one-dimensional representation of women’s acceptance of medicalised childbirth in the 1920s and 30s:

\begin{quote}
To say that women were active participants in the medicalisation of childbirth ignores the complexity of the situation. Women were given a limited view of themselves (as wives and mothers), limited choices in their lives, and limited choices in childbirth (because of the closure of alternative childbirth facilities). Evidence of the increased risks of childbirth being conducted in maternity hospitals in the 1920s was not made available to Queensland women, principally because neither the government nor the Queensland medical profession chose to investigate this possibility.\textsuperscript{78}
\end{quote}

While from the modern viewpoint women’s apparent loss of control over their bodies during this period is a source of anger for many feminist writers, mothers of the time did not perceive the situation in the same way. As Misson suggests:

\begin{quote}
The views of women expressed after 1930 simply came increasingly to demand those features of childbirth management most approved of by doctors themselves. They never had the sense that they had lost control, but congratulated themselves on the extent to which they had been active in ensuring safety and pain relief for themselves and their sisters.\textsuperscript{79}
\end{quote}

Kerreen Reiger makes a similar assessment of the attitudes of women during this era:

\begin{quote}
\end{quote}

\textsuperscript{75} Murphy-Lawless, \textit{Reading Birth and Death}, p.7.
\textsuperscript{76} Murphy-Lawless, \textit{Reading Birth and Death}, p.7.
\textsuperscript{77} Misson, \textit{Protected and Directed}, p.7.
\textsuperscript{78} Selby, \textit{Motherhood in Labor’s Queensland}, p.213.
\textsuperscript{79} Misson, \textit{Protected and Directed}, p.11.
The women that led the campaigns for better obstetrical care shared with the professionals an emerging frame of reference: one which valued the scientific knowledge base, the modern technology and the professional specialization of the medicos.\textsuperscript{80}

In this way, Australian women of the 1920s and 30s came to view themselves as adopting and endorsing a modern, scientific and safe approach to childbirth which had been denied to their mothers and grandmothers.

In seeking to reinterpret women’s tolerance of medicalised childbirth during the first half of the twentieth century, writers like Pyke and Misson highlight important social factors which influenced women’s attitudes to birthing and mothering during this period. For example, Misson suggests that the biggest factor in producing the ‘accord’ between obstetricians and mothers was women’s concern over maternal and infant mortality rates and their belief that the medical profession could provide a solution.\textsuperscript{81} Indeed, in her research, Pyke found that women’s choices about where to give birth during this period were strongly influenced by the way medical professionals represented hospitals as safe and clean environments for birth. From the 1920s, hospitals were being promoted as sterile and modern and the perceived dangers of bacterial infection (specifically septicaemia) were important in shaping where women chose to give birth. While medically-run hospitals would in time advertise themselves as being cleaner than homes, Pyke notes that ‘the promotion of hospitals as the most aseptic environment may not have been a medical truth then [the 1920s and 30s], despite being thus perceived.’\textsuperscript{82}

Another factor which provides context to women’s acceptance of medicalised birthing is mothers’ lack of information about childbirth and reproduction. Both Pyke’s and Robertson’s studies highlight how Australian first-time mothers during the 1920s and 30s were severely restricted by their ignorance of such matters. Pyke shows that women’s limited knowledge of childbirth had the effect of making them less questioning of their hospital experiences; they were ‘subjugated by their ignorance’.\textsuperscript{83} Robertson’s study reinforces this view. She found that girls were often not told about menstruation and pregnant women were sometimes unsure about how the baby would come out of their body. Women accepted this ignorance with a

\textsuperscript{81} Misson, \textit{Protected and Directed}, p.8.
\textsuperscript{82} Pyke, "‘but Nothing Interesting Ever Happened to Us’", p.55.
\textsuperscript{83} Pyke, "‘but Nothing Interesting Ever Happened to Us’", p.60.
stoic and somewhat fatalistic attitude that was reflective of a period when talk of sex and pregnancy was strictly taboo; information about reproduction and childbirth was only ‘for the initiated’.  

Understanding the limited nature of women’s knowledge and choices during this period creates an important context for comprehending women’s behaviours in relation to childbirth. However, as researchers like Misson have found, women giving birth during the 1920s, 30s and 40s carried with them a very different vision of childbirth than that which is common today. The scope of acceptable female identity during the early twentieth century was so limited as to make ‘woman as mother’ the universally accepted standard. As a consequence of this, the childbirth event itself was de-emphasised; the important part was the mothering, not the birth. Within this context, women did not put as much importance on childbirth and were perhaps ambivalent about birth itself. It is therefore difficult to make concrete links between women’s childbirth experiences in the past and women’s expectations of childbirth today.

Australian childbirth history writing in the 21st century

While Australian authors of the 1980s and 90s were focused on history, most twenty-first century writing on childbirth in Australia and New Zealand is concerned with modern debates around caesarean section rates, increasing medical intervention in childbirth, notions of control and power in childbirth, and women’s personal experiences of different care models. Other contemporary writers look at methodological questions about how childbirth can be understood and studied and another group examines women’s expectations of the childbirth process.


Only a few Australian writers in the last fifteen years have looked at childbirth history specifically, and these pieces have usually been short essays or micro histories focusing on one area or topic. Kathleen Fahy (2007) briefly examines the growth in the power of medicine during the late nineteenth and early twentieth centuries, linking this change to the subordination of midwifery in Australia. Fahy challenges traditional history’s negative interpretations of empirically-trained midwives, suggesting that ‘the takeover of midwifery by medicine was an example of gender-based oppression; an oppression from which women and midwives are still suffering’. Lesley Barclay (2008) makes a similar point, linking the past misrepresentation of midwives by medical practitioners to women’s present day experiences of childbirth in a medical setting. According to Barclay, contrary to the narrative of many medical histories:

fee-paying affluent clients of male practitioners had worse outcomes than poorer women in less favourable economic circumstances delivered by midwives. This situation is similar today.

Like other revisionists before them, Fahy and Barclay link the growing legal and social status of medical-men during the late nineteenth century to their ability to severely limit and control midwifery practice in Australia, while at the same time suggesting that this suppression of midwifery has had flow-on effects on the provision of modern-day maternity services.

As evidenced by the writing of Fahy and Barclay, most Australian authors of childbirth history are keenly interested in the debates which make up this field of study. The polemic tone of much of this writing is carried through in the Australian material because the

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Impacts on Women's Fears of Childbirth: A Western Australian Example”, Social Science and Medicine, Vol.63, 2006, pp.64-75.


88 Fahy, “An Australian History of the Subordination of Midwifery”, p.27.

89 Barclay, “A feminist history”, p.4.

90 Barclay, “A feminist history”, p.5.
experiences of British midwives and doctors and those of their Australian counterparts are inevitably linked.\textsuperscript{91} Carol Thorogood’s Politics and the Professions: Homebirth in Western Australia (2001) is an important text for this project because it not only acknowledges this link between Britain and Australia, but provides a comprehensive deconstruction of medicine’s power in the realm of maternity services internationally. In her thesis, Thorogood examines the British roots of the medical takeover of childbirth, strongly criticising the role played by medicine in the warping of natural childbirth into a highly medicalised event. For Thorogood, medicine’s control of childbirth is reinforced by broad acceptance of the medical discourse, and this power has made it possible for medicine generally, and obstetrics specifically, to counteract any opposition to its technological approach to birthing.

Medicine’s dominance of the management of knowledge reinforces…socially constructed boundaries and gives it a controlling surveillance over the construction and distribution of other resources…obstetrics neutralises opposing ideologies by claiming that it is of such critical importance to society that only credentialed members of the profession can provide maternity care. Moreover, obstetricians assert that they deal with such complex and esoteric problems that lay people cannot be expected to make fully informed choices about their care because as Oakley puts it, doctors think they know more about having babies that the women having them.\textsuperscript{92}

Some of these themes are reflected in the work of Kerreen Reiger whose book \textit{Our Bodies, Our Babies: The Forgotten Women’s Movement} (2001), looks at the changes implemented in Australian maternity care from the late 1970s. Reiger shows how maternity service provision was reformed as a result of an upsurge in public dissatisfaction with Australia’s maternity hospitals. Reiger’s research into this ‘forgotten women’s movement’ showed that while some significant changes were made to accommodate women’s concerns, there was no ‘real revolution’ which allowed women ‘effective control over their birthing and the management of their babies’.\textsuperscript{93} In fact, Reiger asserts that just when birthing in hospitals was being made more ‘humane’, rates of medical intervention in birth were increasing and medicine was strongly reinforcing its model of pathological birth.\textsuperscript{94}

Like other Australian historians, Reiger emphasises the role of medicine in the subjugation of midwifery in Australia and notes the subsequent limiting of women’s choices in childbirth. According to Reiger, the medical profession’s policy of universal hospitalisation for

\textsuperscript{91} Thorogood, Politics and the Professions, p.116.
\textsuperscript{92} Thorogood, Politics and the Professions, p.10.
\textsuperscript{94} Reiger, \textit{Our bodies, our babies}, p.3.
childbirth was reinforced by the introduction of the federally funded Maternity Allowance in 1912 and by the increase in medically-run antenatal clinics during the early decades of the twentieth century. Yet as a post-revisionist writer, Reiger also notes the way in which Australian women themselves clearly expressed a preference for hospital birthing during the interwar years particularly, a fact that is strongly reflected in the material used in this study. Women were involved in campaigns to improve hospital services and increase the number of maternity beds. By highlighting this issue, as other authors have, Reiger again demonstrates one of the key complexities in any analysis of changes to maternity service provision across the Western world. While many of the transformations associated with the medicalisation of childbirth seem to have had negative impacts on women and babies, women themselves were often at the forefront of these changes and promoted them as positive alternatives to traditional midwifery practice. Making sense of women’s enthusiasm for childbirth medicalisation in the past is one of the key tasks of post-revisionist historians working in this area and reflects the challenge of attempting to transpose modern expectations of the childbirth process into the historical narrative.

Childbirth history in Western Australia

Unlike many of the other Australian states, there has been very little childbirth history writing centred on Western Australia. While Thorogood’s research contains much of historical value, it is primarily focused on more contemporary debates about obstetrics and midwifery and on the challenges facing home birthing in the modern era. In other texts, the key period of 1900 to 1950, a time when maternity services nationally were undergoing significant changes, has only ever been dealt with in passing, or in short pieces about specific subjects. Similarly, research into the period prior to 1900, for which source materials are severely limited, has also been sadly incomplete. For example in History of Midwifery Practice in Australia and the Western Pacific Regions (1984) W. McDonald and J.A. Davis include a small yet informative section on the history of midwifery in Western Australia. However, like so many texts, and due most likely to a lack of source material, the authors are unable to provide many specific details about midwifery services in this state prior to 1911.

95 Reiger, Our bodies, our babies, pp.17-18.
96 Reiger, Our bodies, our babies, p.18.
The Western Australian childbirth history writing that does exist is limited by an overemphasis on the opening of maternity hospitals and on legislation governing midwifery practice. In fact so much of the material produced in this state concerns the history of our maternity hospitals that the observer could be forgiven for thinking that childbirth history was analogous with maternity hospital history.98 McDonald and Davis’ text – perhaps limited by the breadth of its research parameters – focuses heavily on government legislation and on the opening of midwifery training facilities and fails to investigate the impacts of these important changes on midwives as autonomous practitioners. Indeed, traditional histories of Australian obstetrics tend to ignore midwives and sometimes ignore the involvement of women altogether, instead focusing on the important male obstetricians of the time.99

The way in which midwifery and nursing came to be understood as part of the same profession in Australia, has also had an impact on the extent of historical investigations into the specific experiences of midwives as independent practitioners. The use of the words ‘nurse’ and ‘midwife’ as interchangeable terms – both midwives and nurses were ultimately covered under the same legislation in WA – has meant that the history of Western Australian midwifery has also become enmeshed with Western Australian nursing history. Victoria Hobbs’ But Westward Look: Nursing in Western Australia 1829-1979 (1980) is an example of this phenomenon. Hobbs’ text contains much of interest for the childbirth history researcher simply because nursing and midwifery became so interlinked after the introduction of formal training for midwives in the early decades of the twentieth century. Yet the text, while accepting that midwives were part of the nursing family, pays little attention to their work specifically. For instance, there is no recognition that, before the medicalisation of childbirth, midwives were once successful, independent and autonomous practitioners for instance. For Hobbs, the lack of legislative control exerted over female midwifery practice in the nineteenth century necessarily made midwifery dangerous and in need of management by nursing and medicine.

99 See for example Forster, Progress in Obstetrics and Gynaecology in Australia, p.72.
Generally speaking, the professional nurse carried out treatment on the orders of a doctor if one was available, but this did not apply to the women who acted as midwives and undertook confinements in their own houses or in the patient’s home. There was no legislation against such practice.\textsuperscript{100}

This limited representation of midwives practice means that Hobbs’ text remains primarily a history of Western Australian nursing, not Western Australian midwifery. Like many of the traditional medical histories, Hobbs’ book reflects an incomplete understanding of the successes of empirical midwifery in Western Australia, and echoes past assumptions about the correctness of hospital-based, medically-managed midwifery training.

May Flanagan (1997) is another writer who focuses on the development of institutionalised maternity care in WA. Flanagan charts the development of WA’s hospital-based maternity services from the early charity institutions like the House of Mercy and the Salvation Army’s Hillcrest Maternity Home, through to the establishment of King Edward Memorial Hospital. Most interesting however is her analysis of small midwife-run lying-in homes which were a feature of WA’s maternity services from the latter decades of the nineteenth century through to the end of the Second World War. It is these institutions which are the focus of a good proportion of the primary research for this thesis.

Like many historians working in this area, Flanagan presents the facts but provides little analysis. In her closing remarks she states:

\[\text{[t]he place of birth in the community, which had largely been regarded as a domestic occasion with a midwife, had moved from lying-in homes to purpose-built labour and clinical wards in hospitals under medical supervision. Childbirth…belonged now to the medical rather than the domestic arena…and medical care was available to all women irrespective of their circumstances.}\textsuperscript{101}\]

This medical care, as Selby and others have shown, was not always good for women and babies, but we see no suggestion of that from Flanagan. Medical supervision of childbirth, as it is presented here, is necessarily a good thing for all women. Similarly, the shifting of birth from the domestic sphere to the maternity hospital is represented as an inevitability and something from which all women will benefit. This certainly proved not to be the case. As Reiger’s and Thorogood’s studies demonstrate, women were seeking a return to domestic


birthing from the 1970s and some women, such as those whose experiences Robertson discusses, were actively resisting the maternity hospital and choosing to birth at home much earlier than this.\textsuperscript{102}

This brief analysis shows that the history of WA’s maternity services is an area lacking in in-depth research, and it is into that breach that this study will step. By piecing together a picture of WA’s network of maternity services using varied and disparate sources, it is hoped that an accurate and useful history of WA’s unique experience will emerge. This thesis will also form part of a growing body of revisionist and post-revisionist history writing which seeks to prioritise the voices of women as both mothers and midwives. Following the changes in childbirth location as they occurred from the colonial period to 1950, this work emphasises the importance of the home as a source of comfort and safety for women during childbirth and relates these discussions to discourses of choice in the modern and historical context. By painting a picture of what birth in the past may have been like for women in WA, this research aims to provide historical representations of childbirth which focus on the normal and natural, thereby redressing past historical portrayals of childbirth which often emphasise the pathological. The next chapter shows the interaction of these themes through an analysis of home-birthing during the colonial period in WA.

\textsuperscript{102} See for example the stories of Irene Bell and Mary Waterman who both, after having given birth in a maternity hospital, decided to remain home for subsequent births. See Robertson, “‘Old Traditions and New Technologies’”, pp.57, 66.
Chapter 2

Birthing at Home in the Colonial Period

Traditionally, childbirth in the Western world took place in a woman’s home. It was a relatively private experience, witnessed only by female family or friends. Despite all the changes brought about by the medicalisation of childbirth in Europe – a process which saw the gradual shift in women’s choice of birth attendant from the midwife to the medical-man\(^1\) – the home remained the location of birth for the vast majority of women until the early twentieth century. Most European women in Western Australia, like their counterparts in Eastern Australia, gave birth in their own homes until around the 1930s.\(^2\) Not all homes were comfortable or clean, but they were environments in which births, for the most part, could be conducted relatively safely and where mothers were surrounded by people they knew and trusted.

Colonial women’s childbirth experiences varied significantly depending upon their geographical location and their socio-economic status. Over the nineteenth century, European settlement at Swan River quickly became dispersed across the modern South West and included existing settlements as far south as Albany over four hundred kilometres from Perth. What the surviving evidence shows is that during colonial times, women outside Perth and its surrounds were often isolated in small communities with little access to professional assistance of any kind during childbirth. Women in Perth on the other hand were more likely to be able to access professional care if they could afford to pay, although the quality of care varied. The different roles and responsibilities of doctors and midwives was also a source of diversity in women’s experiences of childbirth in their own homes. Midwives and doctors each offered different services as childbirth attendants in the home and each had a different way of approaching parturition. From the 1880s, concerns were raised by physicians and the public across Australia about the relationship between the quality of midwifery services and Australia’s high maternal and infant mortality rates. Discussion of these issues in medical circles reflected the common anti-midwife stance of many in the medical profession. While

\(^1\) I am using the term ‘medical-men’ because at this time all those who practised medicine in the colony were men. ‘Medical-men’ was also the term used by medical professionals themselves to describe those who worked in medicine.

medical-men and midwives should have shared some of the responsibility for high maternal
and infant mortality rates in Australia, the blame for these deaths was generally laid on
midwives alone.

WA’s colonial medical fraternity

The British ruled and occupied state of Western Australia began its life as the Swan River
colony in 1829. It was, unlike New South Wales and Van Diemen’s Land, originally a colony
for free settlers and no convicts arrived until 1850. One of the key attractions of the new
colony at Swan River was the supposed healthiness of the place: many settlers hoped to
escape here from the crowded and disease-ridden cities of England. It was also a place for
the gentry; only those with sufficient capital could make a successful life during the early
years at Swan River. The early female settlers of Swan River, particularly the wives of
government officials and soldiers, might have hoped for medical attendance during their
confinements. By 1829, medical management of childbirth for wealthy people was the norm
in England. However, little provision seems to have been made for this in the new colony,
with the British government providing only one official medical practitioner for the
management of the health of the first group of settlers. Often then, in the early days,
European women gave birth with the assistance of relatives, neighbours and friends.

It is somewhat ironic that in a colony with so many landed, upper-middle-class British
families in search of an escape from the sicknesses of the large cities back home there should
have been such limited access to good quality medical care. The small number of medical-
men who lived and worked in Western Australia during early colonial times were mostly
medical officers and surgeons who were part of the colonial bureaucracy. As civilian
government officials, they were there to set up and run the colony’s early health services, and
as such, did not work in private practice. Some early settlers did go into private practice
however, and the first to do so was Thomas Harrison who arrived during the colony’s first

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3 Prue Joske, “Preamble”, in Marian Aveling (ed.), Westralian Voices: Documents in Western Australian Social
History, 1979, University of Western Australia Press, Perth, p.205.
5 Frank Hansford-Miller, The Grim Reality of Life for the Early English Settlers of Western Australia: 1829-
6 J.H. Stubbe, Medical Background: Being a History of Fremantle Hospitals and Doctors, 1969, University of
Western Australia Press, Perth, p.6.
year. It is often remarked by Western Australian historians that the medical fraternity at Swan River was incredibly unlucky in that a significant proportion of them died in accidents or from excessive drinking. Frank Hansford-Miller suggests that any judgement about the quality of medical care at the new colony must take this fact into account. Dr. John Whatley, who arrived in 1829 and commenced practice at Bayswater, was drowned ferrying a cow across the Swan River at Fremantle that same year. Dr. Charles Towler, the ship’s surgeon aboard the Marquis of Anglesey, was reported dead in 1831 as a result of an alcohol addiction. Dr. Charles Simmons, the colony’s first Colonial Surgeon, died suddenly in 1831 at the age of 28. Dr. Simmons’ successor, Dr. Collie, after whom the town of Collie is named, also died in 1835 after suffering from tuberculosis for many years.

Many of the medical fraternity who lived and worked in the colony during the first few decades lacked what today would be considered recognised qualifications. Historian David Richards concludes that ‘a significant proportion of WA’s early and pioneer medical practitioners were not formally qualified’. Of the 124 medical-men who lived and worked throughout the colony between 1829 and 1870, forty-five were unable to provide any evidence of ever having received medical qualifications. This was not unusual, for in this era direct experience of medical work was often considered enough of a qualification for a man to set himself up as a doctor. Until 1894 medical practice was not clearly defined or controlled in legislation and the only protection against poor practice was the establishment of the first Medical Board (hereafter the Board) in 1870. Once established, the Board investigated the professional status of the doctors living and arriving in the colony. An analysis of the first registry of medical personnel shows that of the seventeen doctors listed, six had no formal qualifications, their only claim to medical expertise being that they had

7 Stubbe, Medical Background, pp.6-7.
10 Stubbe, Medical Background, p.7.
13 Richards, “Pioneer Medical Men”, p.23.
15 Stubbe, Medical Background, p.25.
been ‘practising Medicine in the Colony before the 1st day of July, 1869’. There were significantly more than seventeen doctors working in and around the colony in 1870, but only that small number was considered worthy of registration by the Board. Notably, the list for 1870 also shows a distinct lack of representation for rural and remote areas, illustrating the fact that during the colonial period, finding a doctor was easier in cities and towns than in the bush.

The provision of maternity services by doctors in Perth and its surrounding suburbs was limited for much of the nineteenth century. The Swan River Census for 1859 records a total of 14 medical-men for the entire colony with only 2 resident in Perth and 3 in Fremantle. The census of 1870 records a total of 25 medical professionals, with 5 working in Perth and 4 in Fremantle. Even so, some historians suggest that during the 1880s in Perth city there were only three or four doctors. This number steadily grew as the population of Perth increased. The post office directories for WA show that during the early 1890s, for instance, there were as many as 12 doctors working in Perth. However this is still a very small number, considering the population of Perth around this time would have been over 10,000.

The medical directory section of the 1895 post office directory for WA shows a total of 67 doctors working across the colony. Of these 6 were resident in Fremantle and 14 in Perth. The rest were distributed as far south as Albany and north to Geraldton and Carnarvon as well as east to York, Northam and Coolgardie. The rapid expansion of Perth and the mining towns in the east of the colony during the 1880s and 90s is highlighted by the fact that two years later in 1897, the number of medical-men working throughout the state had almost doubled to 131. Of these, 30 were now resident in Perth and 8 in Fremantle. More startling is the increase in the number practising in Coolgardie, a booming mining town. In the 1895

16 “Colonial Secretary’s Office: Registration of Doctors, 1870”, reproduced in Aveling, Westralian Voices, pp.231-32.
17 Prue Joske, on “Colonial Secretary’s Office: Registration of Doctors, 1870”, in Aveling, Westralian Voices, p.231.
18 “Colonial Secretary’s Office: Registration of Doctors, 1870”, reproduced in Aveling, Westralian Voices, pp.231-32.
19 WA Census, 1859.
20 WA Census, 1870.
24 See WA PODs ‘Medical Directory’ section, 1895.
medical directory there were 5 doctors listed as residing in Coolgardie; in the 1897 directory there were 22.\textsuperscript{25}

The lack of access to medical care in the colony during the early days of European settlement was certainly something that was noted by pioneer women. Louisa Clifton, a religious young woman who settled at Australind south of Perth with her husband in 1841, noted the paucity of medical assistance in her area for example. Clifton highlighted how medical-men working at Australind often seemed to lack medical skills, reflecting the fact – born out in the medical registers many years later – that some medical practitioners at Swan River did not have any official qualifications.\textsuperscript{26} Medical care was in such demand during the early decades of the colony, however, that a lack of medical qualifications was not something that automatically excluded a man from practising. The appointment of Dr. Joseph Harris, a man entirely lacking in recognised medical qualifications, to the position of acting Colonial Surgeon in 1843 illustrates the dearth of physicians available during the early decades of the colony. At the time of his appointment to the position of acting Colonial Surgeon, Dr. Harris was also the Chief Medical Officer for the settlement at Australind, situated many hours south of Perth, further demonstrating the limited supply of medical expertise in the early colony.\textsuperscript{27}

The majority of doctors at Swan River did not have any qualification which made them experts in maternity work, but a number of these men would have practised midwifery despite this. In England, medical knowledge about birth had been developed empirically through the work of surgeons who were called in to save the mother’s life in difficult labours.\textsuperscript{28} After 1700, theories and ideas about birth processes that had developed on the Continent became widely accepted by British doctors and this knowledge gave men trained in medicine the self-assurance to branch out into midwifery practice.\textsuperscript{29} Initially therefore, entry to midwifery practice for men in Britain was by medical education only, or through a short course such as that offered by William Smellie, a self-taught London-based male-midwife.\textsuperscript{30}

Other midwifery courses, like the one offered by the College of Surgeons in 1852, were set

\begin{itemize}
  \item \textsuperscript{25} See WA PODs ‘Medical Directory’ section, 1897.
  \item \textsuperscript{27} Hansford-Miller, \textit{The Grim Reality of Life}, pp.42-43.
  \item \textsuperscript{29} Wertz and Wertz, \textit{Lying-In}, pp.35-36, 43.
  \item \textsuperscript{30} Wertz and Wertz, \textit{Lying-In}, pp.39-40, 43.
\end{itemize}
up much later. The men who graduated from these courses and those with medical degrees who wished to practise midwifery, referred to themselves as ‘male-midwives’. They adopted this title even though they may not have had any midwifery training.

This situation is reflected in the Western Australian material for, even by the 1890s when Perth and the colony as a whole had significantly more doctors, only a minority had qualifications which made them familiar with maternity work. The medical section of the 1895 WA post office directory shows the qualifications of the doctors working in the cities and major towns. Of the 67 doctors colony wide, 3 had midwifery qualifications at university level and an additional 16 had midwifery licenses given by one of a number of medical institutions based in the United Kingdom. Only three doctors working in Perth during 1895 had some kind of midwifery qualification and only four in Fremantle. The towns of New Norcia, Busselton, Pinjarrah, Northam, Geraldton, Coolgardie, Cue and Shark Bay each had only one doctor resident with midwifery qualifications.

Figures such as these highlight how important midwives must have been to their communities during this period, whether in small rural towns or in larger cities like Perth and Fremantle. While the number of medical professionals in Perth and its suburbs grew during the 1880s and 90s, the population itself was, on the whole, poorer and less likely to be able to afford the services of these skilled attendants. Midwives thus became the most affordable and easily available providers of maternity care. In addition, and as the medical directories show, most medical-men in Western Australia during the colonial period could not claim to have any training or special skill which would make them more qualified than midwives to manage the majority of childbirth cases. In fact, many of the women working as midwives in WA during this period would have been significantly more familiar with normal, natural childbirth than the majority of medical-men working in the colony.

33 WA PODs ‘Medical Directory’ section, 1895.
Midwives during colonial times

It is generally agreed that childbirth in Europe was firmly within the domain of the female midwife until the seventeenth century. Before this time, midwifery was largely seen ‘as an extension of the female sex role’ practised ‘within the confines of a female subculture’. Childbirth was a social occasion, involving female relatives, friends and neighbours as well as the midwife and labouring woman herself. The term ‘midwife’ is derived from the middle English word ‘midwyf’ and literally means ‘with woman’. Midwives were often selected informally from networks of women who had assisted each other at birth and ‘were distinguished by such intangibles as manual dexterity, sensitivity, and luck’. Often these types of women were older, past childbearing age themselves and available for what was sometimes a time-consuming event.

Some historians have asserted that in Western Australia, if assistance was available during childbirth, it was generally offered by the medical-man and not by the midwife. According to this view, all of the Australian colonies, including Swan River, adopted the by-now common practice of employing medically-trained men during childbirth. The lack of convict women in Western Australia along with the fact that many of the first families at Swan River were not of working-class origin also suggests that midwives would not have been very prevalent in the community. In her history of Western Australian nursing, Victoria Hobbs notes that early records do not specifically identify nurses or midwives among the early settlers. Certainly, the lack of accurate records means that the question about the number of midwives working in the early days of the colony is still open. The earliest statistical data available for the colony is located in the Blue Books which were produced annually by the colonial authorities. However, these, along with shipping records, do not list employment or vocational information for individuals. The earliest available census for the Swan River colony was produced in 1859, but it only records numbers of males in employment. So while

35 Wertz and Wertz, Lying-In, p.2.
36 Wertz and Wertz, Lying-In, p.6.
37 Wertz and Wertz, Lying-In, p.6.
these records tell us something about the number of doctors working at Swan River during this period, they shed no light on the female occupation of midwifery. The Western Australian post office directories provide some information about midwives working in the colony, but the first available directory was produced in 1893, leaving the preceding six decades unaccounted for.

Despite the lack of official records, most historians accept that there were midwives working in WA from the early colonial period. May Flanagan as well as midwife and author Carol Thorogood maintain that midwives were active in the early days, particularly in rural areas. Flanagan asserts that many women attained nursing and midwifery skills prior to making the journey to Swan River, and this is supported by the writings of early settlers. General midwifery histories which address conditions in Western Australia during the pioneer period also reinforce the notion that midwives were available at the colony. Certainly there were midwives working in Perth and in rural areas by mid-century, although their numbers would have been limited.

An analysis of local newspapers shows that by the 1860s, there were at least a few midwives active in the Perth area, some of whom had undertaken medical training in Britain. Advertisements appearing in the *Perth Gazette* as well as *The Inquirer and Commercial News*, two mid-nineteenth century Perth-based newspapers, show that at least some Perth midwives had been pupils of medical-men. In 1863, Mrs. McNee advertised herself as a ‘matriculated nurse and midwife, from the Royal Maternity and Inlying Hospital, Edinburgh’. McNee had gained her training in midwifery as a pupil of Alexander Kieller, a medical doctor and man-midwife. Anne Louisa McCaffry was another midwife who had had medical training in Britain and had served four years at a maternity hospital, training under medical-men. In 1863, she advertised her services to the women of Perth as ‘a fit and proper

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40 Thorogood, Politics and the Professions, pp.36-37.  
41 See interview with May Flanagan in Thorogood, Politics and the Professions, p.37. See also Georgiana Molloy, Letter written to Elizabeth Kennedy, 4 April 1830, reproduced online at www.georgianamolloy.com.au, accessed 13/08/2012. In this letter, Molloy refers to Mrs. Trimmer’s servant as a ‘capital nurse’.  
person to act as a midwife’. Mrs. Gaunt also promoted her skills as a childbirth attendant and cited Dr. Ferguson, Colonial Surgeon, as a reference for her abilities.

The qualifications of these women support Thorogood’s assertion that ‘midwifery [in Australia] was a legitimate, respected and well-established health profession’. However this advertising also shows the way shifts in societal attitudes to the provision of maternity care had made it necessary for midwives to promote their association with medical professionals. By doing so, they distinguished themselves from the other, more-common style of midwife and consequently raised their personal and professional standing. The fact that these women could afford to advertise in newspapers at all suggests that their socio-economic status was above that of the average midwife. Similarly, these midwives were advertising their services to a class of people who could afford to purchase and read newspapers. It is therefore not surprising that Gaunt, McCaffry and McNee appear to be the only ones advertising in Perth newspapers throughout the 1860s and most of the 1870s. Mrs. Prokes was a consistent advertiser of her midwifery skills throughout the 1880s, but very few other midwives chose to advertise their services this way.

Indeed, newspaper advertising was not necessary to maintain a midwifery business in Perth during the 1860s, 70s and 80s. For example, McNee’s advertising of her business lapsed during the late 1860s and she did not make another appearance in print until 1889. In that year McNee wrote in to The Daily News to inform its readers that she ‘wishes to contradict the report that she has given up practice’, reassuring the public that she was still available for midwifery work. This example highlights how successful and long-running some midwifery businesses were during this period. Mrs. McNee had evidently been practising for over twenty years.

47 Thorogood, Politics and the Professions, p.25. See also Lesley Barclay, “A Feminist History of Australian Midwifery from Colonisation until the 1980s”, Women and Birth, Vol.21, 2008, p.4.
Even before the 1860s and 70s, well qualified midwives were available. Daphne Popham identifies a number of women who worked very successfully as midwives in rural areas of Swan River during the colonial period. Helen Scott, the daughter of a Scottish doctor, arrived in Fremantle in 1831. She had a good knowledge of nursing and midwifery, attained through many years of helping her father on his rounds. Scott practised as a nurse and midwife at Guildford east of Perth and later moved to Bunbury where she was sometimes the only source of midwifery and nursing knowledge in the district.50 In the latter part of the nineteenth century, a Perth-born woman, Louisa Glasgow, worked as a midwife at Carnarvon, north of Perth. She had nursing qualifications, and after the death of her husband, she supported her family through her midwifery work. By the time ‘Granny Glasgow’ was 76 she had attended at the births of more than 700 babies over 37 years working in the district.51 Medical or nursing training was not a prerequisite for good midwifery however. Other women, many of whose names we will never know, worked as midwives very successfully without having had access to medical training. This point is highlighted by people like Mary Murphy, who was a prominent homebirth midwife working in Western Australia during the 1990s. In an interview conducted with Carol Thorogood, Murphy notes that her great grandmother, a pioneer woman, worked as an empirically-trained midwife in WA’s South West.52 This situation was not particularly unusual, as circumstances dictated that women in rural locations must help each other during childbirth and some women became particularly skilled in this work. Elisabeth Dodd, for example, lived and worked in Moora north of Perth and delivered more than one hundred babies in the local area before retiring at the age of 82.53

Despite these positive stories, during the colonial period many women would have had difficulty sourcing professional assistance for childbirth, primarily because the number of midwives was so limited. Historian C.T. Stannage suggests that there were only nine midwives working in Perth in 1881, and the post office directories for the early 1890s suggest that this number did not rise significantly during the following decade.54 However the

51 Popham, Reflections, p.42.
52 See Thorogood, Politics and the Professions, p.80.
53 Popham, Reflections, p.47.
54 Stannage, The People of Perth, p.134. The Perth Professionals Directory found in the PODs for 1893-95 only lists one or two midwives as resident to Perth during this period. Similarly, the directory for Fremantle lists only two midwives for the period 1893-95. The 1895 list of statewide professionals – that is, professionals working
unofficial numbers of women undertaking midwifery work must certainly have been higher than official records suggest. T.S. Pensebene writes that in this same year, 1881, there were 100 midwives registered on the census for Victoria, and he predicts that unofficially, the number actually practising was closer to 540. This made midwives the second largest subgroup of professionals working in Victoria in 1881. At this time, they represented 27 percent of the total medical labour force. These figures suggest that while there may only have been a small number of known midwives in Perth during the early 1880s, there were no doubt many women who practised midwifery in an unofficial capacity.

Housing and services at Swan River

The delivery of basic necessities was a challenge facing successive governments at Swan River throughout the colonial period and into the twentieth century. An ever-growing population naturally put pressure on housing and the provision of sanitation and water. During the latter part of the nineteenth century, Perth grew rapidly. Waves of migrants flocked to Swan River throughout the 1880s and 1890s in response to the discoveries of gold in the Kimberley, Murchison and Kalgoorlie areas. In 1884 the district of Perth had just over 6000 people, by 1891 it had over 9500, and in 1901 the population of Perth was 44 000. By 1911, Perth and its suburbs had a population nearly double this at 87 000. Such a significant influx of people necessitated an expansion of Perth’s boundaries and led to the creation and extension of suburbs.

This demographic expansion and the pressure it put on sanitation and housing had an impact on families generally and women specifically. Class was a significant factor in determining where families would live, the quality of their housing and their ability to access services. C.T. Stannage suggests that between the late 1890s and the 1910s the suburbs of Perth evolved in such a way that some areas were more desirable to live in than others. Differences between suburbs revolved around important factors such as accessibility of transport,
topography, cheapness of land, and the location of industries.\textsuperscript{58} Consequently, areas like Cottesloe, West Perth and the vicinity of Adelaide Terrace in Perth’s centre housed the wealthy people and had the most attractive and well-built houses. On the other hand, areas such as East Perth and Victoria Park had cheaper houses which attracted a ‘lower-class’ of people.\textsuperscript{59}

These distinctions are relevant because they relate to the way women would have experienced childbirth in their own homes. It is not necessarily the case that poorer women had worse experiences or outcomes than well-off women, although they did give birth in more challenging circumstances. Socio-economic status was a major determinant of housing space.\textsuperscript{60} Houses in working-class and poorer suburbs like Midland Junction, East Perth and Victoria Park tended to be smaller than those in wealthier areas like West Perth and Cottesloe. During the 1890s, some rental accommodation in East Perth provided just 1/26\textsuperscript{th} of an acre of space per house and yard.\textsuperscript{61} In suburbs such as this, more than 1 in 10 houses had only two rooms, while in West Perth 34 percent of houses had 3 to 4 rooms and 23 percent had 7 to 10 rooms.\textsuperscript{62}

Poorer women were also less likely to have had access to clean water or effective sanitation. As early as the 1870s, concern was being raised by the Colonial Surgeon about the lack of sanitation in the houses of some of Perth’s poorer residents. Dr. Alfred Waylen noted that the labourers and artisans of the city were more likely to get sick because they lived:

\begin{quote}
in cottages built with but little regard to sanitation. There is often a total absence of ventilation, as well as drainage, and it is to these defects that, when towards the middle of winter the ground becomes saturated with water, the presence of fever may be ascribed.\textsuperscript{63}
\end{quote}

In 1874, Dr. Shaw, then the acting Colonial Surgeon, made similar observations about the sanitary arrangements of many of Perth’s houses. He made the important link between the

\begin{footnotes}
\item Stannage, \textit{The People of Perth}, p.243.
\item Stannage, \textit{The People of Perth}, pp.243-4.
\item Stannage, \textit{The People of Perth}, p.245.
\end{footnotes}
location of the well, which was at this time the source of all drinking water for most people, and the cesspits used for disposing of waste.

A few yards behind each house is a closet, with an open unbricked cesspit, and again a few yards from this the well…from which water is drawn for drinking and all other purposes. The cesspits are sometimes emptied, the soil being either carted away and used as manure or buried in the stable dungheap.64

Conditions such as this led to numerous health problems for the poorer parts of the population in Perth during the colonial period and even into the twentieth century. Typhoid was endemic in the colony at this time, and lack of sanitation and rapid increases in population also brought bubonic plague to Perth in 1900, 1902 and 1903.65 Some residents lived in very close proximity to open drains, and others had to share toilet facilities with neighbours.66 In 1898, Perth’s medical practitioners, concerned by the prevalence of typhoid, diphtheria and scarlet fever in the area, petitioned the government to establish a system of deep drainage in the city. The petition was signed by some of Perth’s best known practitioners, a number of whom would later take part in the long-running maternity hospital campaign.67 Despite this, by 1916, less than one-fifth of Perth households had access to the sewerage system, and by 1920 the number of houses connected was still less than one-third.68

There were similar problems with the provision of clean water and it was not until the 1910s that a significant proportion of Perth houses had sufficient and clean water piped into their homes.69 Before this time, many houses, even those with water pipes connected, had to cope without any water due to an under supply. Most had to rely on wells and water carts provided by government to supplement the inadequate supplies of piped water.70 The potential impacts of a lack of clean and adequate water in Perth were not lost on some of the more powerful people at the time. In an 1894 speech to parliament, MLA William Traylen linked Perth’s

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64 Dr S.C. Shaw, Annual Report of the Acting Colonial Surgeon, 1874. Western Australian Parliamentary Papers, 1879, no.27, “Correspondence and reports upon the sanitary conditions of the Colony”, p.10, cited in Hunt and Bolton, p.3.
67 Legislative Assembly, Petition of Medical Practitioners of Perth, with regard to the immediate establishment of a System of Deep Drainage in the City, presented 10 August, 1898, reproduced in Aveling, Westralian Voices, p.237-38.
70 Hunt and Bolton, “Cleansing the dunghill”, p.12.
infant mortality rate to impure and inadequate water supply.\textsuperscript{71} Still, the provision of water to houses remained a problem for governments into the twentieth century. In 1911 only 15,075 of Perth’s 22,000 houses had piped water, and several suburbs still depended on bores and tanks for water.\textsuperscript{72} It was not until the mid 1920s that Perth’s water adequately catered for the needs of the vast majority of its citizens.\textsuperscript{73}

The installation of gas and later electricity in Perth’s houses proceeded slowly too. Whilst there was gas powered street lighting in Perth from the 1880s, domestic lighting was limited to those houses on St Georges Terrace and central Hay St. In the mid 1890s houses on the outskirts of Perth were being connected, but by 1894 some Beaufort St residents were still without gas.\textsuperscript{74} Despite the fact that an electric tramway was operating in Perth from 1899, the electrification of the city’s street lighting did not occur in earnest until 1913 and was not completed until August 1922.\textsuperscript{75} By 1914, five thousand houses were connected to the city’s electricity generator.\textsuperscript{76}

What the pattern of the distribution of water, gas, electricity and sewerage pipes to Perth houses shows is that the most wealthy residents located in central Perth were much more likely to live in houses with access to clean water, sanitation, lighting and heating. On the other hand, those living on the outskirts, in the poorer working-class areas of Victoria Park and East Perth, were more likely to have inadequate water supply, limited access to sewerage systems and no access to gas or electricity to provide light or water heating. Women living and giving birth in these conditions would have been significantly less comfortable, and they and their children would have been more likely to suffer from diseases such as typhoid and dysentery.

While the location and space available in the home is significant when examining women’s experiences of childbirth during this period, these factors where not necessarily linked to the outcomes of the birth for mother or baby. Although birthing at home for poorer women was

\textsuperscript{71} Stannage, \textit{The People of Perth}, p.273.
\textsuperscript{72} Stannage, \textit{The People of Perth}, p.277.
\textsuperscript{73} Crowley, \textit{Australia’s Western Third}, p.235.
\textsuperscript{74} Stannage, \textit{The People of Perth}, pp.282-83
\textsuperscript{75} Alexandra Hasluck, “An introduction to Perth as it was”, in Alexandra Hasluck and Mollie Lukis, \textit{Victorian and Edwardian Perth from old photographs}, 1977, John Ferguson, Sydney, p.ix; Crowley, \textit{Australia’s Western Third}, p.234.
\textsuperscript{76} Stannage, \textit{The People of Perth}, p.286.
potentially less comfortable – it could be cold and dark for instance – this does not mean that giving birth in these homes during the colonial period was more dangerous for women than giving birth in a better quality house or in a hospital setting. Deaths in childbirth at this time were usually caused by any one of a variety of puerperal infections, by excessive loss of blood after the birth or by childbirth ‘accidents’. In the majority of cases, the occurrence of these problems was directly related to the abilities of the childbirth attendant, both their ability to properly and cleanly carry out the birth and deal with problems if they occurred, and, if they could not complete the case themselves, their ability to get help in a timely fashion. As we have seen, there certainly were well-trained and highly-educated midwives in Perth from the 1860s, who would have been able to perform all the necessary tasks in order to complete a safe delivery in a woman’s home. Some doctors would have been equally capable. It is clear, however, that some medical-men and some midwives were not up to the task of safely and cleanly delivering a baby. The point here is that the dangers of childbirth during this time were not to do with the quality of housing per se, but to do with the quality of the individual birth attendant.

Midwives in women’s homes

We know much less about working-class births during this period than we do about those that occurred in middle or upper-class homes. The women who were the active participants in childbirth in the working-class context, both mothers and midwives, were less likely to be literate and therefore unlikely to have recorded their experiences. It is necessary therefore to piece together from the information we have the experience of what would have been an average birth during the colonial period. The main factor which influenced women’s experiences of childbirth at this time was their class because it was this which directly influenced their ability to access the services of midwives or doctors. Poorer and working-class women were more likely to employ midwives for their confinements. This choice was

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78 This seemingly obvious conclusion was known to medical authorities during the nineteenth and twentieth centuries, however it was always presumed that midwives were the sole source of bad practice. See James Jamieson, “On Excessive Mortality among Lying-in Women in Victoria”, *Australian Medical Journal* (hereafter *AMJ*), Vol.2, 1880, p.555. See also W. Balls-Headley, “Antiseptic Midwifery”, *AMJ*, Vol.10, 1888, pp.314-23, in which the author notes medical-men are also responsible for failures in antiseptic practice.
certainly a result of their diminished financial flexibility but it was also a gender-based choice made out of a working-class mistrust of male-midwives which had persisted since the 1750s. It was generally considered indecent within working-class circles for any man to be present during childbirth. Male-midwifery posed a particular threat because of the perceived moral hazard in allowing doctors to access a woman’s body in a way that was reserved only for her husband. 80

A working-class woman in Perth during the late nineteenth and early twentieth centuries could have as many as eight to ten confinements. 81 It is unlikely that her husband would be present for any period during the birth. 82 The birth would usually take place in a bedroom, if one was available, which had been specially prepared by the midwife. The use of a woman’s bedroom for childbirth demonstrates the potential for mothers to experience the location of birth as a ‘sanctum’, specifically because it implies the ability to access personal items and facilitates greater comfort through familiar surroundings. During the birth, the midwife would remain with the woman and would be the primary provider of care. If her birth was uneventful, the midwife would offer the woman all the assistance required during the birth and for the following days. As authors W. McDonald and J.A. Davis note:

Observation of the patient; support during labour; assistance at delivery; nutrition and hydration for mother and baby; referral to medical expertise in abnormal processes were the skills of the 19th century midwife… 83

If, at any point during the birth or in the period after the mother showed signs of deviating from the normal process, the doctor would usually be called. However, there were a number of circumstances in which the women of this period could be denied medical attendance when needed. This could include if the midwife did not call a doctor when required, if the doctor refused to attend, if family members – specifically husbands – refused to allow medical attendance, or if women themselves strongly objected to medical attendance. 84 The

80 Versluysen, “Midwives, medical men and ‘poor women labouring of child’”, p.29.
81 Stannage, The People of Perth, p.106. Nationally, women who were born in the 1840s usually had an average of seven children. See Grimshaw, “Marriage and Families”, p.304.
82 This fact was commented upon by obstetricians during the nineteenth century. See Dr John Bryant, “Husbands at Accouchements: To the Editor”, The Lancet, 18 December, 1841, p.421. See also Pat Jalland, Women Marriage and Politics 1860-1914, 1986, Oxford University Press, Oxford, pp.144-45.
83 McDonald and Davis, History of Midwifery Practice in Australia, p.3.
84 For examples see AMJ, Vol.9, 1864, pp.1-5 and AMJ, Vol.12, 1867, p.158.
outcome of such births could be as successful as a full recovery, or as tragic as the death of the woman, the baby or both.

Midwives offered solutions to women’s experiences of pain during labour which speak to a shared experience of childbirth. For example Adelaide woman May Smith, who had nine children over twenty years, noted that during her first birth her midwife:

told me what to do…some of the old fashioned methods, pulling on a sheet with your pains and that. It was jolly good.85

While midwives did not have access to any of the tools and aids to childbirth that the doctor provided, they did have access to traditional ‘medicines’. 86 Castor oil was used regularly to bring on the birth, and Epsom salts were given in prolonged labours. The midwife would also encourage hot baths and walking.87 This last point is particularly important because it reflects on women’s ability to move around during labour, a key facet of women’s experience of the birthing location as a ‘sanctum’.

Midwives often provided a more comprehensive service than doctors because they could take over the mother’s household duties including cooking, cleaning and caring for other children. This style of service was available in some parts of Australia as late as the 1930s when hospital birthing was becoming the norm.88 This factor, along with their common experience of women’s role in the household, made the relationship between midwife and mother somewhat different to that between doctor and patient. Midwives entered the home as helpers in a variety of contexts. By taking on not only the management of the birth but the duties which the woman herself would usually perform in the home, the midwife remained socially and culturally linked to the mother, sharing her personal experience directly over a number of days or weeks.

86 It is commonly accepted by childbirth historians that midwives were specifically not allowed to use forceps or to administer chloroform or other pain reducing drugs. See for example Wendy Selby, Motherhood in Labor's Queensland 1915-1957, PhD Thesis, Griffith University, 1992, p.194n. See also Thorogood, Politics and the Professions, p.38.
87 Interviewees often mentioned the use of these labour aids. See Selby, Motherhood in Labor's Queensland, p.146.
Doctors in women’s homes

During colonial times and into the early twentieth century, middle and upper-class Western Australian women would have employed a doctor for childbirth. In fact, in the early decades of the twentieth century, it became usual to employ both a doctor and a monthly nurse or midwife for confinements. During this period, doctors who entered women’s homes for the purposes of assisting at confinements generally did so in a kindly yet patriarchal manner. In their behavior towards their female patients, most medical men were informed by traditional sexist ideas about the frailty of women. In their dealings with midwifery patients, doctors of the time sought to employ a heroic, rescuing rhetoric in their communication. So while on the one hand, doctors represented themselves as always knowing what was best for women, their patients were generally given a degree of respect in that their feelings about things such as the use of anaesthesia and instruments were acknowledged and given some limited consideration.

J.H. Kellogg in his popular manual *Ladies Guide in Health and Disease* (1895) for instance writes that during childbirth all women’s wishes should be complied with ‘so far as consistent’ with the good outcome of the birth. This directive clearly allows for medical-men to make their own decisions about what is best, without seeming to deny women their right to ask for things or object to procedures.

Just as in poorer households, births in middle and upper-class homes took place in a bedroom which had been specially arranged with all the necessary items including hot water and clean sheets. The childbirth experience differed for wealthy women, however, in that their husband could be and often was present. The attendance of the child’s father at its birth, so much an integral aspect of childbirth today, was important to some women in this past era too. This factor also illustrates the potential for the home in the colonial period to provide a ‘sanctum’ to women during birth. When women were surrounded by people who knew and supported them, they were more likely to feel safe and comfortable during childbirth. Another way the

89 See Selby, *Motherhood in Labor's Queensland*, p.191. See also “Western Australian Legislative Assembly Debate: Registration of Nurses”, 1921, in Aveling, *Westralian Voices*, pp.255-56, in which the member for Pilbara, Mr Underwood, criticises the current practice of employing both a doctor and a ‘nurse’ for regular home confinements.
91 Medical-men of the period often commented on husbands being in the birthing room. See Jalland, *Women from Birth to Death*, pp.156-61. See also Jalland, *Women Marriage and Politics 1860-1914*, pp.145-5. Not all husbands were keen to be present during births. See for example “Henry Charles Prinsep, Diary: A Difficult Birth, June 1869”, reproduced in Aveling, *Westralian Voices*, pp.242-43.
experience differed for upper-class women was that the attending physician generally left the house for extended periods and did not return until the second stage of labour was reaching its conclusion.\(^{92}\) For most upper-class mothers, this meant they were cared for by a nurse or midwife during the doctor’s absence. For those women who could not afford both a nurse and a doctor, however, it was common for them to be left with friends or relatives while the doctor was absent. This fact highlights another important difference between the methods of doctors and midwives during this period. While the service of the midwife included consistent attendance throughout the entire birth, the doctor did not generally guarantee his continued presence.

Unlike poorer women who employed midwives for their confinements, women who employed doctors had access to chloroform. The discovery of this drug was first mentioned in the Western Australian press in March 1848, and it was being used in surgical operations in Perth from 1849.\(^{93}\) The drug could be used to produce total unawareness or to relieve pain without causing unconsciousness.\(^{94}\) Chloroform was usually administered on a handkerchief; the patient would inhale the vapours and, depending upon the amount inhaled, would either experience relaxation and anaesthesia, or would become unconscious. Authorities differed on when chloroform should be used in midwifery, but a respected London man-midwife suggested that it should be administered in all first confinements, in forceps deliveries, in twin births, in cases of retained placenta and in cases of late abortions at the fifth or sixth month.\(^{95}\)

Women’s desires in relation to the use of chloroform during labour were usually respected by medical-men, for not all women were enthusiastic about its use and some remained fearful of its side effects.\(^{96}\) Most doctors employed the tactics explained by Dr. Charles Kidd in his discussion of the writing of Dr. Tanner, a well-known London obstetrician during the 1860s:

> He made it a rule always to take chloroform with him to every case of labour. When the pains became bad, he explains to the patient – provided he finds no objection to the employment of an anaesthetic –

\(^{95}\) Charles Kidd, “A Few Late Notes on Chloroform”, *AMJ*, October 1862, pp.304-08.
\(^{96}\) See for example the instances described in James Young Simpson, *Anaesthesia; or, the Employment of Chloroform and Ether in Surgery, Midwifery, Etc.*, 1849, Lindsay & Blakiston, Philadelphia, pp.151-168. See also Jalland, *Women Marriage and Politics 1860-1914*, p.147.
that he can relieve her of all suffering, if she wishes it, by means of chloroform. Many patients are anxious to inhale; a few decline.\textsuperscript{97}

Statements such as these present the obstetrician as a rescuing figure, eager to relieve the labouring woman of all her pain. Yet the woman herself is afforded the option of rejecting his help, despite the fact that the doctor in question evidently sees the use of chloroform as a universal good. This was not the case for all medical-men, for some believed that chloroform should only be provided in prolonged or complicated labours, and a number of Australian doctors noted that they had offended female patients when they refused to administer chloroform during uncomplicated deliveries.\textsuperscript{98}

In addition to chloroform, medical-men usually carried midwifery forceps with them.\textsuperscript{99} Forceps were made available for broader use by medical-men in Britain from 1733.\textsuperscript{100} Prior to this time, their existence had been a closely guarded secret of the Huguenot family who had invented the instruments one hundred years earlier.\textsuperscript{101} The purpose of the forceps is to ‘reinforce failing or inefficient uterine powers that are impeding the progress of either the first or second stage of labour’.\textsuperscript{102} The instrument was considered necessary in ‘difficult labours’, but forceps were known to cause significant injury to mother and baby if used incorrectly or unnecessarily.\textsuperscript{103} The use of forceps during delivery was also linked to an increased risk of puerperal fever. This fact had been known from early on in the history of male-midwifery, and was a source of great criticism of medical-men who were thought to over-use the forceps in order to hasten deliveries.\textsuperscript{104} Some doctors purposefully kept the use of these instruments to a minimum, but others seemed to use them excessively. For example, the NSW doctor Walter Lindesay who practised during the later decades of the nineteenth century noted in his writings that of the 595 cases he was involved with, he used forceps in

\textsuperscript{98} Kellogg, \textit{Ladies Guide in Health and Disease}, p.476. See also “Discussion on Dr Samuel Knaggs paper”, Minutes of the ordinary meeting of the NSW branch of the BMA, \textit{Australasian Medical Gazette}, September 1888, p.314.
\textsuperscript{99} For a list of what doctors usually brought to a childbirth case see W.E. Fothergill, \textit{Manual of Midwifery: For the use of students & practitioners}, 1896, Macmillan & Co, New York, p.258
\textsuperscript{100} Versluysen, “Midwives, medical men and ‘poor women labouring of child’”, p.31.
\textsuperscript{102} Selby, \textit{Motherhood in Labor's Queensland}, p.195n.
\textsuperscript{104} Donnison, \textit{Midwives and Medical Men}, 2nd ed., pp.43-44.
only 8 cases. This is contrasted by Dr Samuel Knaggs, a medical-man working in NSW during the 1870s who, after three years of practice had, by his own admission, ‘a proportion of one delivery by forceps in every ten cases’.106

Women themselves did not like the forceps, and during the nineteenth century medical-men generally tried to avoid using them. However, by the early twentieth century, forceps were increasingly used in home confinements as a way to hasten delivery, often with negative effects. If a woman were anaethsetised using chloroform, it was much easier to resort to forceps in challenging or lengthy deliveries because a woman’s injuries would not be known until well after the birth. Medical-men at the time were well aware of the ‘need’ for chloroform when instruments were to be used in cases of complicated or prolonged labour. Chloroform was administered as a way to make patients more compliant and to render them unable to resist the use of instruments if these were deemed necessary to complete a delivery. Consequently, during this period, while a delivery with forceps could certainly be conducted safely in the first instance, the role of the instrument as a source of physical damage, puerperal infection or both should not be underestimated. For this reason, wealthy women who had access to this sometimes life-saving method of delivery were at increased risk of dying from infection. As was noted by Melbourne doctor Hubert Jacobs in 1926, the misuse of forceps was at the time the ‘greatest menace to any improvement in our morbidity and mortality statistics’.

Deaths associated with childbirth

It is important to emphasise that in the vast majority of cases, childbirth – for both wealthy women and poorer women – proceeded normally and both mother and child survived the experience. Indeed, demographer Douglas Gordon has noted that maternal mortality has never been a statistically significant cause of loss of female life in Australia. Nevertheless, because the extant records focus on births which were difficult and potentially life threatening, there is a temptation to assume this was the norm. This is simply not the case. Australian maternal mortality rates in the past were certainly high by modern standards, and for some periods some of the Australian colonies had maternal mortality rates that did not compare well to England. However, the information available suggests that maternal mortality was relatively low at Swan River, the Western Australian colony. In the 1860s for example, total childbirth-related deaths at the colony – including both puerperal fever and other childbirth-related causes – never exceeded six per year. Out of a population of between seven and nine thousand women, this is a very low figure. During the very early colonial period, deaths from childbirth-related causes appear to have been very rare. In the four years 1830-1833, ‘childbed’ was recorded as the cause of death only 3 times out of a total of 150 deaths. Additionally, early settlers at Swan River, including some of the few medical-men, made observations about the positive effects of the climate on pregnant women and their children. Milligan for instance noted in his 1831 report that:

"Parturition with the female sex is expeditious and safe, being accomplished by the efforts of nature alone, within from three to six hours. No woman has died in childbirth in this Colony since its commencement, nor am I aware of any died within a month after."
Milligan’s reference to ‘the efforts of nature alone’ was quite apt, for there was otherwise little or no aid for early settler women during childbirth.

Despite these positive representations of maternal and infant mortality in the early colony, it is usual for statistics taken during this period to be confusing and contradictory. According to the WA Blue Book for 1884 for instance, only 7 mothers died in childbirth in WA for that year out of a total death rate for the whole female population of 248. This figure suggests that maternal mortality accounted for less than 3 percent of female deaths. However, if we look closer the Blue Book also shows that an additional four women died of ‘metria’ – which was a term often used to describe puerperal fever – and another fourteen women died of ‘convulsions’, which could also have been childbirth-related if the convulsions were caused by the fatal childbirth complication known as preeclampsia. Consequently, the modest figure of 7 maternal deaths could be as high as 25 deaths, meaning that maternal mortality in 1884 at the colony actually accounted for around 10 percent of the total female mortality. It is impossible to know which figure is more accurate; the real mortality figures most likely lie somewhere between these extremes. Despite this, in 1884, women of child-bearing age at Swan River were just as likely to die from wasting diseases like phthisis and atrophy (around 13 percent of deaths) as they were from childbirth-related causes.

The available statistics suggest that infant mortality during the colonial period was not particularly high at Swan River when compared to other parts of the world. Infant mortality data refer to all deaths of children under one year of age and the vast majority of infant deaths in Australia during the nineteenth and twentieth century were not childbirth-related. Citing data from 1829-1855, Bryan Gandevia notes that of the 1100 deaths recorded in the Swan River colony, only 300 were children aged between 0 and 6 years. Of this number, 5.5 percent were stillborn or died as a result of premature birth, and 2.7 percent of the total died as a result of birth ‘accidents’, meaning that – as far as can be told from these statistics – just over 8 percent of these 300 deaths occurred as a result of negative childbirth outcomes. These figures sound shocking by modern standards, but during the early colonial period the colony’s rate of infant mortality compared favourably to rates in England where in the year

120 WA Blue Books, 1884, p.57.
121 WA Blue Books, 1884, p.57.
1839-40 infant mortality ran at 30 percent of births. During the period 1842 to 1848, infant mortality in Western Australia fluctuated between 4 percent and 15 percent of births, significantly less than rates in England.\textsuperscript{123} In his annual report of 1876, Dr. Waylen, the then Colonial Surgeon of the colony, noted that there were 918 births over the previous year with an infant mortality rate of 114 per 1000, or 11.4 percent.\textsuperscript{124} This rate again compares well with England where during this period infant mortality was estimated at 160 deaths per 1000 live births.\textsuperscript{125}

However, the rate of infant death at Swan River fluctuated significantly from year to year, suggesting that records were not necessarily accurate. In 1887, for instance, the recorded infant mortality at Swan River was 156 deaths per 1000 live births.\textsuperscript{126} The next year it was significantly lower at 124 deaths per 1000 live births, and in the following two years it was even lower at 88 and 90 deaths per 1000 live births.\textsuperscript{127} While these figures evidently show anomalies in reporting, they do suggest improvement in overall infant mortality at Swan River, and this is more than can be said for England where the rate of infant death was as bad in the 1890s as it had been in the 1860s.\textsuperscript{128}

It is impossible to tell how many of the recorded infant deaths occurred as a result of mishaps during childbirth; however, common sense would suggest the number was small, especially considering how many other risks existed. As always, the data are open to interpretation. For instance in 1887, when infant mortality at the colony was very high, the most significant number of children – 77 out of a total of 244 – were categorised as dying from ‘developmental diseases’ which included death from premature birth, death from ‘teething’ and death from heart defects.\textsuperscript{129} The specific list of children who died within this category does not however equate to the reported 77, but only 26, suggesting that the cause of most of

\begin{itemize}
\item \textsuperscript{123} Gandevia, \textit{Tears often shed}, p.33.
\item \textsuperscript{124} Dudley Snow, \textit{The Progress of Public Health in Western Australia 1829-1977}, 1981, Public Health Department of Western Australia, Perth, p.16.
\item \textsuperscript{125} Donnison, \textit{Midwives and Medical Men}, 2nd ed., p.85.
\item \textsuperscript{126} WA Blue Books, 1887, pp.124,126.
\item \textsuperscript{127} WA Blue Books, 1888, pp.130,132; WA Blue Books, 1889, pp.131, 133 and 1890, pp.135, 137.
\item \textsuperscript{129} Interestingly, there was dispute within medical circles at the time as to whether ‘teething’ could be considered a cause of infant death. In reality, it seems deaths under this category could have actually been due to ‘zymotic diseases’ like diarrhoea and dysentery. See J.W. MacKenna, “On the Comparative Effects of Climate on certain Diseases”, \textit{AMJ}, January 1860, p.19n.
\end{itemize}
the infant deaths in the ‘developmental diseases’ category was unknown. More than one in five infants in 1887 died as a result of ‘zymotic diseases’ including typhoid, dysentery and whooping cough. This figure stayed fairly stable over the 1880s and early 1890s, although a gradual fall in the number of children dying from these types of diseases can be seen as the turn of the century drew closer. During this period, ‘developmental diseases’ stop being the leading cause of infant death with ‘local diseases’ instead becoming the primary cause. The category of ‘local diseases’ was very broad and covered things as divergent as gastritis and asthma, hernia and liver disease. In 1888, ‘local diseases’ accounted for 29 percent of infant deaths. In 1889 they accounted for almost 38 percent and in the following year they were the cause of almost half of all infant deaths at the colony. These figures show that causes of infant deaths at Swan River were highly variable and shifted from year to year, which is in keeping with conditions elsewhere in Australia.

Despite gradual improvements in infant health, many women in the colony experienced the death of one or more of their children, and it was only because each family had so many offspring that child deaths numbered significantly less than births. C.T. Stannage describes the experience of a typical working-class woman in mid-nineteenth-century Perth:

[M]ost of these women lost at least one child in infancy; many also suffered miscarriage. Very few of the younger children in a family reached marriageable age with both parents alive, for often they were the eighth to the twelfth child and born to a mother who was in her mid-thirties and a father in his forties. Influenza, ‘colonial fever’ and smallpox, not to mention accidental drownings in river, swamp and well, swelled the death rate in any one family.

Many women, not only those that were poor or working class, had these experiences. Josephine Prinsep, wife of the wealthy landowner Henry C. Prinsep, experienced a stillbirth in 1873 while living in the south-west of the colony. She suffered what would now be referred to as a post-partum haemorrhage and would have died but for the timely arrival of medical assistance. During another birth, Josephine was assisted by a midwife named Mrs.

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130 See WA Blue Books, 1887, p.126.
131 See WA Blue Books, 1887-1897.
133 Douglas Gordon shows how the infant mortality rate in Australia first began to decrease in the early 1890s but then increased slightly for the period 1896-1900. See Gordon, Health, Sickness and Society, pp.178-79.
134 Stannage, The People of Perth, p.106.
Gardiner who oversaw the successful delivery of a baby girl. After the placenta did not come away, however, Henry sent two servants off to Bunbury and Brookhampton ‘to catch Lovegrove [the doctor] wherever he might be’. It took two hours for Dr. Lovegrove to arrive, but he oversaw the successful delivery of the placenta and Josephine’s recovery.\textsuperscript{136}

The rural and remote experience

Josephine Prinsep was fortunate to have had access to professional expertise when she needed it most, but not all rural women in WA were so lucky. Women who could not afford medical or midwifery assistance or who lived in a very remote area generally relied on neighbours or family during the birth of their children and this remained the case for much of the nineteenth century. Indeed it is likely that some mothers were assisted by indigenous women during childbirth, a phenomenon which was noted in other Australian colonies.\textsuperscript{137}

G.W. Eastcott (1938) writes about her own birthing experiences while living south of Perth during the 1880s. She too refers to a Dr. Lovegrove:

> The nearest doctor was Doctor Lovegrove at Pinjarra, about 30 miles away. The farm women had to help each other... We never thought of doctors in those days when they lived so far away and there was only a heavy cart to fetch them.\textsuperscript{138}

Mrs. Eastcott was assisted by her fifteen-year-old sister during one of three births which took place on her farm. For the birth of her second child, she did travel to Perth, but it took three days and she was sitting on top of a load of wood throughout the journey. For the births of her last two children, she stayed at home, and was attended by a neighbouring farm woman.\textsuperscript{139}

Cost was a significant factor in rural women’s decision not to leave home in search of a doctor to attend them during childbirth. Around the middle of the nineteenth century, families living in Albany and Bunbury, situated far south of Perth, could be charged a travelling rate

\textsuperscript{139} Eastcott, “Pioneers of Wagerup”, p.37.
of ten shillings per mile for medical attendance in addition to fees for consultation.  
Certainly some doctors did not charge those who clearly could not pay and in some cases lower fees were negotiated privately however the perception that the cost of medical attendance at childbirth was inhibitive persisted into the early twentieth century and was the source of some complaint as evidenced by this communication to *The West Australian* in 1909:

> Cases are on record where a mother has had to pass, professionally unaided, through her ordeal, because the husband simply could not afford the five guineas, plus hire of conveyance, plus nurse’s fees necessary to secure the proper attention. This possibly explains why some ‘men do not marry’ and why population is not augmented at the desired rate.  

The risk that the journey would bring on the birth, the separation from family and the need for women to remain at home to look after other children were other factors that contributed to women’s reluctance to travel.  

Some well-off families were able to afford the fees for medical attendance at the births of their children despite their rural location. This did not necessarily guarantee them medical attendance however. The Browns were one such family for whom some records remain. In a letter dated 1849, Thomas Brown writes to a friend, William Bussey, about his wife Eliza, whose confinement took place at their farm, Grass Dale, in York, east of Perth. While Eliza and her baby survived the birth, the doctor had to be summoned from over one hundred miles away. It was a traumatic birth, and according to Thomas, Dr. Viveash arrived ‘just in time to save her’.  

On a separate occasion a few years later, Eliza sent for the doctor to attend her during the birth of her fourth child. When the doctor did not arrive, Eliza sent for the local nurse but she was prevented by her own husband from attending at the birth. Eliza’s family finally asked a neighbour for assistance and he sent his housekeeper Mrs. Heffron to attend.  

Other women, who would probably have had medical attendance for their births had they remained in Britain, did not even have appropriate accommodation for a birth. The story of

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141 “The Nurses’ Problem: To the Editor”, *The West Australian*, Friday 30 April, 1909, p.3. Accessed via TROVE archive, 10/03/2015.
the now-famous amateur botanist Georgiana Molloy, who arrived in 1830 at Fremantle, south-west of Perth, while heavily pregnant, is now very well known to Western Australian historians. Various accounts have her giving birth in a tent entirely on her own, with the assistance of a servant, or with the help of a doctor.\textsuperscript{145} Whatever the circumstances, the birth was very traumatic, and resulted in the death of the baby.\textsuperscript{146} In a subsequent birth which took place in the town of Vasse in 1842, Molloy had trouble with her confinement and the doctor was sent for. The town doctor was drunk and unable to assist, so the nearest physician at Leschenault was asked to attend. He, and another doctor, were themselves attending a difficult birth and could not make the journey to Vasse to treat Molloy who was by this time very close to death. Eventually, friends of the Molloys found ‘the only other good doctor’, Dr. Allen, to attend her and she survived.\textsuperscript{147}

Louisa Clifton had similar experiences. When, during her first pregnancy, she went into labour prematurely, Louisa sent for the doctor who arrived after a number of hours. She later gave birth to twins who died shortly after.\textsuperscript{148} This incident encouraged her to summon a doctor immediately she went into labour for the second time when living at Bunbury further south of Perth. On this occasion Dr. Ferguson had to travel from Australind by boat to reach her and Louisa had delivered the child herself by the time he arrived.\textsuperscript{149}

These stories of maternal difficulties during childbirth reinforce conventional ideas about women’s experiences of birth in the past. They are highly visible narratives that create a picture of childbirth trauma that would not have been reflective of the majority of births during this period at Swan River. However, these accounts do highlight important aspects of the rural and remote experience which was unique in a number of respects. The small number of medical-men available outside of Perth and its surrounds were spread over a large geographical area, making medical help even more difficult to access given the travel time required. Medical-men often charged a fee for the expense of travelling, so this increased the cost of a medical visit significantly. The ability to choose one practitioner over another was also limited by distance, which may have forced some families to use the services of

\textsuperscript{146} Hasluck, \textit{Georgiana Molloy}, p.99.
\textsuperscript{147} Hasluck, \textit{Georgiana Molloy}, pp.308-09.
\textsuperscript{148} Russo, \textit{A Friend Indeed}, pp.13-4.
\textsuperscript{149} Russo, \textit{A Friend Indeed}, p.281.
substandard doctors despite being able to pay for medical attendance. The experiences of colonial-era women living in rural and remote areas of the colony therefore highlights issues related to choice in childbirth and further emphasises how geographic and class factors played a significant part in women’s encounters with birthing. The notion of ‘choice in childbirth’ as it applies to modern-day birthing experiences did not have much relevance to colonial women in rural areas who were, in the main, unable to control many aspects of their care during childbirth.

Numerous other settler women, whose stories we will never know, no doubt had similar experiences during childbirth. These women often relied on each other for support and assistance, and from time to time this arrangement crossed class boundaries. Both Louisa Clifton and Eliza Brown helped other rural women during their confinements, suggesting that the informal reciprocal arrangement of caring for each other during childbirth was not confined to working-class women. In a letter to William Bussey, Eliza notes that on two previous occasions she had acted as attendant to women ‘of the labouring class who were without nurse, doctor, or neighbor or any female but myself within several miles at the time of their illness’.150 Louisa Clifton often acted as an intermediary between labouring women and the doctors whom she sought out to attend them. She was very specific about her role, for she was not a midwife, and was only able to offer ‘counsel and concern’.151

Clifton was often highly critical of the standard of care available at Australind, particularly the work of Dr. Henry Carpenter, whom she blamed for the death of a fellow settler, Mary McGlashen. In what was a stark contrast to Louisa’s own circumstances, Mary had given birth entirely unattended in a bush hut and was very ill after her delivery. Dr. Carpenter was sent for, but he needed to be led across the flooded Collie River in order to get to Mary. Mary herself needed to be taken to a nearby farm for treatment, and she died before anything could be done for her.152 It is unlikely that Mary’s death can be directly attributed to Dr. Carpenter, but historians have noted that other women at Australind attended by him contracted puerperal fever, casting doubt on his cleanliness.153 Other doctors also incurred Louisa’s

150 Eliza Brown, Letter written to William Bussey, no date, reproduced in Cowan, A Faithful Picture, p.76.
151 Russo, A Friend Indeed, p.197.
152 Russo, A Friend Indeed, pp.195-96.
153 Russo, A Friend Indeed, p.197. It should be noted that historians Frank Hansford-Miller (The Grim Reality of Life,p.45), and B.C. Cohen (A History of Medicine in Western Australia, p.52) both suggest that Dr. Carpenter was more of a heroic figure and certainly not poorly trained or unclean.
criticism during their time at Australind. Noting that Eliza Lennard was just about to give birth, Louisa sent for Dr. Millard, but he failed to impress her and she subsequently asked a tradesman’s wife to attend Lennard during her labour instead. During her rounds visiting women, Louisa often made mention of women who had delivered their babies on their own or with only the assistance of friends. One such woman, a Mrs. Clarke, was living in a tent when Louisa visited her.

What Louisa Clifton’s letters and the letters of the Brown family show among other things, is that Louisa and Eliza had an expectation of medical assistance during childbirth that many of the working-class women they visited would not have shared. Medical assistance was certainly not the norm for working-class women in Britain during this period. These women were, in the main, still giving birth in their own homes with the assistance of a female midwife. Wealthier women like Louisa and Eliza, however, increasingly had the expectation that during childbirth a male doctor was necessary, and they had no hesitation in acquiring doctors for other women. This demonstrates the growing trend at the time to employ doctors rather than midwives and also shows the important role of women in facilitating this shift.

These changes in the manner in which maternity services were delivered continued to gain momentum during the colonial period as midwives increasingly came under fire from medical-men. Midwives had long drawn criticism from medical practitioners within the tight-knit medical profession; over the turn of the century, these concerns began to have more relevance to ordinary people. While during the colonial period midwives had been important, even essential, to the functioning of both large towns and rural communities, their ability to function independently of medical oversight would gradually be eroded over the coming decades. Simultaneously, the medical profession itself was growing in power and significance within society and medical men were able to command great respect. With support from the state, medical professionals were able to suppress alternative practice and came to have a great influence on both the regulation and management of maternity care.

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154 Russo, A Friend Indeed, p.246.
155 Russo, A Friend Indeed, p.196.
Chapter 3
The Changing Status of Midwife and Doctor

During the last three decades of the nineteenth century and into the early twentieth century there was growing public concern about the quality of midwifery services across Australia. Public and professional medical perception maintained that mortality rates for mothers and infants were too high, and that the provision of services for childbirth needed to be overhauled. While the quality of midwifery services was a matter for both medical-men and midwives, professional and public concern focused primarily on the midwife as the source of bad practice. At the same time, ‘medical science’ was developing new approaches to diseases and their management. From the 1870s, doctors came to command greater respect in the community and their growing influence contributed to a state-sanctioned suppression of so-called ‘quack’ medicine in Western Australia. As medicine entered its ‘Golden Age’, independent, empirically-trained midwives gradually came more and more to be seen as second-rate providers of care.

The suppression of the midwife in its Australian context

While upper and middle-class families often employed medical-men to manage maternity cases in the home, most Australian mothers during the early twentieth century still employed midwives at their confinements. The vast majority of women who worked as midwives during this period were not officially ‘trained’ in midwifery, particularly in WA where training was not yet available. The situation was similar for many medical-men. During the nineteenth and early twentieth century, not all doctors practising midwifery in Australia were necessarily well-trained. For example, even as late as the 1920s, the obstetric training for medical students at Sydney University constituted just two weeks watching births at the Women’s Hospital and a handful of lectures. Doctors themselves were highly critical of the

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3 Selby, Motherhood in Labor's Queensland, p.156.
quality of obstetric training in Australia. In his 1939 autobiography Viewless Winds, H.W. Moran writes about his time at Sydney University medical school in the early 1900s:

Since our practical work was limited to a dozen actual midwife cases, we graduated after passing an examination in theoretical obstetrics without really knowing how to confine a woman. Every one of us, after qualification, went to our first midwifery case trying to comfort himself with the thought that ninety percent of deliveries came head first. We also secretly resolved to be fussily inactive while the old midwife helped the women through. At least we could always contrive to look wise.

Most medical-men were not as reflective as Moran and saw the midwife as a hindrance rather than a help during childbirth. Yet, concern about the mismanagement of childbirth cases by midwives was legitimate, for there were instances of negligence which had disastrous consequences for women and their families. Some of the most disturbing reports were of midwives purposefully tearing women’s perineums during labour in order to precipitate the birth. Other instances where the attending midwife failed to birth the placenta had also resulted in maternal deaths. The inability of medical practitioners to recognise their own part in these endemic problems, however, is significant. The finger was pointed firmly at midwives.

Medical criticism of midwives centred on their supposed ignorance of the ‘mechanism’ of labour, and the assumption that women – by their very nature – were unable to understand scientific ideas or manage instruments. Midwives were portrayed as meddlesome and ignorant. Some obstetricians wanted midwives to be completely removed from the provision of maternity services, and others refused to acknowledge that midwives had ever made any

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7 AMJ, Vol.1, 1879, p.307; R. Worrall, “Case of Transfusion”, Australasian Medical Gazette (hereafter AMG), Vol.9, 1890, p.117.
8 Various authors have examined the way the medical profession in Australia and internationally conducted an ‘orchestrated campaign’ during this period to sideline traditional midwifery which had the effect of deskilling midwives. See Nita Purcal, “Traditional Midwifery and its Influence on Contemporary Maternity Care: A brief historical review of events in New South Wales”, Birth Issues, Vol.7, No.2, 1998, pp.58-65. See also Thorogood, Politics and the Professions, pp.40-50.
Throughout Europe, the United States and Australia, nineteenth century women were encouraged to avoid the employment of midwives and instead were urged to engage the services of medically-trained (male) childbirth attendants. In his ladies manual, American medical doctor J.H. Kellogg (1895) states that:

[under no circumstances, except in emergencies, should the important process of parturition be placed wholly in the hands of a midwife whose qualifications, such as she may possess, are wholly derived from experience at the bedside, no matter how large be the number of cases she may have attended. No one person could by practical experience alone in a life-time acquire all the knowledge necessary to meet the urgent emergencies which are liable to arise at any time in childbirth.]

Similarly, British doctor George Fullerton (1884), who lived and worked in Australia for over thirty years, encourages mothers not to be resistant to the presence of a man during childbirth:

[Civilised society has wisely established the rule that educated medical practitioners should attend mothers in their hour of trial…We know also that some women, from a feeling of false delicacy, do not wish to have a doctor, preferring rather to entrust their own safety and that of their offspring to midwives, who are too often incapable of rendering the necessary service.]

According to Fullerton, it is a ‘civilised’ society that encourages women to have medical-men attending their confinements. By comparison, it is ‘uncivilised’ to have midwives or neighbouring women as attendants.

In a piece entitled “Midwifery by Midwives” the 1879 volume of the Australian Medical Journal (hereafter AMJ) commented on the frustration that many in the medical world felt about the seeming public acceptance of midwives as appropriate attendants at childbirth.

To the average non-medical mind, a midwife of the ordinary old woman type, is equal to all emergencies, but statistics show, that in districts where the practice of midwifery is principally performed by women, the mortality is double what it is in localities where it is exercised by properly-qualified medical practitioners….The evil is not beyond remedy, but popular ignorance renders any remedy difficult, especially as tradition and usage have so long recognised the unskilled midwife as a person whose rights are not only lawful, but indisputable.

It was a complaint that was regularly aired in the AMJ and similar Australian publications. These sorts of articles perpetuated the stereotype of the midwife as an ‘old woman’, and not as a competent practitioner in her own right. The AMJ felt justified in questioning not only midwives as practitioners, but also the role of women as childbirth attendants. Since the science of midwifery had increased in importance for the medical profession as a whole, the problem of whether women should be allowed to practise it was the cause of much discussion.

It is, as we need hardly say, still a question in debate as to whether the practice of obstetrics should be permitted to women at all; but it should be no question, that, if it is to be so permitted, those who so practice should be fully competent to deal, not only with ordinary cases in which little skill is required, but with some of those of a difficult or dangerous nature, in which self possession, skilled knowledge, and promptitude are of the utmost consequence.

The suggestion being made by the editor of the AMJ and other medical-men at the time was that midwives – and by extension all women – were incapable of dealing with any case of parturition in which complications arose. Traditionally, in circumstances such as these, midwives would have turned to doctors or surgeons to assist in completing a delivery, but this system was flawed in many respects. Sometimes events deteriorated quickly and there was no time to call in assistance; other times, doctors could not be found to help; and in some cases, doctors refused to help midwives with their clients.

The event which had precipitated the 1879 AMJ article had been a case which took place in Richmond, Victoria, in which the attending midwife had sent for medical assistance but was unable to find a doctor to assist her. Mrs. Addison, the wife of a labourer, died two days after the birth of her child as a result of post-partum haemorrhage caused by a retained placenta. The inquest into Mrs. Addison’s death determined that had medical attendance been obtained, it is likely she would have survived. The AMJ commented:

16 Doctors were sometimes called to attend to women who appeared to have had normal deliveries followed by the retaining of the placenta. Out of 240 cases recorded by Dr. Samuel T. Knaggs in NSW during the 1870s for instance, he encountered 13 retained placentas. In 6 of these cases, the baby had been born before his arrival and Knaggs made no hesitation in blaming the retained placenta on the midwives and nurses present. See Knaggs, “Report of 240 cases of Midwifery”, p.4.
The case incidentally illustrated the inefficiency of the ordinary midwife, and demonstrated the desirability of the state guaranteeing the payment of medical men when sent for by midwives under circumstances of this kind.18

Contrasting representations of midwives and doctors in stories such as these are very informative because they illustrate how the two groups were treated quite differently by medical and judicial authorities. In most cases, midwives were blamed for adverse outcomes because they could be represented as lacking in knowledge, while doctors were allowed the benefit of any doubt. So while Mrs. Addison’s midwife had done the right thing and sent for assistance, her lack of knowledge in the first instance – her inability to diagnose and remove the retained placenta – had caused Mrs. Addison’s death. The fact that no doctor was found, and the circumstances surrounding this lack of medical assistance, were not examined by the AMJ. In fact, the implication of the AMJ’s comments was that, without a guarantee of payment, no medical-man would attend the case.

The obvious way to prevent events such as these was to set up a system of midwifery training, a system that could provide the ‘proper education of midwives’.19 This idea was problematic for many in the medical profession, however, as the author of “Midwifery by Midwives” goes on to explain:

When the question was some time ago debated in England as to the training of accoucheuses, some of the highest authorities in obstetric medicine insisted that it would be a dangerous principle to adopt, to legalise obstetriciuses who had not gone through a regular medical course of study...although some of them [midwives] are understood to hold certificates of some kind, it is very well known that none of them have undergone such training as fits them to deal with even moderately dangerous emergencies.20

While the AMJ was reluctant to admit it, it is clear that medical professionals at the time were unwilling to provide a system of training to a group of women who, once trained, could provide an equivalent or better service than the medical-man.21 As other writers have asserted, medical-men were reluctant to relinquish their new-found authority over childbirth, particularly not to untrained women.22 Even before the training of midwives was under

consideration, medical-men struggled to reconcile themselves with the professional competition provided by midwives. In a letter to the *NSW Medical Gazette* in 1874, Dr. Jacob Faithful complained about the way ‘old women’ were taking away midwifery cases from medical-men.

Is it not a great nuisance to the profession that about two-thirds of the Midwifery cases in this city and suburbs, are attended by old women who profess to be midwives?...I have heard of one or two of them who average about ten midwifery cases a week, and these cases ought to have been attended by the medical practitioner. It is therefore a great loss to his private practice to have these cases go into the hands of these old, and in many cases very ignorant women, who presume…they are quite competent to undertake the practical duties of a most critical and important department of the medical profession.23

It is clear from statements such as these that midwifery work was very important to the general medical practitioner. When they took on midwifery cases, midwives represented a threat to the medical man’s livelihood because they prevented him from attracting new patients to his general practice. The reluctance of some in the medical profession to facilitate the training of midwives was therefore linked to doctors’ fear of greater competition.24 Midwives who were equipped with medical knowledge would be much better positioned to compete with medical-men for childbirth cases, and would constitute a powerful rival for the male practitioner.

Underlying much of this rhetoric is the presumption that all practising midwives were ignorant and their representation was such that as ‘old women’ they had even less right to participate in important medical affairs. The inherent sexism in these depictions of midwives was usual for the times, however, even a cursory analysis of midwifery work in colonial WA demonstrates that a significant number of midwives who worked at Swan River and its surrounds did not fit the mould of the old and ignorant midwife. Many were skilled and successful practitioners and a smaller group of women operating in Perth were highly trained and strongly influenced by medical men. The suggestion, expressed over many years in the *AMJ* and other publications, that all midwives were unsuitable for the work of assisting at childbirth, does not reflect the broader reality of midwifery as it was experienced by women in WA over the colonial period. While ‘bad’ practice certainly did exist, it was not confined to midwives and was certainly not the norm.

The Western Australian experience

Historian Philippa Martyr has highlighted the way medical professionalisation in WA was linked to the suppression of alternative practitioners, and this claim has relevance to the situation of Western Australian midwives during the nineteenth century. At a time when medical practitioners were defining their practice and consolidating their control of medical knowledge, ‘quacks’ became the focus of a campaign to protect the public from bad practice. Martyr’s analysis of the suppression of ‘quack’ medicine in WA during the nineteenth century sheds some light on the concurrent treatment of midwives during this period:

The major reason for the campaign of occupational closure by orthodox practitioners against their competition – the consolidation of orthodox practice as the dominant mode of health care in Western Australia – was practical enough. Yet this was overlaid with a philanthropic rhetoric which made use of the exclusion of the alternative practitioner ‘to protect the public’ while justifying other quite different interests. This rhetoric was just as important to medical professionalisation in Western Australia as the actual action taken. Without the ideological claim to ‘protect the public’, orthodox medical practitioners could not establish themselves as the controllers of medical knowledge, the vital part of the process of professionalisation.25

This point highlights how important it was for medical practitioners to claim that alternative practitioners like midwives were a danger to public health. In doing so they were able to limit the scope of what was and what was not acceptable practice in midwifery, thus giving the medical profession greater control over who was allowed to participate in the business going forward. By defining ‘safe’ practice as medical practice and contrasting this with the supposed evils of ‘untrained’ midwifery, medical men ensured the continuation of their role in midwifery as well as the gradual decline of their primary competition in that field.

These issues played themselves out in WA over the colonial period and into the twentieth century. Professional disputes between midwives and medical professionals often took place and were written about in local newspapers. Disagreements and claims of malpractice were directed at both medical-men and midwives and it was sometimes the case that midwives attacked each other. In January 1866, Mrs. McNee, ever the newspaper correspondent, defended her practice from ‘one of her own sex, a self-taught woman’ who had ‘circulated the report that she [Mrs. McNee] has no diploma’. In her defence, Mrs. McNee insisted that

McNee evidently found it effective to align herself with the medical establishment, highlighting her qualifications and at the same time denigrating ‘self-taught’ midwives. McNee’s diploma had been obtained in Edinburgh where she had ‘studied and practised under Alexander Kellier, M.D.… in the Royal Maternity Hospital’. While there were other midwives with medical training working in Perth during this period including Anne Louisa McCaffry and Mrs. Gaunt who both advertised their medical references in the press, it is unclear if any other midwives apart from Mrs. McNee did actually hold midwifery diplomas.

A number of years later, McNee again needed to defend her midwifery against accusations of malpractice. This time, Henry Wood wrote to *The Perth Gazette and West Australian Times* in support of McNee:

> In consequence of a certain medical gentleman having spread reports reflecting on the ability of Mrs. McNee as a midwife in connection with my wife’s recent accouchement and subsequent severe illness, I feel it my duty to publicly testify my wife’s entire satisfaction with Mrs. McNee’s treatment…

The identity of the ‘medical gentleman’ and the specifics of his complaint do not appear in the newspapers of the time, but the community support for Mrs. McNee and the consequent anger at the man who had spoken out against her are significant. Wood goes on to criticise the unnamed medical man, asserting that ‘the cowardly intention of damaging a rival’s reputation by propagating untruth is too contemptible to need further comment.’

Claims of malpractice in midwifery were directed at doctors too, generally by members of the public. In 1886 a correspondent in *The Western Mail* strongly criticised Dr. Holmes of Guildford, a government medical officer, for his failure to attend a woman in childbirth. It was not the first time there had been complaints about Dr. Holmes who was at risk of losing his government position due to ‘his gross neglect to attend patients when called upon’.

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30 Wood, “To the Editor”, *The Perth Gazette and Western Australian Times*, Friday 29 September, 1871, p.3.
his defence, Dr. Holmes insisted that the case in question had already been assigned to a midwife whom the patient had neglected to send for, instead calling on him at the onset of labour.

[A] proper arrangement was made with the mother…to engage the midwife for her daughter…and, as usual, the midwife would send for the doctor if beyond her skill; nothing could be more satisfactory. It appears, however, they did not carry out the doctor’s original advice…

This shows that not all medical-men were aiming to remove midwifery from the hands of women. Some medical-men, like Dr. Holmes, were satisfied with the current arrangements whereby midwives undertook the majority of midwifery work, calling on the doctor only in times of trouble. Dr. Holmes’ reaction to being called upon when there were no apparent problems with the case might also suggest he was unused to midwifery work. According to the original correspondent, when asked to attend the case, Dr. Holmes said that ‘he would not depart from his regular routine’.

While it was not uncommon for the public to criticise medical-men, midwives were the main target for claims of malpractice at Swan River. When claims were made against them, these women were at a significant disadvantage because of their gender and their lower class status. This fact was rarely noted at the time, but occasionally the injustice of the system was highlighted by the press. For example, after a Victorian midwife was acquitted of manslaughter in 1872, one newspaper questioned why she was brought to trial at all, suggesting that ‘the only reasonable inference to be drawn is, that the poor woman belongs to a class which is not in favour with doctors…’

One Western Australian case which highlights these issues is a Supreme Court dispute between a midwife, Mrs. Delilah Uridine, and a doctor, Herbert Birmingham, which was heard in October 1888. In a bold and no doubt expensive move, Uridine initiated a court case against Birmingham, claiming he had made slanderous comments about her abilities as a midwife. Her lawyer asked the court to award £500 in damages to make up for the effect these comments had had on her business. While Uridine’s ability to employ a lawyer attests

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33 “The Guildford Medical Officer Again”, *The Western Mail*, Saturday 20 March, 1886, p.12.
34 See *The Belfast Gazette*, July 19, 26 and August 2, 1872, cited in Forster, “Mrs Howlett and Dr Jenkins”, p.1052.
to her being relatively well off, her opponent, Dr. Birmingham, was able to employ a barrister as well as a lawyer, significantly increasing his legal clout.

One of the key facets of the case was the timing of the arrival of Birmingham at a confinement that was being attended by Uridine. In what appears to be a reoccurring theme of the time, Uridine claimed to have called for medical assistance at the confinement of a Mrs. Gee, but was left waiting for an hour before Birmingham attended. Upon the completion of the delivery, the doctor announced that the child had died and that the death was the fault of the midwife. Uridine’s failure to call the doctor earlier was, in the doctor’s opinion, the cause of the child’s death. In her defence, Uridine claimed that the child had been alive when she left the room and that had the doctor come earlier, the child may have been saved.

*The West Australian* reported on the proceedings extensively, giving a blow-by-blow account of the hearing. What is notable in these accounts is the way the evidence provided by Uridine was given limited consideration when it was compared to that given by Birmingham. Birmingham’s failure to attend at the birth for an hour was given little attention by the court, and Birmingham’s lawyers called a cohort of other doctors to testify against Mrs. Uridine, casting a shadow on her treatment of Mrs. Gee. While an analysis of the case clearly shows that Mrs. Uridine was not an innocent party, the timing of the arrival of the doctor and the subsequent death of the child were matters of debate in which the evidence did not clearly point to the innocence of Dr. Birmingham either. Even so, the court found in favour of Dr. Birmingham and ordered Mrs. Uridine to pay court costs. In his judgement on the case, His Honour Mr. Justice Stone found that, while he did have some sympathy for the midwife, she should have sent for the doctor much earlier. However he made the interesting point that in order to make this judgement he ‘had to rely almost entirely upon the evidence given by the medical-men’. In this case, the superior class position of the medical-men as well as their gender apparently rendered their evidence more significant and more ‘factual’ than that.

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provided by Mrs. Uridine and, significantly, their evidence was given more weight than the facts provided by Mrs. Gee herself. At this time, women – particularly parturient women – were given little credit by medical-men for knowing their own bodies, and could not therefore be relied upon to accurately recount events. As one medical-man noted in reference to a female patient ‘my knowledge of Mrs. R.’s case…has been derived entirely from herself, and is necessarily very imperfect’.

This case certainly suggests that medical-men of the period were able to use their professional ties with one another to undermine midwives as individuals and midwifery as a female occupation. It also demonstrates a reluctance among the elites of Perth society to support midwives against their male rivals. Medical-men throughout Australia had strong links to state institutions including the judiciary and the parliament, and were often highly influential individuals. In one Tasmanian case for example, Doctor T.C. Smart Esquire, the defendant in a malpractice suit, received a letter of congratulations from over 350 fellow medical practitioners, patients, and law makers after he successfully defended against the claim. This letter was published in the *AMJ*, along with a lengthy reply from Smart thanking his friends and colleagues for their support while he was ‘under this persecution’.

The ‘Golden Age’ of medicine

Doctors like Smart and Birmingham were part of a profession which was coming to the peak of its powers, both scientifically and socially. The so-called ‘Golden Age’ of medicine began from the 1870s, and after this period, the medical profession took on significantly more power within society. Medical-men working during this period were able to claim a partial role in the successes of medical science and were accorded more respect in the community. Before this time, medical operations often resulted in death or permanent disability to the patient. Overall mortality was high and the medical profession was not seen as effective at reducing mortality rates. It was generally believed that the death of a patient could be blamed almost entirely on the attending medical practitioner. Popular perception had it that ‘a man must fill a churchyard before he becomes a doctor’. The consequence of these commonly-

42 “Medical News”, *AMJ*, July 1861, pp.226-29.
held ideas was that alternative health practitioners like midwives were still able to command significant sections of the market. As author T.S. Pensabene notes:

The sum effect of the inadequacies of orthodox medical practice was to blur the distinction between the registered and alternative practitioner. Despite the legal authority given to medical practitioners to treat sickness and disease, the community was not prepared to grant the doctor a professional status greater than that of the alternative practitioner. The public judged the doctor’s medical knowledge to be as unreliable and inadequate as his rivals.44

This attitude to medical practice was gradually eroded over the second half of the nineteenth century and a new era began which saw what Evan Willis calls ‘the production of doctor dominance’ in the provision of health care.45 The initial development of anaesthetics in the 1840s and the discovery of antisepsis in the 1870s began the shift towards the recognition of medicine as a science. In combination, the employment of anaesthesia and the implementation of antisepsis made surgical operations much more successful, gradually changing the perception of the medical practitioner from a butcher to a lifesaver.46 Within this context, medical men were able to develop theories of disease which made treatments more effective, vaccines and drugs were introduced and the public view of the profession of medicine began to shift.47 There were also substantial leaps forward in the identification of diseases and their management. Many microbes and viruses were classified and isolated and improved treatments for common illnesses such as tetanus, diphtheria and syphilis were developed.48 From the 1890s, when the universal application of antiseptic techniques began to take effect, hospitals became less objectionable to ordinary citizens and by the 1920s it was possible to operate on nearly all the organs of the body without generating infection.49

While these advances in medical science were significant, they do not on their own account for the overall reduction in mortality which was observed during this period. Between 1870 and 1920 the profession of medicine benefited from improvements in hygiene and public health which occurred concurrently with the Golden Age. The introduction of sewerage schemes and drainage at the same time as reductions in disease outbreaks were observed

45 Willis, Medical Dominance, p.93.
46 Pensabene, The rise of the medical practitioner, p.36.
48 Pensabene, The rise of the medical practitioner, p.47.
‘created a synergism which was seen by society as a victory for medicine rather than engineering’. Imp"ovements in nutrition, a gradual reduction in working hours, advances in the quality and suitability of clothing and housing as well as falling family size and better personal hygiene all contributed to an overall decrease in mortality during this period, highlighting the numerous ways in which social and economic progress – not medical science – contributed to improved health outcomes for different social groups. Despite this, doctors and physicians benefited from the perceived successes of medical science and began to command much greater respect. While an overall decrease in mortality was, in the main, coincidental to the rise of medicine, the skill and status of the medical practitioner was no longer in doubt.

The success of medical doctors during the Golden Age was also linked to their gender and class status. Doctors were in the main middle and upper-class men, and as such had important and significant links to the state. From the 1870s, governments throughout Europe and the colonies began to support medicine at the expense of other alternative practitioners, including midwives. Legislation giving medicine a greater say in public health matters demonstrated the commitment of governments to provide the medical profession with autonomy over medical practice, including midwifery care. As medical-sociologist Evan Willis writes:

The basis for the dominance of the medical profession during that age was state patronage and support. To a large extent the state…[was] largely willing to leave ‘matters health’ to this small, relatively homogenous group of largely upper middle class, white, men…a sort of ‘elective affinity’ existed between state interests…and the interests of this group.

As time went on, the inability of traditional midwives to compete with the superior class, professional and gender profile of medical-men made resistance to medicalised approaches to childbirth difficult and allowed medical practitioners to claim that only they could be trusted with the management of childbirth. Under such sustained attack, one of the ways that midwives in WA and throughout Australia managed to continue their businesses was through the establishment of lying-in homes, small hospitals where women came to give birth and rest after their confinement. The following chapter explores the growth of this style of

50 Barclay, “A feminist history”, p.5.
52 Barclay, “A feminist history”, p.5.
confinement as well as the social factors which influenced birthing during the early decades of the twentieth century in Perth. This period brought about a significant series of changes to WA’s existing maternity services. At the time, these changes were received with enthusiasm by the majority of the public, particularly women themselves who had been agitating for improvements since the 1880s. Yet this era of change also saw the increasing destabilisation of midwifery as an independent female profession, and the continuation of a campaign by medical professionals to exert greater control over midwifery training and practice.
In Australia, the transition from women birthing in homes to birthing in maternity hospitals occurred over a number of decades. Between 1870 and 1950, the lying-in home emerged as an alternative birthing location to the home. It was neither a large institution run by trained nurses and obstetricians nor the mother’s own home, but something in between. These homes were common throughout metropolitan and country WA until the 1950s.\(^1\) The rise of lying-in homes occurred at a time of great social change and population growth in the state. Midwives and their practice remained under sustained attack from medical professionals and by the turn of the century the push towards the regulation of ‘untrained’ women was well under way. In this context, lying-in homes were an important part of the fabric of WA’s maternity services: they provided empirically-trained midwives with consistent work in a semi-institutionalised setting while offering women some of the benefits of a lying-in period away from household duties and responsibility for other children. However, while lying-in homes provided a much needed service, they were also under-regulated for long periods, and there is no doubt that some mothers and babies died as a result of the poor quality of care offered at some homes.

In the first decade of the twentieth century, public concern about the quality of maternity services in WA paved the way for a raft of new state government legislation which made it illegal to practise midwifery without a licence and forced empirically-trained midwives into hospital-based training. As a result of these changes, the autonomy and independence of midwives as professionals became severely limited. These broader societal concerns and the resulting increase in regulation of midwifery services was one of a number of factors which shaped mothers’ ability to make choices about the birth of their babies. Poorer women were particularly affected by such regulations as they were more likely to depend on the services of empirically-trained midwives who were themselves restricted in their ability to access state-sanctioned training programs. Women’s choices in childbirth were again restricted both by their socioeconomic and geographic status as well as by the impact of the combined actions of the medical profession and the state legislative apparatus.

Choice and the lying-in home

Though very little information remains about lying-in homes in colonial WA, it is clear that over the period of their existence these homes took at least four forms. Some were set up by government, either through an existing institution or at the request of concerned public officials but this only occurred in extreme circumstances and was a service only ever provided to those who had no other choices about where to give birth. A separate group of lying-in homes was established by charities: through pre-existing charitable organisations, or by groups that had been created specifically to provide maternity services such as the House of Mercy, which was established in 1891. These homes were significant in size and often accommodated over ten patients at one time. During the 1890s for example, the House of Mercy had accommodation for up to 14 women, and in the 1930s Subiaco’s St John of God Lying-in home had as many as 37 beds.²

The other two styles of lying-in home were similar to each other in that they were run by an independent midwife or nurse-midwife working for herself. These women could be trained or untrained, although in the years prior to 1916 the majority would have been untrained, because midwifery training in WA was very limited until this time. The primary difference between these midwife-run lying-in homes was their size. On the one hand there were women who ran larger homes from properties bought specifically for the purposes of running a business; on the other, there were midwives who conducted their business from their own home and provided care for only a handful of women at any one time. One example of the former type is nurse Alice Stockley who, during the period 1912 to 1914, purchased a number of properties adjacent to her home in Newcastle St, Perth on which she built her own lying-in home.³ Similarly in 1900, Mrs Edmunds of Kalgoorlie owned and ran her own purpose-built hospital which included an ‘extremely comfortable maternity home’.⁴

The establishment of lying-in homes made it possible, for the first time, for women to choose not to give birth at home. Nevertheless, during the colonial period and into the twentieth

century, women’s choices about where to birth their babies were always limited by geographic and class factors. The lying-in home sphere is a particularly interesting representation of these limitations because the four different styles of home which emerged over this period were identifiable from one another by the different classes of women who used them. The better style of home, run by a midwife who employed staff and provided private rooms, was out of reach for the average working woman. The charity-run homes were specifically for the poorest citizens, while Perth’s House of Mercy was strictly for unmarried women only. These distinctions further problematise the notion of ‘choice’ in childbirth during this period. While birth location choice did exist for some women, many facets of the childbirth process were still determined by an individual’s ability to pay for services, as well as by the specific expectations of different class groups. Consequently, mothers’ interactions with the location of birth as well as the childbirth experience itself were often influenced by factors beyond their own control.

**Government and charity lying-in homes**

In both Australia broadly and WA specifically, any form of government involvement in maternity care prior to the 1900s was highly unusual. The provision of lying-in homes was not something which generally concerned the colonial governments of the nineteenth century, although government involvement did take place in WA on a number of particular occasions. In all these cases, authorities concentrated solely on the needs of unmarried or very poor women, a focus shared by the charity organisations working in this area. The broader context to any government involvement in maternity care was the perceived necessity to maintain moral standards in the community and to prevent pregnant women from living on the streets. Colonial authorities were interested in maternity service provision only to the extent that it impacted on other, more important areas of concern.

The first instance of government involvement in the colony’s maternity services occurred in the 1850s, when a section of the Poor House on Murray Street was partitioned off for inmates who were pregnant and a lying-in area was set up. One of the concerns raised about the existence of this lying-in service was that it had moral implications for other inmates.
At the time of the facility’s inception, admitting unmarried pregnant women was seen as introducing women of bad character. According to some historians, the facility disappeared between the 1870s and 1890s. However, evidence of the existence of the service can be seen in 1896 when the ladies of the House of Mercy Committee expressed concern about the easy manner in which young women were admitted there.

Government provision of maternity services continued at the Women’s Home during the early years of the 1900s. In 1909 this institution, also on Murray Street, housed as many as 15 pregnant or lying-in women at a time. These inmates were expected to work in the laundry along with the other residents of the home and lived in very cramped conditions. The mixing of unmarried pregnant girls with the ‘old women’ who made up the majority of the home’s inmates was again a challenge for authorities. An investigation into the Women’s Home conducted by the Public Service Commissioner in 1905 found that under the instruction of the matron, the lying-in women were made to eat with their faces to the wall so as not to be ‘too closely observed’ by the other inmates.

The link between government involvement in maternity care and the perceived need to prevent moral degradation in the community was also apparent at Fremantle in 1886 when the government again chose to intervene in the provision of care for child-bearing women. In April, the Reverend D. Watkins of Fremantle wrote to William Dale, superintendent of the Fremantle Poor House, requesting accommodation and assistance for a heavily pregnant, young, unmarried woman. His request was rejected, and Watkins sent his original letter, along with Dale’s rejection, to officials in Perth, requesting that a lying-in hospital be provided for the area. In response, a Perth administrator wrote to Dale a few days later, reiterating Watkins’ request that the Poor House provide accommodation for lying-in cases and noting that the provision of this service would prevent unmarried women from becoming prostitutes. In response, Superintendent Dale wrote to the Colonial Secretary, stating that there is ‘absolutely no accommodation for such cases at present in the home’.

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9 Colonial Secretary’s Office, Correspondence Files, 1883-1983, SROWA, Item no.1886/1603, Cons.527.
Dale then took it upon himself to suggest a much more expensive option, a completely new building complete with full-time staff to provide the necessary care. According to Dale there should be space for at least eight cases at once with a ‘separate lying-in ward’ as well as quarters for a matron. Interestingly, Dale suggested that the building should be ‘enclosed by a brick wall’ – presumably to assist in the supervision of the inmates – and that the home should be ‘placed under the management and control of a Board appointed by his Excellency the Governor’. Apparently impressed by Dale’s suggestion, the Governor requested that the cost of such a building be assessed, and it was concluded that government outlay for the project would be £200 plus the cost of employing a midwife as a permanent appointment. At the Executive Council meeting of 31 May 1886, £300 was put aside for a lying-in service to be created at Fremantle.\(^\text{10}\) What became of this money and the building it was meant to fund is unclear, because there was no government-run lying-in home in Fremantle during the 1890s. What this anecdote shows is the challenging situation created when women became pregnant outside of marriage and needed accommodation and care. There were virtually no government resources available for these women and many would have been unable to afford to pay for care privately.

While Western Australian governments were reluctant to become involved in the provision of maternity care, the need for these services only increased as the turn of the century grew closer. The gold rush of the 1890s precipitated a huge influx of people into Perth and the surrounding areas, and this put increased pressure on health and welfare services. In the ten years between 1891 and 1901, Western Australia’s population increased from under 50,000 to over 185,000 as a result of the discoveries of gold at Coolgardie and Kalgoorlie among other places.\(^\text{11}\) Consequently, the last decade of the nineteenth century saw a significant increase in charitable institutions providing care for those in need. For maternity care, the options remained limited, but from 1890, some services, particularly for unmarried mothers and those in dire hardship, were provided by charitable organisations. The Sisters of the People, a benevolent group made up of missionary nurses, did attend childbirth cases in women’s own homes when required. The St John of God religious order set up hospitals to provide health care for those on the goldfields at Coolgardie and Kalgoorlie, and both of

\(^{10}\) Colonial Secretary’s Office, Correspondence Files, 1883-1983, SROWA, Item no.1886/1603, Cons.527.

\(^{11}\) Flanagan, “Lying-in (or Maternity) Homes”, p.340.
these hospitals ultimately provided maternity services. In 1898 the organisation established the St John of God Hospital in Subiaco, although maternity services were not provided at this hospital until 1937 when an application to run a maternity ward at the hospital was granted.

Other limited services were provided at the old Lunatic Asylum in Finnerty Street, Fremantle which became a ‘women’s home’ in 1900, and at Hillcrest Hospital in North Fremantle which began offering maternity services from 1903.

The House of Mercy

The most prominent institution for out-of-home maternity care in Perth during this period was the House of Mercy, which took its first patients in 1891. The home was a charitable institution run by a committee of wives and mothers from the Perth gentry, and it was specifically for the care of unmarried mothers-to-be. The name ‘House of Mercy’ was chosen because it reflected the feelings of many members of the committee towards women and girls who had become pregnant out of wedlock. Despite the fact that the inmates of the home had ‘strayed from the path of moral rectitude’, they would receive the help they needed.

It was the intention of the committee that the girls who stayed at the home should become ‘good’ mothers and useful members of society. To this end, the ladies of the committee sought to:

help the girls to regain their self-respect, and assist them in obtaining respectable situations, the members trusting that their efforts may be the means of helping their unfortunate sisters to once more become respectable members of society, and prevent them being forced into greater depths of sin and degradation.

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13 Central Board of Health, Files – General, 1899-1987, SROWA, Item no.1944/1116, Cons.1003.
18 House of Mercy, Annual Report for year ending 31 October 1899, Ngala Mothercraft Home and Training Centre Collection, State Library of Western Australia (hereafter SLWA), Acc.6093A/35.
This rhetoric reflected the view that the inmates were unable to function as mothers and citizens without the instruction provided at the home.\(^{19}\) The expectation from the committee and the public was that during their stay the young women should ‘show by their work their gratitude to the home’.\(^{20}\) There was a presumption made, both by the management committee, and by the public at large, that women who found themselves pregnant out of wedlock were morally destitute and were therefore likely to have on-going problems associated with their weak characters. Thus, women entering the home were expected to sign an agreement which signified their intention to obey house rules and reinforced their commitment to living in the home for at least six months.\(^{21}\)

The home was originally located in Lake Street, Perth, but the institution was moved twice before it found an ongoing home in Lincoln Street in East Perth in 1901.\(^{22}\) So as not to encourage repeat offenders, the home only took on cases for a first pregnancy.\(^{23}\) Inmates were expected to remain in the home for at least three months after their confinement, and no less than six months in total. This time commitment was framed by the ladies of the committee as being an opportunity for the young mothers to form a lasting bond with their child.\(^{24}\) The six-month stay also allowed for the successful moral retraining of inmates. During their time at the home, the young women were ‘reclaimed’ through hard work, specifically in the House of Mercy laundry, the traditional work place for ‘fallen’ women.\(^{25}\) As time went on, the scope of training offered to the young women who lived at the home was expanded to include cooking lessons, needlework, housework and dressmaking.\(^{26}\) The emphasis of their time in the home was on redemption through prayer. Mothers were expected to work hard and attend worship services daily.\(^{27}\) Though records of admissions are patchy, in the period from when


\(^{20}\) “Home for Women”, \textit{The West Australian}, Tuesday 14 February, 1928, p.4.

\(^{21}\) See “Alexandra Home”, \textit{The West Australian}, Friday 24 September, 1926, p.6.

\(^{22}\) Porter, “‘A Mangle, Wringer, Bowl, Scissors, A Bible and a Prayer Book’”, p.38.


\(^{27}\) House of Mercy, \textit{House Rules}, 1892, Ngala Mothercraft Home and Training Centre Collection, SLWA, Acc.1796A.
the home opened in 1891 to 1898, 66 women were recorded as having been living in the home, and a total of 45 babies were recorded as having been born there.\textsuperscript{28}

Initially, the day to day running of the home, including the management of births, was undertaken solely by a matron, Miss Dickson. Dickson was not a medically-trained midwife, and her background in midwifery work is unclear. After only six months, and in keeping with the public’s new-found trust in medical-men, it was decided by the committee that a doctor must always be present at births in the home. Dickson stayed on as matron at the House of Mercy for over five years and, as well as being responsible for the inmates and their children, her work included the management of the laundry business. She was also expected to take the women and their children to church every Sunday and to maintain a religious feeling in the home.\textsuperscript{29} Dickson’s time as matron ended in April of 1897 when she attended a house management committee meeting drunk. While this was no doubt seen by the ladies of the committee as a blight on her character, it is important to note that during her time as matron of the home, no woman had died during childbirth and the laundry had been run so successfully that it was self-sustaining.\textsuperscript{30}

While the home was usually free of maternal deaths related to childbirth, the record for infants, certainly in the early years, was not so favourable. Historian Anne Porter has pointed out that the lack of focus on the babies born at the home was a reflection of the fact that the chief aim of the ladies of the committee was to reclaim ‘lost’ women and assist them to rebuild their lives. The babies were secondary to this primary goal.\textsuperscript{31} Two babies died at the home in the period October 1894 to January 1896. The mothers of both these children were typhoid sufferers who had been transferred to the Colonial Hospital during pregnancy. In May and June of 1896 three more babies died at the home and an additional five died during 1897. There appears to have been a severe contagious disease at the home in the summer of 1897/98 because another three babies died early in 1898 from an illness which the matron also contracted.\textsuperscript{32}

\textsuperscript{28} Porter, “‘A Mangle, Wringer, Bowl, Scissors, A Bible and a Prayer Book’”, p.39.
\textsuperscript{29} Porter, “‘A Mangle, Wringer, Bowl, Scissors, A Bible and a Prayer Book’”, pp.38-9.
\textsuperscript{30} Porter, “‘A Mangle, Wringer, Bowl, Scissors, A Bible and a Prayer Book’”, p.40.
\textsuperscript{31} Porter, “‘A Mangle, Wringer, Bowl, Scissors, A Bible and a Prayer Book’”, p.42.
\textsuperscript{32} Porter, “‘A Mangle, Wringer, Bowl, Scissors, A Bible and a Prayer Book’”, p.42.
Annual reports issued by the management committee over the next few years paint a picture of a small institution challenged by the size of the tasks at hand. There never seemed to be enough money and, although the laundry business was successful and self-sustaining, the reports strongly express a continuing need to ask the public and various benefactors for ongoing financial help. Staffing provided a consistent challenge and in 1903, the matron was changed three times. Infant mortality remained a problem at the home. In 1899, two of the sixteen children born at the home died, and no reason for their deaths was provided in the annual report for that year. In 1902 one baby of the five born at the home died, and in 1904 another three died out of the twelve born for that year. In 1905 one-third of the babies born at the home died, and in the following year another baby died; the only explanation offered was that the child had been ‘delicate from birth’. In 1907, 1908 and 1910 the home lost two, one and two babies respectively.

The limited nature of the records of births as seen in the matron’s diary for this period illustrates the lack of focus on the babies. When babies were born it was common for the matron to record only the name of the mother, the date and the statement ‘confined, a boy’. Women whose children died shortly after birth received a little more attention in the diary. Lucy W. for instance ‘had a son at 4am, lived 24 hours’. Another woman, the young mother of twins received ‘Jessie C. 22, had twins, girl adopted, boy died’. In these diaries, significantly more attention was paid to the general goings-on of the home, including the successful attempts made by some young women to escape, as happened twice in 1895. The visits of doctors, the running of the laundry and the behaviour of the inmates were evidently of more concern to the matron and to the management committee than were the babies themselves.

33 See House of Mercy, Annual Reports 1899-1910, Ngala Mothercraft Home and Training Centre Collection, SLWA, Acc. 6093A/35.
34 House of Mercy, Annual Report for year ending 31 October 1903, Ngala Mothercraft Home and Training Centre Collection, SLWA, Acc. 6093A/35.
35 House of Mercy, Annual Report for year ending 31 October 1899, Ngala Mothercraft Home and Training Centre Collection, SLWA, Acc. 6093A/35.
36 House of Mercy, Annual Report for year ending 31 October 1906, Ngala Mothercraft Home and Training Centre Collection, SLWA, Acc. 6093A/35. See also House of Mercy, Annual Reports 1902, 1904, 1905, Ngala Mothercraft Home and Training Centre Collection, SLWA, Acc. 6093A/35.
37 See House of Mercy, Annual Reports 1907, 1908, 1910, Ngala Mothercraft Home and Training Centre Collection, SLWA, Acc. 6093A/35.
38 See for example House of Mercy, Matron’s Diary 1895, cited in Lang, The Open Door, p.17.
The House of Mercy annual reports also reflect a lack of interest in the babies, complemented by a keen focus on the moral resurrection of the mother. In the annual report for 1901 the positions of all but one of the fourteen children born at the home for that year is given rather abruptly as: three still born, two died after birth, one adopted, one ‘out to nurse’, three left with their mothers, and three remaining at the home. Of the children that had died, president of the committee Annie Lawley and Honourary Secretary Mary L. Denbigh note only that the infants were ‘delicate from their birth; every attention was given them by the matron and doctors’. Comments such as these are also reflective of general attitudes to child mortality during the colonial period. Although the majority of babies and infants survived to adulthood, infant death was a common occurrence. For example at the House of Mercy, in the seventeen years from the beginning of 1894 to October 1910, an average of eleven babies were born every year and on average two of these eleven died.

Over the life of the home, the management committees (which were made up entirely of well-to-do women) adopted a moralistic and paternalistic attitude to the inmates which was a reflection of broader social expectations of female behaviour. The shame associated with pregnancy outside of marriage made the existence of the home necessary, primarily because many young pregnant women had nowhere else to stay. A significant proportion of the girls admitted during the early years were domestic servants who would have been forced to leave their work (and thus their place of lodging) once their pregnancy became noticeable. Some of these women were assisted immigrants who had been brought over to WA from Britain to satisfy the unmet demand for domestic servants. Between 1860 and 1900, 1700 women were given assisted passage to WA, and a number of them ended up at the House of Mercy. For example, of the 66 girls admitted to the home between November 1891 and October 1899, at the height of the program of assisted female immigration to WA, 18 were known to be British immigrants.

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43 These calculations are based on figures from House of Mercy annual reports 1899-1910 and from figures appearing in Porter’s essay. See Porter, “‘A Mangle, Wringer, Bowl, Scissors, A Bible and a Prayer Book’”, p.39.


46 Lang, *The Open Door*, p.25.
The House of Mercy differed significantly from other charity-run lying-in homes in Perth and Fremantle because its primary aim was to reform its residents. The control exerted by the management committee and the matron over the inmates of the home is reflected in the House Rules. The rules dictated, among other things, that upon admission, inmates were to give any money in their possession to the matron. This money would then be ‘taken care of by the committee till they leave, or appropriated to their use if necessary’. In addition, any money earned by an inmate in the laundry business would be controlled by the committee, a percentage of which would then be paid to the inmate upon her leaving the home. There was to be no swearing or improper language and no alcohol was to be consumed at the home. Any inmate found intoxicated or who was reported for swearing could be fined or expelled. The use of the term ‘inmate’ in these house rules is important because it demonstrates how the young women staying at the home were viewed by the committee. They were not merely ‘patients’ who would soon return to their normal life, but individuals of questionable moral character who were in need of reform. In its dealings with unmarried mothers-to-be, the House of Mercy adopted a gendered, controlling rhetoric designed to re-establish the inmate’s commitment to Christian understandings of female morality. Women who came to the home were therefore expected to feel ashamed of their past lifestyle and were required to gratefully receive the rehabilitation the home offered.

The identification of the women who stayed at the House of Mercy as ‘inmates’, the punitive nature of the laundry work along with the strictness of the house rules are all reminiscent of Goffman’s ‘total institution’ model. Young women who came to the House of Mercy during this early period were, from the moment of their arrival, no longer in control of their own lives. Their movements in and out of the facility were severely restricted and their potential escape from the institution was guarded against. Inmates were continually under the supervision and control of the matron and breaking the house rules had severe consequences. The commitment required from inmates to remain in the facility no less than six months also highlights another way the House of Mercy adhered to the ‘total institution’ model. By limiting an inmate’s movement in this way, the institution was able to perpetuate a tension

47 House of Mercy, House Rules, 1892, Ngala Mothercraft Home and Training Centre Collection, SLWA, Acc.1796A.
48 House of Mercy, House Rules, 1892, Ngala Mothercraft Home and Training Centre Collection, SLWA, Acc.1796A.
between the home world of the outside and the internal world of the facility, at least for a certain period of time. The tensions created between the inside and outside in such institutions are used by staff as leverage to manage inmates.\(^{49}\) The forfeiture of money and personal items upon entry to the home was one way in which the institution was able to use this leverage. Women who broke the house rules could be fined, meaning that they had less money to take away with them after their six-month stay. The removal of cash from inmates and the management of their finances by the committee also worked to highlight the inmates’ lack of agency in the outside world and entrenched their dependency on the institution.

Yet, the case of the House of Mercy draws attention to another facet of the complex interaction between contemporary attitudes to choice in childbirth and the stark realities of women who lived in this earlier period. Women who found themselves pregnant and unmarried were left entirely without choices and were, in a very real sense, dependent on the mercy of others. Many would have had no housing and, had they not been resident at the House of Mercy, had no access to skilled attendance at birth. So while the home was no doubt a difficult and repressive place for many women at the time, it at least provided a relatively safe physical space for women to give birth during a period when other options were limited. It therefore remains difficult to accurately assess the House of Mercy as an institution. Nor is it possible to fully understand the experiences of the women who lived and birthed there for, as is the case for many poorer women during this period, their feelings were never recorded. The matron’s diary records do show that some inmates chose to run away from the home rather than commit to its rules, suggesting that at least some women found the institution too much to bear. Yet, while some inmates may have felt the oppression of the ‘total institution’, others may have eagerly embraced the ‘second chance’ the home offered them.

**Midwife-run lying-in homes**

Lying-in homes like the House of Mercy could only ever cater for a limited number of women and these charity institutions overlaid existing services offered in small, midwife-run lying-in homes. While these smaller homes had always been available in an unofficial

capacity, they began to form a more significant part of Perth’s maternity services after the
turn of the century. Some of the homes accommodated two or three women at a time, and
they often doubled as the attending midwife’s own home. During the early decades of the
twentieth century lying-in homes became larger, and some had room to accommodate up to
ten women. 50 The midwives running these larger homes could sometimes afford a small staff
to assist in managing the patients. For instance, as early as 1900, Mrs. Edmunds, resident of
the goldfields town of Kalgoorlie, advertised her purpose-built, private hospital facility which
boasted a ‘commodious maternity ward’ with ‘separate nursing staff’. 51

Lying-in homes were dotted throughout Perth city and spread into the suburbs as the suburbs
themselves grew. There was usually at least one lying-in home in every country town.
Advertising material from the 1890s and into the 1910s and 20s shows how widely spread
lying-in homes were. Some of the metropolitan locations known to have lying-in homes prior
to 1911 include East Perth, Perth, Subiaco, Maylands, West Perth and Fremantle. 52 An
analysis of lying-in home advertising in Perth newspapers also shows how the number of
homes increased dramatically after 1900. In 1899 a single lying-in home situated on Bulwer
Street in Perth advertised itself as providing ‘accommodation for ladies’ with ‘resident
nurses’ at ‘moderate’ terms. 53 In 1904, another home, in addition to the one in Bulwer Street,
began advertising. 54 By 1910, lying-in homes had their own advertising section in the Sunday
Times, with every issue having as many as nine or ten midwives advertising their home. 55 By
1914 there were 149 lying-in homes registered in Western Australia. 56

During the early decades of the twentieth century, the ever-increasing number of lying-in
homes had some impact on women’s choices about where to give birth. In Perth and its
suburbs particularly, women could choose from a number of different homes run by different
midwives. However, these ‘choices’ were always limited by socio-economic factors, and a

51 “Wanted Known”, Kalgoorlie Miner, Saturday 28 April, 1900, p.6. Accessed via TROVE archive,
29/04/2013.
52 See “Maternity Homes”, Sunday Times, Sunday 11 September, 1910, p.7; “Nurse Barnes”, Kalgoorlie Miner,
archive, 02/07/12.
54 “Maternity Home”, The West Australian, Saturday 7 May, 1904, p.12. Accessed via TROVE archive,
02/07/12.
56 Flanagan, “Lying-in (or Maternity) Homes”, p.351.
proportion of women would have found the cost of attendance at a lying-in home prohibitive. For example, advertising from 1910 suggests that in the city, two guineas for the confinement was usual plus an extra pound for each week spent ‘waiting’. This put the total cost for a confinement and a two-week lying-in period at four pounds two shillings, around two weeks pay for a general labourer. At this price, the cost of attendance at a lying-in home would have been out of reach for many working women, for whom four pounds two shillings constituted over one month’s income. While the provision of the five pound Commonwealth government Maternity Allowance from 1912 could potentially have made it easier for many women to attend a lying-in home for the birth of their baby, some working women may still have found the extra cost of out-of-home care unaffordable.

By 1923 the price charged for a confinement at some Perth lying-in homes had risen to almost three guineas with lying-in charged at one pound ten shillings per week. During this latter period, the total cost for a two-week stay and a confinement was around six pounds two shillings, which constituted a little over one week’s pay for a skilled tradesman. In real terms this price increase was not significant given changes in the cost of living and inflation over the period between 1910 and 1923. However in 1923 the Maternity Allowance payment of five pounds would not have been enough to cover both the cost of attendance at birth and the lying-in period, again highlighting how socio-economic factors hindered women’s choices in regard to childbirth. Poorer women were particularly limited during this period because the cost of attendance at a lying-in home in WA was generally more than in some other states. Until the 1930s in Queensland for instance, nurses and midwives charged around three guineas for the confinement and lying-in, significantly less than the amount

58 In 1910, metropolitan-based members of the Western Australian General Workers Union were paid around eight shillings and six pence per eight hour day for basic construction work. See “The Sons of Martha. A Column for the Workers”, Sunday Times, Sunday 24 April, 1910, p.5. Accessed via TROVE archive, 07/06/13.
61 Western Australian wage rates in 1923 varied across trades, however most skilled tradesmen earned between four and six pounds per week. See Western Australian Pocket Year Book, 1923, p.44.
62 See Reserve Bank of Australia Pre-decimal Inflation Calculator, accessed online at rba.gov.au, 14/10/2015.
expected in WA during the same period.\textsuperscript{63} In the 1910s, some midwives, like Nurse Ellen Jones in Collie south of Perth, were charging four guineas for the full service.\textsuperscript{64}

In her study of lying-in homes in Queensland, historian Wendy Madsen suggests that in order to attract patients, it was necessary for midwives to have good relationships with doctors.\textsuperscript{65} In WA, some women who ran lying-in homes were on good terms with local medical men, and relied on them for more complicated deliveries or surgeries.\textsuperscript{66} Others even used their professional relationships with medical practitioners to help attract clients. In 1910, Nurse Lloyd somewhat vaguely advertised her lying-in home as being ‘recommended by leading doctors’.\textsuperscript{67} Possibly to give their lying-in homes an air of authenticity and safety, midwives occasionally established a ‘committee of inspection’ for their home, made up of respected community members, though the extent to which these committees had any impact on the standards of practice in lying-in homes is open to debate. In one case, the committee of the Star of Hope Lying-in Home disbanded itself with the complaint that its members had ‘no proper control’ over the affairs of the home.\textsuperscript{68} The midwife in charge, Martha Morgan, responded strongly, making the point that the committee had only ever been ‘ornamental’ and was not there to control the running of the home in any way. In a public letter she writes:

\begin{quote}
[w]hat they wanted to control, unless it was the cash, puzzles me; it could hardly have been the babies. I, the matron, consider myself quite capable to control the affairs of the home…[t]he home has been now three years in existence and I have not lost one child or mother…\textit{I formed the committee of inspection to let the public know that the Home was worthy of patronage.}\textsuperscript{69}
\end{quote}

Situations like the one described at the Star of Hope were not the norm, yet it is clear that midwives felt a need to promote their homes as clean and safe in any way they could. During a time when midwives were being professionally undermined by medical practitioners, it was perhaps necessary for individual midwives to distinguish themselves from the image of the ‘Sairey Gamp’ practitioner. Some advertised their homes as being ‘recommended’ by various

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\item \textsuperscript{64} Winifred Willis, Transcript of Oral History Interview conducted by Jan Wallace, 1988, SLWA, OH1963, p.1.
\item \textsuperscript{65} Madsen, “‘Working from Home’”, p.56.
\item \textsuperscript{66} This was the case with Nurse Jones of Collie who often worked together with the local medical-men Dr Cameron and Dr Rigby. See Willis, Transcript of Oral History Interview, p.3.
\item \textsuperscript{67} See “Maternity Homes”, \textit{Sunday Times}, Sunday 11 September, 1910, p.7.
\item \textsuperscript{68} “Star of Hope Lying-in Home”, \textit{The West Australian}, Wednesday 18 January, 1899, p.5. Accessed via TROVE archive, 29/04/2013.
\item \textsuperscript{69} “Star of Hope Lying-in Home. To the Editor”, \textit{The West Australian}, Friday 20 January, 1899, p.3. Accessed via TROVE archive, 29/04/2013. Emphasis added.
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\end{footnotesize}
medical authorities, and it was also common for homes to advertise their ‘healthy position’ and ‘sea views’.\(^{70}\)

In country areas, lying-in homes were particularly essential to the proper functioning of maternity services. In some towns the single lying-in home, run by a midwife, was the only source of out-of-home expert attendance for childbirth, there being still no hospital services for childbirth in the early decades of the twentieth century.\(^{71}\) The midwives running these homes were often highly skilled. Nurse Ellen Jones, who arrived in WA in 1898 and appears on the first WA Register of Midwives in 1913, was one such woman.\(^{72}\) In an oral history interview conducted for the WA State Library in 1988, Jones’ daughter Winifred Willis recalls her mother’s lying-in home at Collie which operated during the early decades of the century. According to Willis, Nurse Jones could accommodate six to eight patients at a time in her home and it was not unusual for her to be personally attending six lying-in women at any one time. Like many midwives in country areas, Jones had good working relationships with local doctors and she often had medical-men assisting her at births, particularly for the administration of chloroform and any surgical procedures. The cost of four guineas for the confinement and a ten-day lying-in period was slightly more than the usual price paid by women in Perth, though this price included the standard procedure of circumcision for male children.\(^{73}\) In addition to running her lying-in home, Nurse Jones attended local women in their own homes and performed all the usual tasks expected of a midwife, including cleaning and washing. The exceptional skills of midwives like Jones – who had no formal midwifery training – are highlighted by their ability to perform complex deliveries without medical aid. According to Willis, her mother was able to deliver twins and breech births without the assistance of a medical-man, and Willis notes that her mother did this in Collie on a number of occasions.\(^{74}\)

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\(^{71}\) This was the case for nurse Monger’s lying-in home at Narrogin. See Central Board of Health, Files – General, 1899-1987, SROWA, Item no.1939/0623, Cons.1003.


\(^{73}\) Willis, Transcript of Oral History Interview, pp.1,3.

\(^{74}\) Jones appears on the 1913 Midwives Register under the ‘grandmother’ clause which allowed untrained women who had been in practice at June 1909 to register and continue working as midwives. See Willis, Transcript of Oral History Interview, p.3.
The number of lying-in homes in Western Australia steadily increased over the 1920s and 30s, and only began to decline during the years spanning the Second World War. Some of the smaller homes closed when the midwives running them ceased to practise; others were put out of business by changing expectations of the quality of service that should be provided. During the 1930s and 40s there was increasing demand for beds in these homes, and that translated to demand for better drainage, sewerage and laundry facilities. At times, some homes were overcrowded and, with many women volunteering for war service in the 1940s, there was a shortage of midwives and nurses to staff some of the larger homes. May Flanagan has suggested that during the war years in WA, the price that could be charged for confinements was imposed externally, and this may have put some pressure on smaller lying-in homes. Further, towards the end of the 1940s, state government industrial awards and regulations stipulated that staff had to be provided quarters, and that lying-in homes had to have a separate labour ward, which could have exacerbated financial pressures. These limitations and controls had a considerable impact on midwives and their lying-in home businesses.

A good example of the challenges of running a lying-in home during this period can be seen in the difficulties experienced by Nurse Monger at Narrogin, almost 200 kilometres south of Perth. Nurse Monger first made an application to run a lying-in home in 1933. Her facility, the only location for out-of-home maternity care in Narrogin, had an average case load of almost one hundred patients per year. In 1939, Monger moved her home to other premises and two years later the report of the annual inspection (then carried out by the Public Health Department) concluded that her supply of water was insufficient for a lying-in home. At risk of having her lying-in home closed down, Monger wrote to Health Department officials, insisting that her home must remain operational. At this time, her lying-in home provided an invaluable service to the local community because there were only two other midwives in the district and both were elderly. Monger was allowed to keep her home open, but the water

75 Flanagan, “Lying-in (or Maternity) Homes”, p.351.
76 Flanagan, “Lying-in (or Maternity) Homes”, p.351.
78 Flanagan, “Lying-in (or Maternity) Homes”, p.351.
79 Central Board of Health, Files – General, 1899-1987, SROWA, Item no.1939/0623, Cons.1003.
rations imposed on Narrogin during the war years made it very difficult for the home to operate. During 1944 for instance, water was supplied to the home on only one day a week and this supply remained the sole source of water until Monger purchased her own water tank.\textsuperscript{80}

The home was also in financial trouble. In 1942, Monger travelled to Perth to meet with the Under Secretary of Public Health. She requested that the government provide a subsidy for her facility of £100 per year for the duration of the war. In making this request, she pointed out that, since Narrogin District Hospital did not take maternity cases, her lying-in home was of ‘vital necessity to the district’.\textsuperscript{81} Monger’s request for financial assistance was met with resistance from the Minister for Public Health, who felt that any subsidy for the running of the home should be partly funded by the local people. Nurse Monger never received a subsidy to run her home, yet she continued to manage the facility for another three years before selling it in 1945.\textsuperscript{82} Even at this time, Narrogin District Hospital did not provide maternity services to the Narrogin community, demonstrating how integral these small lying-in homes were in some country towns.

Some of the lying-in homes operating in Perth during the early years of the twentieth century became quite well known and have particular historical significance. Nurse Stockley’s Private Hospital in West Perth, later to be known as Swan Hospital and then Blaich Appin Maternity Hospital, was one such institution. The home was the subject of a small book published in 2009; a year earlier the property itself was recommended for entry into the Town of Vincent’s Municipal Heritage Inventory, and later became heritage-listed.\textsuperscript{83} The midwife who ran the home, Alice Maud Mary Stockley, was born in 1866 in Devon, England and came to Fremantle with her second husband and her four surviving children in 1907. She was a trained nurse, and she was listed in the first WA Register of Midwives published in 1913.\textsuperscript{84}

Stockley had worked as a midwife prior to her 1913 registration, with her home at 47 Newcastle Street in Perth operating as a lying-in home in 1911. Intent on enlarging her

\textsuperscript{80} Central Board of Health, Files – General, 1899-1987, SROWA, Item no.1939/0623, Cons.1003.
\textsuperscript{81} Central Board of Health, Files – General, 1899-1987, SROWA, Item no.1939/0623, Cons.1003.
\textsuperscript{82} Central Board of Health, Files – General, 1899-1987, SROWA, Item no.1939/0623, Cons.1003.
\textsuperscript{83} See “Heritage Assessment for 590 Newcastle Street”, p.1; Smoker, \textit{The Smoker and Stockley families}, p.34.
business, Stockley purchased a vacant lot at 590 Newcastle Street in the early months of 1912 and in the following year purchased an additional two lots on the same street. By 1913 she was running a large purpose-built lying-in home with space for ten patients. The home evidently had a good reputation with medical-men because Stockley had at least five doctors assisting her at the home throughout her time there, and it appears that she rarely delivered babies without their help.\(^85\) It was also one of the most spacious lying-in homes available at the time with advertising material issued by the home in 1913 claiming that ‘each patient has a separate room’;\(^86\) In addition to these ten rooms, the hospital had a labour ward and a dining room but, in keeping with the intended purpose of the building, there was no surgical ward. According to Stockley’s granddaughter Viola, who spent a considerable time at the hospital as a child, the dining room was always kept sterilised so that the doctors could perform circumcisions there. As was the custom at the time, baby boys were given brandy before these operations.\(^87\)

Nurse Stockley ran her hospital from 1913 to 1946 when she sold it to nurses Menzies and Jackson.\(^88\) In 1939 she changed the name of her lying-in home to Swan Hospital and this is how it was known until 1946 when it was renamed by its new owners as Blaich Appin Maternity Hospital.\(^89\) The home was purchased by the WA Health Department in 1949 and remains under the ownership of the Health Department today.\(^90\) Along with other lying-in homes such as the House of Mercy, and the property at 30 Bulwer Street, Perth, Blaich Appin Maternity Hospital is considered highly significant to WA’s maternity history.\(^91\)

**Women’s experiences of childbirth in lying-in homes**

The experiences of mothers in these homes is difficult to determine due primarily to a lack of records. Women giving birth during the late nineteenth and early twentieth century rarely spoke openly about reproduction and were unlikely to record their experiences of childbirth.

\(^{85}\) Smoker, _The Smoker and Stockley families_, pp.25-26, 31.
\(^{87}\) Smoker, _The Smoker and Stockley families_, p.31.
\(^{88}\) “Heritage Assessment for 590 Newcastle Street”, p.6.
\(^{89}\) See WA Post Office Directories (hereafter PODs) ‘Medical Directory’ section, 1939-1946, accessed online via SLWA website, 27/05/2013.
\(^{90}\) “Heritage Assessment for 590 Newcastle Street”, p.6.
\(^{91}\) This property on Bulwer Street in Perth was known to be a lying-in home for most of the 1920, 30s and 40s and was under the management of midwife Eleanor Harvey for the majority of that time. See WA PODs, ‘Private Hospitals’ under ‘Trades Directory’ section, 1925-1942.
It is clear from the information available, however, that lying-in homes in WA varied from one another markedly and this suggests that women’s interactions with these homes as places for birth would have been highly variable. It is of some interest to compare lying-in homes as sites of childbirth to women’s own homes, as these were at this time in Perth, the only two location choices available to women who could afford to pay for care. Some of the larger and more expensive homes had private rooms which afforded a degree of privacy and comfort during lying-in and would have more closely resembled a woman’s own home. At the same time, these larger lying-in homes often had a labour ward to which mothers were removed, and it is in these somewhat clinical surroundings that a woman would actually give birth.\(^9^2\) This arrangement was deemed necessary in some lying-in homes in order to maintain an antiseptic environment for the birth; it was certainly a more clinical and hospital-like atmosphere when compared to home birthing.

In smaller lying-in homes it was usual for a number of women to share a large room. Often in this situation there would also be a labour ward to which a mother would be taken once the birth was imminent. Shared rooms allowed women to have company during their lying-in period and this certainly would have alleviated feelings of isolation and loneliness. This arrangement contrasted significantly with women’s experiences of birthing in their own home, where they were the sole patient. In lying-in homes, many women were under the care of only one or two midwives, and as a result, individual attention, so usual in home-birthing, would not have been possible in some cases. Shared rooms also heightened the sense of being observed by others and this too would have made the lying-in experience considerably different for women who were used to birthing at home where privacy could be sought.

Lying-in homes as sites for childbirth differed from homes in other important ways too. Some of the larger homes were very much like small maternity hospitals and were run in ways which best suited the matron in charge. The convenience of the midwives working in these larger homes would have been prioritised over the feelings of patients and the many challenges of running such a home would have made it necessary to place limitations on the movements of individual patients and their visitors. Unlike women’s own homes, where visitors would come and go at the request of the mother or her family, visitors to lying-in

\(^9^2\) As noted above, Nurse Stockley’s lying-in home in West Perth had private rooms for each patient as well as a labour ward.
homes were required to come between certain hours and in some cases were not allowed at all. Women staying in these homes were also away from their familiar possessions and conveniences, did not have full freedom of movement, were required to eat unfamiliar food and were surrounded by strangers for the majority of their stay. These factors could have made the lying-in experience difficult for some women and suggest that lying-in homes rarely acted as ‘sanctums’ for women during childbirth.

The rest from home duties and from other children could have been one of the great appeals of lying-in homes. The ability to take a break from home-life and its associated responsibilities may have provided women with much-needed respite. Similarly, some of the smaller homes, particularly those run by a single midwife out of her own home, would have been much more familiar to mothers and would not have had the clinical appearance of the larger, more expensive lying-in homes. Some midwives only had space to accommodate one patient at a time, making individual attention and privacy more likely for women giving birth in these homes.

The power structures at play in lying-in homes were starkly different to those which existed in women’s own homes. Birthing within the home provided mothers and their families with a degree of control over the childbirth process unknown to those birthing in lying-in homes during the same period. The childbirth event necessitated the entry of skilled assistance into a woman’s home, but significantly, these skilled individuals were invited in and as such, lost a degree of their control. By operating within a woman’s home, and more specifically in a woman’s bedroom – a place which all present acknowledged as her domain – childbirth attendants had to adopt a more accommodating position when it came to making decisions during childbirth. This does not necessarily mean that birthing women were encouraged to make decisions themselves, although some certainly would have made their opinions known, but birthing in the home did require that the midwife or doctor attending had to clear decisions about the birth, if not with women themselves, at least with husbands, friends and relatives. The situation in lying-in homes was considerably different, because it was the mother, as the patient, who entered into the domain of the midwife and thereby gave up a degree of control over her treatment. By consenting to attendance in a lying-in home, women were consenting to abide by the expectations and rules of that home, as established by the midwife or matron. As such, women may have been subjected to treatment or routines which they would have objected to had they been giving birth in their own homes.
As with many aspects of women’s experiences of maternity care during this period, it is difficult to be certain about how mothers may have felt during their stay in a lying-in home. The fact that these homes were popular with women and provided a significant amount of WA’s accommodation for maternity cases during the period before the 1940s, attests to the fact that a proportion of women preferred to be cared for at lying-in facilities rather than in their own homes. This again points to the problems of applying contemporary ideas around the importance of choice and location into the historical narrative of childbirth. While unfamiliar people, unfamiliar food and restrictions on movement may appear to have been disincentives to the use of lying-in home services, these inconveniences appear to have been tolerated by mothers who rarely complained publicly about their treatment at these homes. Just as would be the case in large maternity hospitals during the 1920s and 30s, women during the late nineteenth and early twentieth centuries accepted the lying-in home for what it was and appeared grateful for the care they received there. While lying-in homes could never act as ‘sanctums’ for mothers, their role was nonetheless an important one to Western Australian women.

Regulation of lying-in homes

Increasing regulation of lying-in homes during the interwar years and beyond made the running of these small businesses significantly more difficult for midwives. In the early years, regulation of lying-in homes had been limited or non-existent. The colonial government’s first foray into regulation came in the form of the 1898 Private Hospital Act which established the licensing requirements for any private hospital, including lying-in homes. The Act provided regulations for the standards of these homes including the space required per patient and the various facilities necessary for serilisation of instruments. Inspections of private hospitals were conducted annually by district medical officers who then put their recommendations to members of the District Board of Health. These initial attempts to regulate lying-in homes are a good example of the growing powers of the medical profession during this period. The Act gave medical doctors, as agents of local health boards, the power to recommend or challenge a midwife-run lying-in home, thus providing legal

93 Flanagan, “Lying-in (or Maternity) Homes”, p.343
authority to doctors to oversee midwifery practice in some contexts. This was a significant shift from earlier times, when midwives had operated independently of medical oversight.

In some cases, this oversight was important for maintaining reasonable standards in lying-in homes. The treatment of typhoid patients was of particular concern. In 1896, 663 cases of typhoid were recorded in Perth, and this figure more than doubled the following year to 1,408. There were also typhoid outbreaks in the goldfields and in the colony’s south-west region in the 1890s. The treatment of these patients in lying-in homes was not uncommon, particularly in country areas where it may have been difficult for nurses and midwives to maintain a consistent flow of maternity patients. The practise was a constant source of concern for members of local health authorities. At Bunbury during the 1890s for instance, lying-in homes were generally seen as being a ‘menace’ to public health. In April of 1898, concern was raised about a lying-in home in the centre of Bunbury town at which a typhoid sufferer had died and others were still being treated. Later in the month the sale of a lying-in home premises was stopped due to the fact that cases of typhoid had been treated there. A similar situation emerged in relation to one small midwife-run lying-in home at Kalgoorlie, nurse Whittle’s Lying-in Home. The home was first reported as being recommended for licensing in 1902 and from reports of births in the area, it is clear that at least one baby was born there in that year. A year later, the medical officer Dr. Swanston, reported to the Kalgoorlie Board of Health that he had inspected Nurse Whittle’s lying-in home and found that he could only recommend it if a maximum of two patients were lying-in at one time. In addition, he insisted that occupants of the home could only be midwifery patients, and as such the home was not to be used as a hospital for the treatment of infectious diseases.

Nurse Whittle must have complied with this order, as she went on running her lying-in home over the next few years without any further complaints from Dr. Swanston.

95 See “Board of Health”, Bunbury Herald, Tuesday 19 April, 1898, p.3. Accessed via TROVE archive, 23/03/2013.
96 “Health Board”, Bunbury Herald, Tuesday 5 April, 1898, p.3. Accessed via TROVE archive, 23/03/2013.
98 “District Health Board”, Kalgoorlie Miner, Wednesday 30 April, 1902, p.6; “Births”, Kalgoorlie Miner, Tuesday 1 April, 1902, p.4. Accessed via TROVE archive, 03/06/2013.
In the case of Nurse Whittle’s lying-in home at Kalgoorlie, it appears that inspections were regular; however the extent to which the regulations stipulated under the 1898 Act were actually enforced throughout WA is unclear. Certainly, historians including May Flanagan have claimed that standards in many lying-in homes in WA were poor. Negative newspaper reports dating as far back as the 1890s helped to generate an environment in WA which was increasingly hostile to lying-in homes. The perceived failures of these homes in Victoria, New South Wales and South Australia were often reported upon in the Western Australian press, and the midwives running them were strongly criticised. For example, in 1906 the WA press reported on an investigation being undertaken into the 450 lying-in homes in New South Wales. The inquiry found that many of the homes were run down and poorly ventilated. In addition, a number of midwives in the state were accused of various types of malpractice and some had been before the courts multiple times. According to the findings of the investigation, midwives in Sydney were doubling as abortionists and young women who had their babies in lying-in homes ‘largely drifted onto the streets’.

This style of rhetoric formed part of the campaign against midwives in Australia because it helped to portray their practices as being a danger to public health while simultaneously linking midwives to the perceived immoral activities of abortion and prostitution. While it is impossible to fully test these claims, the quality of many of the homes discussed in this study suggests that a significant proportion of lying-in homes were well-managed and run by skilled midwives. Yet, the findings of the 1906 New South Wales investigation highlighted the apparent variation in lying-in home services during this period. For example, while the services offered by the larger homes would have been too expensive for a single working woman, some of the smaller lying-in homes, those run by a single midwife from her own home for instance, would have been accessible to this group, particularly after the introduction of the Maternity Allowance in 1912. Thus the claim that women giving birth in lying-in homes in Sydney ‘drifted on to the streets’, may have been reflective of one facet of

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the lying-in home sector, but this suggestion should not have been projected on to all lying-in homes, many of which were inaccessible to poorer women.

While no extensive investigation into WA lying-in homes was undertaken during this period, many of the themes of the NSW investigation are reflected in the historical material relating to Western Australia’s own lying-in homes and infant boarding houses, suggesting that a proportion of Perth’s midwives were not providing a safe service to women. Charges of manslaughter or murder were not regularly laid against midwives in WA, but evidence suggests that some midwives were involved in providing abortions. For example in 1908 Perth-based midwife Elizabeth Pears was accused of murder and later found guilty of manslaughter after she performed an abortion on a young single mother who later died.104 Pears was sentenced to seven years jail.105 Ten years earlier in 1898, midwife Margaret Ann Smith had also been found guilty of manslaughter and was sentenced to seven years jail after the death of Margaret Buckley during a failed abortion. This conviction was later quashed due to inadmissible evidence being used against Smith, but the investigation into the death had found that the midwife had three immature foetuses buried in her back yard.106 Smith was again implicated in another case of death from a failed abortion in 1904 but there was not sufficient evidence to convict her and she continued her practice.107

These occurrences were not common in Perth, reinforcing the impression that the majority of midwives provided a relatively safe service; however, other facets of the infant care system were in need of an overhaul. The great need for legislation designed to protect infant life was highlighted early in 1907 by a much-publicised case of ‘baby-farming’. The Mitchell Case – named after the nurse who was accused and convicted of the manslaughter of a five-month old infant – was deeply shocking for the Perth community. The case uncovered an alarming

situation in infant boarding-houses where young, unmarried mothers, forced to work to support themselves, left their babies to be cared for by nurses. The mother in question was a single woman, Miss Booth, who had given birth to her baby at the House of Mercy in September 1906. She left the home when she found employment and her daughter was subsequently sent to live at Mrs. Mitchell’s home, which was at the time recommended by the Perth City Council. Although she supplied food for her baby, paid the boarding fee and visited regularly, Miss Booth was unable to see her daughter in the weeks leading up to the baby’s death. She was usually told that her baby was ‘sleeping’ and could not be disturbed. When Miss Booth was eventually shown the baby, it was clear that the child was emaciated and in need of medical attention. The infant was admitted to Perth Public Hospital immediately but she died within 24 hours. The resulting investigation found Mrs. Mitchell guilty of wilful starvation and culpable negligence, and she was later sentenced to five years imprisonment.

The case shed light upon some significant problems with the licensing and inspection of Western Australian boarding-homes. Mrs. Mitchell’s home was inspected every two weeks by a woman employed by the Perth City Council and it was reported that doctors and religious men visited regularly, yet no problems with the home had ever been reported to authorities. In newspaper reports of the inquest into the death of baby Booth, it was suggested by some witnesses that the inspector was ‘very friendly’ with Mrs. Mitchell, and that she never actually went inside the home itself, instead being satisfied with chatting to Mrs Mitchell on the doorstep. During the investigation it was revealed that the home was squalid and dirty and that baby Booth was not kept in a clean condition. Doctors who visited the baby at the home shortly before the child was taken to the public hospital noted that the infant was emaciated and covered in flies. Police officers investigating the case found that a number of infants had died at the home and that Mrs. Mitchell had failed to report the

110 Flanagan, “Lying-in (or Maternity) Homes”, p.344.
113 Flanagan, “Lying-in (or Maternity) Homes”, pp.343-44.
In addition, the investigation revealed that of the 32 children Mitchell had looked after during her time running infant boarding houses, 29 had died and of those, 22 had been attended by the same doctor. Despite this dire situation, members of the local Board of Health had had no record of unsatisfactory reports relating to Mrs. Mitchell or the boarding house she ran.

It was clear that the Mitchell case was not an isolated incident. When the facts of the case were first publicised in February 1907, *The West Australian* reported that in the case of one woman who was a registered manager of an infant boarding-house in Perth, no less than thirty infants had died at her home in the past two to three years. At another home, 13 infants who had all been admitted in succession, died in the space of a few weeks. While these types of homes were not strictly lying-in facilities, in the case of Mrs. Mitchell it was reported during her trial that she did in fact conduct confinements at her house.

In response to the outrage caused by the Mitchell case, new legislation, based on similar statutes in Victoria and South Australia, was introduced into state parliament in October 1907 and was passed in December. The *State Children Act* created the State Children’s Department which administered the new measures, including stricter licensing of lying-in homes. Previously, licensing of these homes had been left to municipal authorities such as local Boards of Health; henceforth, licences would be issued directly from the central authority of the Children’s Department and departmental employees would conduct regular inspections of the homes. The Act also provided for better control of boarded-out infants and the individuals who cared for them. Under the Act, foster carers would need to be registered, and there would be greater oversight of the activities of all agencies or individuals caring for wards of the state.

122 Annette Davis, “Infant Mortality and Child Saving: The Campaign of Women’s Organizations in Western Australia, 1900-1922”, in Penelope Hetherington (ed.), *Childhood and Society in Western Australia*, 1988, University of Western Australia Press, Nedlands, p.167.
Lying-in homes remained under the control of the State Children’s Department until an amendment to the *Health Act* in 1918 transferred the management of such homes to the Public Health Department. In the intervening years a number of women were prosecuted for running lying-in homes without a licence. In June 1917 Lillian Plummer of North Fremantle appeared in the Children’s Court and was found guilty of evading the *State Children Act* by running an unlicensed lying-in home. According to press reports at the time, Plummer’s defence was that she was unaware of the existence of the Act and did not know of the requirement to have her home licensed. The prosecuting counsel explained that Plummer had been brought before the courts in order to give a warning to other women who were known to be running unlicensed homes in North Fremantle. After being threatened with imprisonment, Plummer was ultimately fined two pounds and ten shillings, although this fine was reduced to five shillings after representations were made on Plummer’s behalf by members of the Women’s Christian Temperance Union. In a letter dated 19 July 1917, the Acting Secretary of the State Children’s Department recommended that Plummer’s fine be reduced due to the fact that she ‘bears a very good reputation’ and was ‘a poor woman’.

The regulation of Western Australian midwives

The perceived need to stamp out unqualified midwifery practice remained a national issue for many decades. In WA, this translated into a publically-voiced call for tighter controls on midwives and their practise and the state government ultimately responded with legislation aimed at regulating midwifery. The 1911 *Health Act* provided, for the first time, a legally defined status for midwives and established the Western Australian Midwives Board (hereafter the Board) which managed the official register of midwives. The Board consisted of the state’s Principal Medical Officer, Dr. James William Hope as well as another

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123 Flanagan, “Lying-in (or Maternity) Homes”, p.344.
124 Chief Secretary’s Department, Correspondence files, 1883-1983, SROWA, Item no.1917/1754, Cons.752.
126 “Unlicensed Lying-in Home”, *The West Australian*, Friday 29 June, 1917, p.6; Chief Secretary’s Department, Correspondence files, 1883-1983, SROWA, Item no.1917/1754, Cons.752.
128 Carol Thorogood, Politics and the Professions: Homebirth in Western Australia, 2001, PhD Thesis, Murdoch University, p.82.
doctor and two midwives. Much to the frustration of the peak national nursing body at the time, there was no nursing representation on the Board.

After the introduction of the legislation, it became illegal for any person to practise midwifery unless their name appeared on the register. It also became illegal for unqualified medical practitioners to practise midwifery, except in an emergency. This had an indirect impact on lying-in homes because it became necessary for the proprietors of these facilities not only to register their homes but to also become registered midwives themselves. Women wishing to register with the Board had to provide evidence of training at a recognised training institution, or have evidence to support their claim to have attended at least 20 births under medical supervision prior to June 1909. This ‘grandmother’ clause allowed women such as Nurse Jones from Collie, who had extensive empirical knowledge, to register and continue working as midwives, at least for a limited time. It is noteworthy, however, that some applications to the Board for registration were from women who were over 60, were illiterate, or who had attended as few as 2 cases per year.

The first register of midwives was compiled throughout 1911 and by the end of that year it listed 633 women, 105 of whom had recognised certificates of training. At the end of the following year, the number of registered women had increased to 894, with 134 having recognised training. In 1913, there were 862 women on the register, and just as in the previous two years, the vast majority did not have any recognised training and were therefore included under the ‘grandmother’ clause. As there were no public hospital services for maternity cases in Perth at this time, and there were fewer than 150 lying-in homes registered, it follows that the majority of the women listed on the register around this time would have been independent midwives providing a service in women’s own homes. Of all

129 Hobbs, But Westward Look, p.53.
130 Hobbs, But Westward Look, p.40.
131 Thorogood, Politics and the Professions, p.82.
132 Hobbs, But Westward Look, p.54.
133 Thorogood, Politics and the Professions, p.82. For more information on the Health Act and how it related to midwives see Hobbs, But Westward Look, pp.52-3.
134 How long this time was is unclear, however correspondence between public health officials and doctors suggest that it was a very limited period. See Central Board of Health, Files – General, 1899-1987, SROWA, Item no.1910/0158, Cons.1003. See also Thorogood, Politics and the Professions, p.82.
135 W. McDonald and J.A. Davis, History of Midwifery Practice in Australia and the Western Pacific Regions, 1984, Western Australian Branch of the National Midwives Association, Perth, pp.4-5.
136 “Registration of Midwives”, Australian Medical Journal (hereafter AMJ), November 1913, p.1293.
137 Thorogood, Politics and the Professions, p.82.
the women on the register in these three years, only a small proportion were able to provide any evidence of formal qualifications such as certificates of midwifery attained in Britain, or qualifications from hospitals in the eastern states.\textsuperscript{138} This fact highlights what many historians have since noted about midwifery training in WA in the early decades of the twentieth century: it was severely limited.\textsuperscript{139} So few midwives on the 1913 register were able to provide evidence of formal qualifications because there was almost no way of obtaining those qualifications in WA at that time.

The 1911 Health Act had a significant impact on the profession of midwifery in WA because it brought midwifery practice more firmly under medical control.\textsuperscript{140} Of particular import was the fact that the Board – which had a significant amount of power under the Act – was chaired by a medical man, Dr Hope, which, as Carol Thorogood puts it ‘gave non-midwives authority over midwives’.\textsuperscript{141} Perhaps more importantly, the Board was also in control of the development and assessment of midwifery training in WA.

\text{[T]he Board’s curriculum (in terms of its duration, process, outcomes and evaluation) was dominated by physicians. For example, medical practitioners gave the lectures, set examinations and evaluated the students’ knowledge. Consequently, the courses were limited and primarily concerned with the preparation of nurse midwives willing to provide hospital-based care.}\textsuperscript{142}

The legislation itself also showed a significant bias in favour of medical practice which not only helped to facilitate a shift towards the greater reliance on medical assistance for childbirth but also highlighted the growing links between the profession of medicine and the state legislature. For example, while midwives on the register had to prove their good character by producing a letter from a recognised doctor, medical practitioners practising midwifery were excused from this requirement. Midwives also had to pay an annual fee to register and had to notify the Board of a change of address, neither of which was required of medical practitioners.\textsuperscript{143} This scrutiny of midwives was in keeping with changing attitudes towards non-medical health care providers. Medical control of childbirth relied on a rejection of the midwife as sole attendant, and this expectation had a direct influence on the Act. As

\textsuperscript{139} See Flanagan, “Lying-in (or Maternity) Homes”, p.345.
\textsuperscript{140} For an extensive analysis of this, see Thorogood, Politics and the Professions, pp.82-85.
\textsuperscript{141} Thorogood, Politics and the Professions, p.83.
\textsuperscript{142} Thorogood, Politics and the Professions, p.83.
\textsuperscript{143} Thorogood, Politics and the Professions, p.82.
the ‘grandmother’ clause shows, only women who could prove that they had worked under medical supervision were allowed to register to practise in Western Australia.

The broader public and even some midwives supported the changes laid down in the Act but there were dissenting voices.¹⁴⁴ For example one woman, a correspondent to The West Australian, complained in 1909 that the proposed legislation restricted some women because it forced them to employ doctors who were, according to the writer, an ‘expensive and unnecessary fifth wheel to the coach’.¹⁴⁵ For some, the legislation did not go far enough because under certain conditions, the ‘grandmother’ clause allowed empirically-trained women to register and receive the same recognition as a medically trained woman, thus creating unfair competition.¹⁴⁶ In response to this, one registered midwife, herself a possessor of recognised midwifery training, defended ‘untrained’ women insisting that:

such women, on due proof of their practical experience and good character, should be treated in the same way as master mariners, doctors, and chemists were when the Acts governing their professions were brought into force…I fail to see that “grossly unfair competition” will result from allowing those who have been practising for years to continue doing so; it would be “grossly unfair” to stop them while permitting nurses with only medical and surgical certificates to register. As it is, the number of registrations will be all too few, and I fear there will be a dearth of midwifery nurses after January 1.¹⁴⁷

Defence of traditional midwifery was not usually aired in newspapers, but these ideas highlight how important empirically-trained midwives were to their communities, particularly in a state where recognised midwifery training was not readily available. Although some may have objected to the registration of ‘untrained’ women under the ‘grandmother’ clause, their registration was necessary, at least in the short term, as the number of medically trained women was so few. Indeed, many so-called ‘untrained’ midwives working in WA at the time had much more practical experience of childbirth than the graduates of midwifery training schools in the eastern states and yet they were prevented from registering under the Act. One elderly woman for example, a midwife who had attended over one thousand cases in Britain,

was debarred from registering in Western Australia because she had never worked under medical supervision.148

These inconsistencies in the legislation were reflective of negative perceptions of midwifery practice generally but they had a particular effect on empirically-trained midwives and the poorer women who employed them. Broader social concerns around the quality of maternity services in WA as well as anxieties over high infant mortality rates had helped create momentum for regulatory change in relation to midwifery services, but the push toward greater regulation of midwives had a significant effect on some women’s ability to access care. Poorer women were more likely to use the services of empirically-trained midwives, the practitioners whose activities were targeted under the Act. The Act’s grandmother clause protected some midwives, specifically those who had evidence of having worked under medical supervision. However, many midwives, including those with decades of experience, were unable to register because they had never worked with medical oversight. Such women were no longer able to practise legally and were thus unavailable as childbirth attendants.

Other midwives, due to their poverty or rural location, were prevented from participating in training and were consequently unable to register to practise. The services of these women were then lost to their communities who often relied solely on the local midwife for care during pregnancy and birth. The results of these efforts to regulate midwifery practice are another example of how socioeconomic and geographic factors limited mothers’ ability to make choices about their childbirth experiences. While the regulation of midwifery services in WA was necessary in a broad sense, the transition to greater regulation occurred in such a way that many empirically-trained midwives were no longer able to provide their services with poorer women most affected by this change.

At this time, efforts to regulate maternity services in WA were part of a larger campaign to subsume midwifery into nursing, a profession which had already accepted its subordination to medical practice. The process of midwifery’s absorption into the profession of nursing has a long history which has been discussed at length by other historians.149 Traditionally, the

relationship between nursing and midwifery was such that the term ‘nurse’ could be used to refer to both general nurses and ‘untrained’ midwives. However as the occupation became professionalised, nursing, through its association with medicine, became a highly regarded and sought after profession; empirically-trained midwives lacked this ‘aura of respectability’.\(^{150}\) By defining trained midwives as nurses, it was possible to distinguish between untrained women working in the community and trained women working in hospitals.\(^{151}\) Those with training were ‘nurses’ and those without were ‘midwives’. Thus, identification with midwifery had negative connotations and highlighted a woman’s lack of formal training. Despite this, WA was the last state in Australia to formally position midwifery practice under the state’s Nurses Act. In 1944, the Midwives Board was disbanded and control of midwifery practice was handed to a Nurses Board. This was the final step in the incorporation of midwifery into nursing in WA, and according to Thorogood, it ‘marked the end of midwifery as an independent profession within the health system’.\(^{152}\)

The beginnings of nursing and midwifery training in WA

Prior to the twentieth century, nursing and midwifery training courses throughout Australia varied widely in their quality and in the length of time required to complete the qualification. Nationally, statutes related to midwifery education generally placed the profession under the auspices of nursing, following the traditional British nursing training model.\(^{153}\) A woman first became a general nurse after completing a three-year course. If she wanted to specialise she then undertook six months of midwifery training, and finally, she could complete a course in infant health.\(^{154}\) While it was possible to complete midwifery training without first holding a general-nursing certificate, this was frowned upon by nursing organisations, particularly the professional nursing body, the ATNA.\(^{155}\) Midwifery training was first made available at the Melbourne Lying-in Hospital in the 1860s and at the Benevolent Asylum in Sydney during

\(^{150}\) Thorogood, Politics and the Professions, p.42.
\(^{151}\) Thorogood, Politics and the Professions, p.45.
\(^{152}\) Thorogood, Politics and the Professions, p.49.
\(^{153}\) Thorogood, Politics and the Professions, p.41.
\(^{154}\) Training in infant health nursing was not available in WA until 1928 when a course was established at KEMH. Prior to this time, general nurses needed to travel interstate to gain a certificate in infant health. See Jenny Gregory & Jan Gothard (eds.), *Historical Encyclopedia of Western Australia* (hereafter HEWA), 2009, University of Western Australia Press, Crawley, p.184.
the 1870s, however there were no nationally recognised midwifery training courses in WA until 1916.\textsuperscript{156}

Even though there were no teaching facilities in this state for much of the first decade of the twentieth century, WA was one of the first jurisdictions in Australia to regulate midwifery and to establish the requirement for midwifery training.\textsuperscript{157} Instruction for nurses in this state had been available from 1896 when training began at the Perth Public Hospital. The Fremantle Public Hospital and the public hospitals at Coolgardie and Kalgoorlie also ran nursing training courses from 1897 and 1898 respectively.\textsuperscript{158} These courses were managed by hospital matrons who gave the practical and theoretical instruction to nursing students. Due to the previous lack of nursing training courses in WA, most hospital matrons had completed their training interstate or overseas. For example, the matron of the Perth Public Hospital in 1896, Miss A.H. Gordon, was from South Australia; her counterpart at Fremantle was from England and had trained at a hospital in Cambridge; and Miss Rosa Snodgrass, matron of Coolgardie hospital, had trained at Melbourne’s Alfred Hospital.\textsuperscript{159} In the years following the introduction of the first nursing training courses, the number of nurses who emerged fully trained in WA was very small, so much so that it was necessary to recruit nurses from interstate to staff WA hospitals. Historian Victoria Hobbs suggests that in the early years, the number of nurses graduating in WA from all the nursing training institutions would not have exceeded 12 per year.\textsuperscript{160}

The 1911 Health Act established, for the first time, the requirement for midwives in WA to be trained. As stipulated by the Board, training was to be provided for a period of six months (although this was later extended to twelve months), and pupils were required to attend at least twenty cases of labour and to nurse at least twenty patients during the lying-in period.\textsuperscript{161} Importantly, this training structure required hospital-based instruction, and as such firmly established the subordination of the nurse to the doctor.\textsuperscript{162} Based on the ideas of Florence

\textsuperscript{156} There seems to be some disagreement between historians about the dates on which these hospitals began offering training. See for example Thorogood, Politics and the Professions, p.44; Fahy, “An Australian history”, p.27 and Strachan, “Present at the Birth”, p.16.
\textsuperscript{159} Hobbs, \textit{But Westward Look}, p.13.
\textsuperscript{161} Hobbs, \textit{But Westward Look}, p.48.
\textsuperscript{162} Fahy, “An Australian history”, p.27
Nightingale, the nurse’s primary function was ‘to obey doctors and to ensure that their orders were carried out’. 

The only WA-based course which allowed graduates to register on the WA midwives register was run out of the old Fremantle Asylum which had been operating as a women’s home since around 1900. During 1909 the state’s medical authorities had invested considerable effort in the development of a midwifery-training course, something which the government of the time recognised was a necessity. The Fremantle course, to be run under the management of Dr. D.E. Williams of Fremantle, was the final result of these efforts, and in December 1909 a committee of medical men (known then as the Fremantle Medical-Men) set out the rules for the running of the course. Training would run for a period of six months and trainees were required to assist the doctor at twenty cases of actual labour. In addition, students had to attend lectures, receive clinical instruction and successfully complete an examination.

Even though there was no requirement for applicants to the course to have had previous nursing training, other factors made participation impossible for some women. For example, potential students were only to be aged between 24 and 45 years and had to provide ‘certificates of moral character and physical fitness’ to be signed by a clergy-man and by a medical practitioner respectively. The cost of the course was also prohibitive for many women; at ten guineas it was unlikely that the average midwife could have afforded to participate. In making these rules, the medical-men were able to restrict trainees to women who most successfully embodied the medical ideal of what a midwife should be. The age limit prevented ‘old women’ from accessing training, while the certificate of moral character guarded against those who were seen to be linked to prostitution and abortion. The cost of the course similarly prevented the participation of poor or working-class women.

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163 Thorogood, Politics and the Professions, p.41.
164 Stubbe, Medical Background, p.18.
165 For further discussion of this see Flanagan, “Lying-in (or Maternity) Homes”, p.345.
166 Central Board of Health, Files – General, 1899-1987, SROWA, Item no.1910/0158, Cons.1003.
169 This is not clearly stated in the rules of the course, however it is implied in various government documents relating to the establishment of the training program. See for example James W. Hope, Annual Report, Western Australian Votes and Proceedings of Parliament, 1910-1911, cited in Hobbs, But Westward Look, pp.46-7.
170 Central Board of Health, Files – General, 1899-1987, SROWA, Item no.1910/0158, Cons.1003.
Indeed, these factors may have been why there was initially very little interest in the course. In April 1910, Principal Medical Officer Hope wrote to the Fremantle District Medical Officer concerned that classes had not started. In a rare show of government concern for maternity services, Hope conceded that ‘the government are very anxious to get training done’. The following month, after only two applications for the course had been received, Hope wrote to Dr. Williams, suggesting that the government fund five additional student places in the course so that training could begin in July. In addition, Hope determined that the course fees would be lowered to three guineas to attract more applicants. Reaction to the lowering of fees was swift, and by July of 1910, 20 students were enrolled for midwifery training at the old Asylum.

The role of government in the setting up and running of the Fremantle midwifery training course was significant. At this time it was imperative for WA to have some training places available for midwifery students as the 1911 Health Act legislated the need for all midwifery practitioners to be trained. The Act itself was useless without the establishment of training facilities. In his 1910 annual report, Hope noted the importance of the Fremantle course, and suggested that women graduating from the program could be subsidised by the government to live in remote areas and provide maternity care to women unable or unwilling to seek medical assistance during childbirth. It is clear that the priority of the state’s medical authorities at the time was simply to establish midwifery training in any way they could and not necessarily to comply with external expectations about the quality of that training. Thus in 1910 Hope wrote of the Fremantle course:

In some quarters it is thought that only thoroughly qualified and trained nurses should be entrusted with maternity cases, but the practice in many parts of the world has been in the direction of giving special women training for this work without requiring them to be thoroughly certificated trained nurses…

As time went on, the state’s medical authorities continued to direct the running of the course from afar. In November 1911, a letter from the Commissioner of Public Health to Dr.

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171 Central Board of Health, Files – General, 1899-1987, SROWA, Item no.1910/0158, Cons.1003.
172 Central Board of Health, Files – General, 1899-1987, SROWA, Item no.1910/0158, Cons.1003.
Williams requested that the classes continue into the future and that they be extended from six to twelve months. In addition, the Commissioner reiterated the importance of the course itself, in the light of the fact that those women who had been ‘grandmothered’ under the 1911 Health Act would soon not be allowed to practise unless they could demonstrate that they had completed some recognised training. In response to this, the Fremantle Medical-Men agreed to continue the course, but only on the understanding that the government would pay them 105 pounds to be distributed amongst the course examiners.\(^\text{175}\)

After the introduction of the 1911 Health Act, demand for the training program at Fremantle increased and by 1913, 65 students had graduated from the course. The program was, at this time, the only course in WA which allowed those women who completed it to register as qualified midwives and a total of 26 graduates of the course did so.\(^\text{176}\) The course ran for six years and only ended after midwifery training was established at King Edward Memorial Hospital.\(^\text{177}\) However, while the Fremantle training course was recognised in WA, the body which oversaw nursing training in Australia, the Australian Trained Nurses Association (hereafter ATNA), deemed the Fremantle course not to be up to national standard.\(^\text{178}\)

Somewhat ironically, the ATNA’s rejection of the course was due to the fact that the matron of the asylum, Mrs. Fraser, did not have a qualification which was recognised by the ATNA.\(^\text{179}\) Mrs. Fraser, while still matron of the home, had undertaken the course being run there as a pupil and in 1913 was registered as a midwife on the WA Register.\(^\text{180}\) She was not, however, considered appropriately trained by the ATNA and the organisation’s consequent refusal to recognise the course meant that the women who completed it could not register as trained midwives in other Australian states.\(^\text{181}\)

\(^{175}\) Central Board of Health, Files – General, 1899-1987, SROWA, Item no.1910/0158, Cons.1003.
\(^{176}\) Stubbe, Medical Background, p.18; Hobbs, But Westward Look, p.47.
\(^{177}\) Flanagan, “Lying-in (or Maternity) Homes”, p.347.
\(^{178}\) Hobbs, But Westward Look, p.24. See also the 1977 oral history interview with Beryl Grant, then matron of Ngala Hospital. Beryl Grant, Transcript of oral history interview conducted by Chris Jeffery, 1977, SLWA, OH2260/5, p.32. Interestingly, The fact that the training offered at Fremantle would not be recognised by the ATNA had been noted by government officials in July 1910. See Central Board of Health, Files – General, 1899-1987, SROWA, Item no.1910/0158, Cons.1003.
\(^{180}\) Hobbs, But Westward Look, p.47.
\(^{181}\) Flanagan, “Lying-in (or Maternity) Homes”, p.347.
The ATNA and the management of midwifery training

The role of the ATNA in the development and management of midwives and their training was significant at this time. The organisation was founded in 1899 when it was primarily concerned with developments in New South Wales. Within a few years, branches of the ATNA were formed in other states starting with Queensland in 1904, South Australia in 1905, Western Australia in 1907 and Tasmania in 1908. Victoria had formed its own nursing body in 1901, however the Victorian Trained Nurses Association worked closely with the ATNA. The ATNA was important because it established standards for nursing practice and training in Australia. As Willis has pointed out, the formation of the association shows nurses using the same techniques as doctors to achieve professionalisation and ‘upward social mobility’. It was an association for the trained nurse:

its activities were directed to the protection and well being of the trained nurse practitioner who was self-employed in the private nursing field…the number of trained nurses employed as hospital staff being comparatively minimal.

For trained nurses, membership of the ATNA was evidence of being a professional of the highest standard and the letters ‘ATNA’ were a status symbol to be displayed by nurses after their name on official documents.

Even though the number of trained nurses working in Australian hospitals in the early 1900s was low compared to those in private practice, nursing training itself was carried out in hospitals. The standard of this training was highly variable. After the establishment of the ATNA, hospitals were encouraged to apply to the Association to have their particular training program recognised in order to ensure that their trainee nurses would be guaranteed membership of the organisation upon completion of their training. In WA, the nursing training courses at Coolgardie Hospital, Kalgoorlie Hospital and at Perth Public Hospital were all recognised by the ATNA in 1900. This accreditation by the ATNA created better uniformity of nursing training across Australia but it also gave the Association an inordinate amount of power over the standards of that training. In WA it was very difficult in the early

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183 Willis, *Medical Dominance*, p.107.
years for public hospitals to comply with the Association’s expectation that the matron and some of the trained staff be members of the ATNA. In some instances it was not possible to organise staffing in this way, and this resulted in the deregistration of the hospital. Thus as hospitals throughout Australia accepted the directives of the ATNA with regard to their training syllabus, they ‘virtually handed over the control of nursing training to the association’.  

The ATNA played an important role in the changing status of midwives during this period. ATNA policies on midwifery training further reinforced the notion that all midwives must first be nurses. These directives operated to not only limit nursing practice but to exclude empirically-trained midwives from the profession of midwifery. These issues were particularly relevant in WA during the early years of the twentieth century, where ATNA-accredited midwifery training was not available until 1916. Before this time, nurses with general training were precluded from working as midwives under ATNA rules and this severely limited general nursing practise at a time when in-home care was still the primary source of income for most nurses. Hobbs suggests that despite the risk of deregistration from the ATNA, almost all Western Australian trained general nurses practiced midwifery at some point. However, they would have done so under the supervision of medical practitioners in most cases and would not have worked as independent midwives like their empirically-trained counterparts.

The ATNA did have a register of what was termed ‘obstetric nurses’ and from 1904 it was possible to be listed with having only completed a twelve-month midwifery course at a recognised institution. But given that no such institution existed in WA until 1916, achieving registration with the ATNA would have been almost impossible for the average WA midwife who would have needed to travel interstate to complete the course. Obstetric nurses were also limited in their practice because they were, as the ATNA dictated, expected to work under the supervision of medical practitioners. As such, obstetric nurses undertook midwifery in a limited capacity because their primary role at confinements was to nurse the

188 Trained nurses who were practising outside their field of training were always expected to work under the direction of medical practitioners. See Hobbs, But Westward Look, p.24.
189 Noeline Williamson, “‘She walked...with great purpose’: Mary Kirkpatrick and the history of midwifery in New South Wales”, in Margaret Bevege, Margaret James and Carmel Shute (eds.), Worth Her Salt: Women at work in Australia,1982, Hale & Iremonger, Sydney, p.7.
patient and to carry out the instructions of the doctor. In this way they were distinct from their empirically-trained colleagues who were able to conduct the entire confinement and lying-in on their own.

ATNA rules about the length of midwifery training courses was also a significant problem for WA-based nurses and midwives. When Principal Medical Officer Hope began the process of developing the Fremantle training course in 1909, it was initially set out at six months. Hope requested that the ATNA liberalise its rules so as to allow women who had completed the course to register as obstetric nurses with the Association but his request was firmly rejected. One year later the length of the course was defended by Hope in his 1910 annual report as being ‘eminently satisfactory’. Indeed, a six-month course was in keeping with the requirements of WA’s 1911 Health Act. However in November 1911, the Commissioner of Public Health requested that the Fremantle course be extended to twelve months in order to make it easier for students to build up the necessary experience. In 1908, the ATNA made some small concessions to WA-based nurses by allowing them entry to the obstetric register if they could prove that they had attended twenty cases of labour under medical supervision. Applicants also had to pass an examination, and the offer was only available until 30 June 1909. How many women took up this offer is unclear, but the shortness of the time frame, along with the expectation of medical supervision, would no doubt have excluded many empirically-trained midwives from applying.

The end of independent midwifery

While one of the aims of WA’s midwifery training legislation had been to standardise the quality of maternity services being offered by midwives, for some years after the introduction of the Act, WA’s population of midwives consisted of both hospital-trained and empirically-trained women. For certain traditional midwives, their class status and lack of formal education made their participation in hospital-based training impossible. On the other hand, hospital-trained midwives would have been ill-equipped to work at home.

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192 Central Board of Health, Files – General, 1899-1987, SROWA, Item no.1910/0158, Cons.1003.
193 Hobbs, But Westward Look, pp.34-35.
194 Thorogood, Politics and the Professions, p.45.
confinements, which still constituted the majority of births until the 1930s. Presumably WA’s population of ‘untrained’ midwives may still have found employment at home confinements, at least for a number of years. Even so, the eventual removal of the ‘grandmother’ clause in the Act meant that empirically-trained midwives were no longer legally able to work in the field unless they undertook hospital-based training, the completion of which would have been impossible for some women. Indeed, the inability of poorer women to participate in midwifery training schemes was seen by some as a way to ‘materially alter’ the ‘class of women entering the profession’ and thus leave midwifery open to ‘the educated middle class’. As a 1908 editorial in The Western Mail commented, if the WA government were to establish large midwifery training schools:

There would be very few of the cottagers, bred among the fatal old superstitions which have accompanied our midwifery from time immemorial, because such women, living of necessity from hand to mouth, could not afford to spend so long a time without receiving a salary.

While the midwifery training legislated by the 1911 Health Act provided for the standardisation of midwifery services and delivered much-needed education to some midwives, it also had the impact of dividing midwifery instead of improving the status of all midwives. The Act also contributed to public mistrust of midwives by reinforcing the idea that all midwives were ignorant and incompetent and therefore in need of ‘supervision’ during their work. Independent midwifery suffered as a result of the continued assertion that medical supervision was required for midwives to provide a good and reputable service.

Over the decades following the introduction of the Health Act, through their hospital-based training and their assimilation into the ranks of nurses, midwives in WA gradually ceased to operate as independent professionals. Yet, once midwives adopted hospital-based training, bringing themselves under the auspices of nursing, they were given more credibility as health care providers. As Thorogood notes, this fact sheds light on the earlier conflicts between midwives and medical-men:

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198 Thorogood, Politics and the Professions, pp.45-46.
Medicine’s acceptance of hospital-based midwives provides unequivocal evidence that the early struggle between medicine and midwifery was not about midwives’ right to exist or their competence, but over their rights to independent status.\textsuperscript{199}

Midwives who worked in the hospital system were limited in their role and capacity as childbirth attendants because as nurses they had to carry out the orders of doctors. In some early maternity hospitals midwives rarely managed the actual births of babies and were instead relegated to observing patients and reporting these assessments to the hospital’s medical practitioners.\textsuperscript{200} They were thus unable to fulfil the traditional role of the midwife – to be ‘with woman’ during childbirth.\textsuperscript{201} For those midwives working outside the hospital system as independent practitioners or as operators of lying-in homes, there was undeniably more autonomy, but the days of the lying-in home and home birthing were numbered. While having a baby at home in WA was still possible in the 1930s, it was by then already a marginal choice.\textsuperscript{202} The financial pressures of running lying-in homes led to their gradual decline during the 1940s and very few were operating after 1945.\textsuperscript{203} The future of birthing and of midwifery lay, at least for a time, in the maternity hospital and it is to these institutions, and the social conditions which generated them, that this study now turns.

\textsuperscript{199} Thorogood, Politics and the Professions, p.43.
\textsuperscript{200} Thorogood, Politics and the Professions, p.43.
\textsuperscript{202} Most women in WA were having babies in hospitals by this time. See Thorogood, Politics and the Professions, p.80 and Gregory and Gothard (eds.), HEWA, p.131.
\textsuperscript{203} Flanagan, “Lying-in (or Maternity) Homes”, p.352. See also Gregory and Gothard (eds.), HEWA, p.131.
Chapter 5
Social Factors and the Changing Face of Maternity Care

In the early years of the twentieth century, public perception of both the necessity for more-extensive midwifery training and larger-scale institutionalised maternity care for those in financial hardship, led to the creation of a powerful social movement in Perth which ultimately led to the establishment of WA’s first dedicated maternity hospital. The pressure for the development of such an institution built up over time and was partly the result of significant social changes which impacted on Australia broadly and WA specifically during the first decades of the twentieth century. During this time, concern over the running of lying-in homes in Australia and WA fed into existing fears about the quality of midwifery practice generally. Within the context of the perceived successes of medical science, alternative practitioners came to be viewed as not having access to the knowledge and skills of the qualified medical practitioner and there was an increasing crack-down on so-called ‘quack’ medicine.¹ A nationally-declining birth rate and worrying infant mortality figures provided the context for greater state involvement in the provision of maternity services. Government’s new-found eagerness to take more responsibility for mothers and their babies resulted in significant changes to maternity care nationally and locally. By 1916 Perth had a maternity hospital partly funded by the state and women had access to a nationally-funded baby bonus. These changes paved the way for a push towards universal hospitalisation for childbirth and the subsequent expansion of hospital-based maternity services throughout WA. However, while women campaigned for improvements to maternity services, the social and institutional infrastructure of modern obstetrics began to dominate the landscape of childbirth and the results were not always beneficial to women or their babies.

Midwifery, birthrates and abortions: Public reactions in WA

The supposed knowledge gap between midwives and medical men had long been a topic of discussion in medical circles, and had led to repeated calls from medical professionals for the suppression of unqualified midwives and the training of those women who did continue to

practise. In 1880 for example, honorary physician at the Melbourne Hospital Dr James Jamieson attributed the high rates of maternal mortality in colonial Victoria to ‘such large numbers of women being attended by untrained midwives’. He suggested a system of midwifery training ‘with a view to making the registration of midwives compulsory’, and he insisted that trained midwives should work under medical supervision. By the early twentieth century, the anti-midwife rhetoric had intensified. In 1913 for example, the *Australian Medical Journal* (hereafter *AMJ*) published an article entitled ‘The Elimination of the Midwife’ in which the author described the necessity of completely eradicating female midwifery practice through the establishment of publicly-funded maternity hospitals with accompanying nursing training facilities. The creation of these free and low-cost public services and the continued education of the public about the necessity of institutionalised maternity care would, according to the author, ‘make the midwife unnecessary and her elimination inevitable’.

The medical authorities’ long-running campaign against midwives initially had little direct effect on the uptake of female midwifery services. By the 1900s however, there was an increase in consumer demand for medical services generally and the majority of this growth came from middle and lower income earners. From this time, it became more common to seek medical advice for the treatment of illnesses which, twenty years earlier, would have been self-diagnosed or ignored. Negative representations of midwives which had long been circulated in medical journals and amongst medical-men themselves, gained greater currency with the public and this fuelled increasing pressure for improvements in maternity services including compulsory midwifery training.

From the 1900s, claims of malpractice significantly hindered WA-based midwives and created an environment in which the public urged further government regulation. The state of WA’s maternity services generally was strongly criticised in a bold article featured in the *Sunday Times* in 1902. The article – entitled ‘Microbe Missionaries, Gang of Gruesome Gamps, Serious Spread of Septicaemia, Dirty Doctors Distribute Disease and Death’ –

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4 “Elimination of the Midwife”, *AMJ*, February 1913, p.909.
5 Pensabene, *The rise of the medical practitioner*, p.82.
6 Pensabene, *The rise of the medical practitioner*, p.90.
condemned Perth’s medical and nursing communities who were accused of ‘negligence and callousness’ in their dealings with child-bearing women.\(^7\) The primary concern of the authors was the seemingly alarming rates of septicaemia in the Perth community and the apparent reluctance of the medical profession to admit that the infection was causing the deaths of parturient women. By continuing to see patients after treating a case of septicaemia, doctors and nurses were unconsciously spreading disease throughout the community.

[1] It is regarded as a miracle in Perth if a mother has ‘a good time’ and gets up, as our mothers used to, on the ninth day….Is there one doctor in town who has not one or more of these sad cases on his visiting list and who does not at the same time proceed on his daily round? And that without so much as returning to his home to disinfect himself after entering a tainted room!….a medical man assures us that “the doctors of Perth are perfectly filthy…Their instruments are filthy and they themselves are filthy. Their hands are filthy. They carry enough septic poisoning about under one finger nail to poison the whole community”.\(^8\)

In addition, the Perth medical community was accused of falsifying death certificates in order to cover up the many cases of infection. According to the authors, doctors in Perth were ‘guilty of what would be called manslaughter…if perpetrated by a layman’\(^9\).

In keeping with tradition, the article claimed that midwives and nurses were even dirtier than doctors, and perhaps more to blame for the deaths of women in childbirth. Nurses’ fingernails were ‘little better than traps and receptacles for the death-spreading pestilence’ of septicaemia.\(^10\) For the authors, it was far worse to have an unclean nurse than an unclean doctor.

[A]bove all it is necessary to have cleanly nurses. Another physician has described the bulk of the nurses in this State as a “gang of old gamps.”….some of them have no sense whatever of cleanliness. Antiseptics are nuisances to them, and they will travel from one case of midwifery to another without so much as suspecting that their clothes would be all the better for disinfection.\(^11\)

The 1902 *Sunday Times* article is surprising primarily because doctors came in for heavy criticism. The condemnation of midwives and nurses on the other hand was to be expected, and certainly in keeping with popular ideas about female midwifery generally. Whether these commonly-held attitudes reflected the true state of midwifery practice in WA is unclear.

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\(^{8}\) “Microbe Missionaries”, *Sunday Times*, Sunday 9 March, 1902, p.12.

\(^{9}\) “Microbe Missionaries”, *Sunday Times*, Sunday 9 March, 1902, p.12.

\(^{10}\) “Microbe Missionaries”, *Sunday Times*, Sunday 9 March, 1902, p.12.

\(^{11}\) “Microbe Missionaries”, *Sunday Times*, Sunday 9 March, 1902, p.12.
Certainly some women working as midwives would have fitted the ‘gamp’ stereotype, however it is doubtful whether this label could be applied to a significant proportion of Perth’s midwives during this period. Late nineteenth century legislation related to the running of lying-in homes for example, stipulated that each patient needed a certain amount of space and that instruments needed to be sterilised. The records which remain show that in many homes, midwives were conscious of these expectations and made an effort to employ the principles of antisepsis.

The report of the 1903 Royal Commission on the Decline of the Birth-Rate and on the Mortality of Infants in New South Wales played an important role in this debate around the quality of midwifery services. In the lead up to the establishment of the Royal Commission, there had been growing disquiet about Australia’s falling birth rate. During the 1870s and 1880s, Australia’s annual rate of population increase averaged over three percent. After 1891, however, net migration to Australia failed to provide significant rates of population growth, and natural increase then became the primary basis for the expansion of the population. Between 1891 and 1900 there was an uninterrupted decline in the national birthrate, leading to concerns about the nation’s future. Importantly, the social, gender and racial context to such concerns was such that it was the failure of white women to adequately reproduce the white population that caused the greatest fear for policy makers. It was this so-called ‘race suicide’ which was deemed the greatest risk to the nation.

In August of 1903 the NSW Premier responded with the appointment of a Royal Commission which was to investigate ‘the causes which have contributed to the decline of the birthrate in NSW and the effects of the restriction of child-bearing upon the well-being of the community’. The report of the Commission was handed down in 1904 and was widely

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13 The material relating to Nurse Jones at Collie, Nurse Stockley of Swan Hospital and Nurse Monger in Narrogin, indicates that midwives running lying-in homes generally made an effort to disinfect their homes and instruments. See Winifred Willis, Oral History Interview conducted by Jan Wallace, 1988, State Library of Western Australia (hereafter SLWA), OH1963; Rod Smoker, *The Smoker and Stockley families and the Swan Maternity Hospital*, 2009, Rod Smoker, Perth; Central Board of Health, Files – General, 1899-1987, State Records Office of Western Australia (hereafter SROWA), Item no.1939/0623, Cons.1003.
16 Hicks, ‘This Sin and Scandal’, p.xv.
publicised in the WA press.\footnote{For a comprehensive analysis of the report of the Commission, its findings and the public reaction to them, see Neville Hicks, *This Sin and Scandal*: Australia’s Population Debate 1891-1911 (1978).} The authors of the report were unhesitating in their condemnation of female midwifery in NSW, suggesting that most midwives were ‘uneducated, untrained, and unsuitable’ and that midwives by definition were ‘surgically unclean’.\footnote{Report of the Royal Commission on the Decline of the Birth-Rate and on the Mortality of Infants in New South Wales, 1904, quoted in Ruth Teale, *Colonial Eve: Sources on Women in Australia* 1788-1914, 1978, Oxford University Press, Melbourne, pp.125-26.} In the context of a declining birth rate, the crime of administering an abortion was considered by the commissioners to be particularly deplorable and nurses and midwives were identified as the main culprits.\footnote{“The Birth-Rate Decline: Royal Commission’s Report”, *The West Australian*, Tuesday 29 March, 1904, p.7. Accessed via TROVE archive, 16/07/2013.} The Commissioners emphasised the importance of medical oversight of midwifery practice and insisted that an administrative body must be established to manage the training and examination of obstetric nurses.\footnote{“Population Question, The Birth-Rate and Infant Mortality, An Interesting Report”, *The West Australian*, Saturday March 5, 1904, p.8. Accessed via TROVE archive, 16/07/2013.} Lying-in homes came in for criticism too, with the Royal Commission recommending that there be tighter controls on the operations of these homes including government oversight of any advertising that the homes might publish.\footnote{“Infant Mortality, Report of the Royal Commission, Regulate the Artificial Foods”, *Western Mail*, Saturday 9 April, 1904, p.50. Accessed via TROVE archive, 21/08/2013.} The Commissioners also sought the extension of public hospital facilities for the accommodation of pregnant women and sick infants, claiming that a lack of publicly-funded maternity beds was one of the underlying causes of infant mortality.\footnote{Annette Davis, “Infant Mortality and Child Saving: The Campaign of Women’s Organizations in Western Australia, 1900-1922”, in Penelope Hetherington (ed.), *Childhood and Society in Western Australia*, 1988, University of Western Australia Press, Nedlands, p.161.}

Surprisingly, the WA state government spent very little time reflecting on the findings of the Royal Commission, and while the content of the report was widely publicised by WA newspapers, the public response was also fairly muted.\footnote{F.K. Crowley, *Australia’s Western Third: A History of Western Australia*, 1970, Heinemann, Melbourne, p.157.} This may have been due to the fact that WA’s population, unlike that in other states, was actually slowly increasing during this period, and that much of this increase was due to an excess of births over deaths.\footnote{“Infant Mortality”, *Western Mail*, Saturday 9 April, 1904, p.50.} Even so, public contribution to the debate in WA through letters to the editor, supported most of the Commission’s findings. There was broad agreement with the idea put forward by the Commissioners that the fall in the national birth rate was due to the increasing age of newly-wed couples, the pursuit of leisure and a reluctance to have children. As one contributor
opined, the ‘evil’ of the birth rate decline in Australia was due to ‘an intense and increasing selfishness which is destroying the finest instincts of human nature’.  

The identification of abortion and contraception as major contributors to birth-rate decline met with enthusiastic agreement from the WA public. In response to a Commonwealth government initiative to prohibit the importation of ‘preventatives’ one 1904 contributor commented:

> No one, except the abortionists brigade and their customers, will gainsay the wisdom of this action. Anything tending, as this measure will, to lessen the prevalent evil of abortion must obviously meet with the hearty concurrence of every decent member of the community.

Not content with the efforts of the Commonwealth government, the author continues with a plea for the WA state government to contribute to the campaign against prevention and abortion:

> And therefore we think that the Commonwealth Cabinet’s proceeding will be of practically little benefit unless supported with co-operation by the States. The whole matter of abortion, or birth prevention, is the more intimate concern of the States…Judged by results the present State armoury against abortion – and we speak particularly of Western Australia – is little better than harmless, and the evil has grown to grave proportions in spite of it…Let them [the States] make stringent laws against the manufacture and sale of preventatives. Let them stop the many loop holes of escape that the present laws hold for abortionists.

While it was not explicitly expressed in the public commentary surrounding abortion and contraception, it was usual for midwives to be identified as the primary culprits when it came to the provision of these services. Indeed, as highlighted in the previous chapter, Perth-based midwives were occasionally prosecuted as a result of their involvement in providing abortions, but these cases only came to the attention of authorities following the death of the mother. It is therefore difficult to assess the extent to which midwives in Perth were involved in the provision of this service.

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28 WA midwives were sometimes accused of performing abortions. See for example the reports of the inquest into the death of Muriel Elliott who died in 1903 as a result of septic poisoning caused by an artificial abortion. “Death of Mrs. Elliott”, The West Australian, Tuesday 19 January, 1904, p.6. Accessed via TROVE archive, 08/05/2013.
Midwives and Infant mortality in WA

By focusing on abortion, contraception and the ‘selfishness’ of the younger generations, the report of the Commission reflected commonly-held views about existing social evils. One such factor highlighted in the report which consistently caused public concern in WA was infant mortality. As discussed in Chapter Two, the infant mortality rate in colonial WA was not excessive and generally better than rates in England. However, the gold-rushes of the 1880s and 1890s created significant social and economic problems in the colony. Large increases in population combined with a lack of housing and an increasing number of first-time parents led to living conditions which were antithetical to infant health, and the impact of these social changes lasted well into the 1900s. With the exception of the Northern Territory, WA had the worst infant mortality rate of any Australian state for eleven of the first twenty years of the twentieth century. Infant death rates from 1901-1906 fluctuated between 104 and 142 per 1000 births, significantly worse than rates in New South Wales where infant mortality during the same period never exceeded 110 deaths per 1000 births and, in 1906, was as low as 74 deaths per 1000 births. In some years, infant mortality in WA was worse than rates in Britain, which had an average infant mortality rate of 128 per 1000 births in the years 1901 to 1910. While historians have attributed these alarming rates of mortality to poor living conditions, the impact of these statistics on lying-in homes and the midwives who ran them could be felt. Even though a significant majority of infant deaths were not related to childbirth, the link between midwives and excessive mortality rates was firmly entrenched in the minds of the public and policy makers.

The report of the 1903 Royal Commission shows how midwives came to be blamed for infant deaths over which they had no control. As reported in the press, the Commissioners made special mention of WA’s poor record on infant mortality. In listing the causes for excessive infant mortality, the Commission placed ‘defective care of the new-born by ignorant or

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30 These statistics are taken from Davis and do not include the deaths of Aboriginal babies and infants. See Davis, “Infant Mortality and Child Saving”, p.163.
33 “Infant Mortality”, Western Mail, Saturday 9 April, 1904, p.50.
careless midwives’ second on a list of sixteen underlying causes of infant death. The first reason listed was ‘premature birth and defective viability’. The list included references to the underlying health of the mother and to the poor quality of artificial infant foods, including tainted cow’s milk which was known to cause gastro-enteritis. The report also highlighted the fact that medical opinion was unanimous in its belief that ‘a large proportion of the deaths of infants is a consequence of their improper feeding’. It is clear that the Commissioners knew that excessive infant mortality was linked to poor feeding regimes and to the underlying living conditions and health of mothers, facts that are supported by the historical analysis. Nonetheless, the Commission was still prepared to blame the ‘ignorance’ of midwives – who had no control over the pre-existing health of women, nor over infant feeding regimes – as one of the primary reasons behind high infant death rates.

WA’s infant mortality rate was particularly high in 1903, just one year before the Commission’s report was released. Overall, with minor aberrations in 1906, 1912 and 1919-20, attributable to the increased incidence of diarrhoea during those years, WA’s infant mortality rate began trending downwards from 1904. This was in keeping with national and international trends which saw a sudden and so-far-unexplained decrease in infant mortality across developed nations in the early years of the twentieth century. Interestingly, historians and medical specialists have been unable to convincingly link this international decline in infant mortality to improvements in medical practice. It is clear, however, that while rates of infant mortality as a whole decreased in the early decades of the twentieth century, deaths of neonates (children up to the age of one month old) did not significantly reduce. Thus in the WA context, historian Michael Durey writes that with regard to the dramatic reduction in infant mortality seen in the early decades of the century, the decline ‘occurs primarily in the

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34 “Infant Mortality”, Western Mail, Saturday 9 April, 1904, p.50.
35 Michael Durey provides some very helpful statistics on this issue. In 1903 for instance, the total post-neonatal death rate (that is children aged over one month and under 1 year) in WA was a disturbing 142 per 1000 at risk. The proportion of this number that died as a result of diarrhoeal diseases (such as gastro-enteritis) was 75 percent. The following year the proportion of total post neo-natal deaths that resulted from diarrhoea was 80 percent. These figures show how significant diarrhoea was as a cause of infant death in WA at this time.
36 The date of 1904 is based on infant mortality figures compiled by Davis. See Davis, “Infant Mortality and Child Saving”, p.163.
38 See for example Gordon, Health, Sickness and Society, p.190.
post-neonatal period, as a consequence of fewer deaths from gastroenteritis and from the syndrome known as weanling diarrhoea.  

What this shows is that during the early decades of the twentieth century in WA, the rate of death for children up to one month old was unchanged despite the improvements in the rate of death for children one month and older. It is the children in the neonatal category that would have been most affected by poor midwifery outcomes, since midwives and obstetricians would have had little control over the health of children after one month of life. Thus, while midwives’ poor practice was blamed for high rates of infant mortality generally, only the neonatal proportion of the total infant death rate can possibly be linked to childbirth attendants. For example, while the total infant death rate in Perth in 1901 was 129 for every 1000 babies born, the neonatal death rate for the same year was only 30 per 1000. It is this smaller group of infants which were most likely to have been the victims of poor midwifery, not the majority of children, who died after the first month of life. The fact that the neonatal death figure was relatively constant over this period can be seen in the similar figure for the year 1910. The total infant mortality rate for that year was 83 for every 1000 babies born, a significant reduction from previous years. However the neonatal mortality rate was 29 for every 1000 babies born, showing virtually no improvement from nine years earlier. These WA figures are in keeping with the experience of other Australian states over a similar period. In his 1928 analysis of maternal mortality in Victoria, Dr. Robert Marshall Allan illustrates that in the period between 1881 and 1927, deaths of infants over one month and under 12 months old declined significantly, as did total infant deaths. Deaths in the neonatal category (children under 1 month) stayed virtually unchanged over this 46 year period.  

Evidently, the supposed ‘ignorance’ of midwives had little to do with total infant mortality rates. Neonatal death rates on the other hand can justifiably be linked to midwifery, including the midwifery work performed by male medical doctors. In his analysis of the causes of neonatal deaths, Allan identifies prematurity as a significant factor, but he also emphasises the role of injury at birth – a point which constitutes a direct criticism of childbirth attendants.

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41 The figures for these calculations are taken from Durey, “Infant Mortality in Perth”, pp.66-67.
The one factor occupying a high place was that of the complications of labour and birth trauma. Intracranial injuries were observed in 80% of the infantile deaths following breech delivery, in 68% of forceps applications and also in 36% of the normal deliveries.43

While many of these complications of labour are beyond the control of the attendant, it is interesting to note that it is just these types of complicated labours – breech deliveries and those needing forceps – which would have been attended by medical-men, not midwives. Additionally, Allan highlights the fact that it was not usually the poor health of the mother during pregnancy that led to the death of the neonate, but that these deaths were ‘influenced more by complications of labour and the methods of delivery’. He goes on to emphasise the importance of limiting interference in natural birth, implying that the over-use of instruments and excessive intervention during labour was strongly linked to the high neonatal death rate.44

What this demonstrates is that, while Australian midwives certainly played a role in neonatal deaths, a fair degree of responsibility must also rest with medical practitioners. In addition, the association of midwives with high rates of infant deaths generally – both in historical writing on childbirth in Australia and in contemporary reports from the early decades of the twentieth century – is both inaccurate and over-simplified. The report of the Commission is just one example of how information about infant mortality was misrepresented resulting in the implication of midwives as the primary cause of infant death. During the period when the Commission was making its claims about midwives, neonatal deaths in WA fluctuated between 32 and 35 per 1000 births and accounted for between one-quarter and one-third of total infant deaths.45 This is certainly a significant proportion of the total, but it is inaccurate to position midwives as the primary cause of high infant deaths in WA because the vast majority of children in this category died as a result of illness related to improper feeding.

The criticism of midwives by the Commission contributed to broad public unease about maternity service provision in Western Australia. In response to the disturbing infant mortality figures which appeared in 1903 and 1904, correspondents to The West Australian and Western Mail insisted that the state government spend money on the provision of better maternity services for Perth, including better trained nurses and midwives.46 This public

45 These claims are made based on statistics provided in Durey, “Infant Mortality in Perth”, pp.66-68.
disquiet was part of a growing expectation amongst some sections of the community, that
governments at all levels become more involved in maternity care. It was felt that only
through government initiatives and government funding could fundamental and lasting
improvements to maternity care be made. The Western Australian government responded to
this through the 1907 *State Children Act* which put tougher controls on infant boarding
houses, and the 1911 *Health Act* which made the registration and training of midwives
compulsory. These initiatives were followed by the most significant federal government
intervention in maternity care that had ever occurred: the introduction of the first Baby Bonus
in 1912.

**The 1912 Maternity Allowance**

The Commonwealth government’s *Maternity Allowance Act* of 1912 allowed for a one-off
payment of five pounds to be made directly to every European mother, married or single,
who gave birth to a living child. The fact that the allowance was only provided to white
women and not to indigenous women demonstrates that the intention of the bonus was not
humanitarian but economic and social. The identity of ‘mother’ was thus racialised in line
with national policies which prioritised the reproduction of a homogenous white population.
In giving the allowance the Commonwealth government was demonstrating its interest in the
‘health of its labour force’ not its concern for the welfare of women generally. In 1912, the
five-pound bonus had the value of around two weeks income for a male worker and five
weeks pay for a working woman, making it a significant amount of money.

The allowance was used for a variety of purposes including hiring in-home help or purchasing baby products
like prams. Women also used the bonus to cover the cost of medical attendance during
labour. By 1912 some women were already choosing to employ doctors instead of
midwives at their confinements, and the allowance removed some of the financial difficulties

associated with this decision. Consequently the provision of the bonus saw an immediate shift away from the employment of midwives and a significant increase in the number of births which were managed by male doctors. For example, when the bonus was introduced in 1912, around 63 percent of births nationally were attended by doctors. Ten years later, this number had increased to 76 percent. In Victoria specifically, the rate of cases attended by doctors rose steadily from 68 percent in 1911 to 79 percent in 1918. By 1926, the rate of doctor-managed births in Victoria was a startling 90 percent. While the allowance was not the only factor in this increasing employment of doctors at confinements, it certainly helped to further the medical claim over midwifery and reduce the role of midwives in the sector.

Despite this, anecdotal evidence from the early decades of the twentieth century suggests that doctors, nurses and midwives all sought to cash in on the maternity allowance by raising prices or establishing lying-in homes. A survey conducted in Sydney in 1914 for example, highlighted the fact that many nurses had increased their fees in the two years since the bonus had been introduced, some by as much as 40 percent. The exploitation of the allowance undoubtedly continued for many years: historian Julie Harvey notes that as late as 1944 a source informed the then Prime Minister John Curtin that WA-based doctors were taking on maternity cases for financial gain despite their lack of obstetric training. The readiness of some practitioners to exploit the allowance is reflective of the confusion around the expectations of its use by women. Many medical professionals believed that the money should be used exclusively to employ medical assistance at childbirth; alternative uses of the money were therefore frowned upon by some. Thus in 1913 the President of the Geelong branch of the British Medical Association was deeply offended at the suggestion from one woman that she was going to purchase a brand-name pram with her five pounds.

While the primary intention of the maternity allowance had been to provide economic security for families expecting children, the government also intended that the bonus would

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52 This was noted in 1923 as part of a Royal Commission report into national insurance. See T.H. Kewley, *Social Security in Australia 1900-72*, 2nd ed., 1973, Sydney University Press, Sydney, p.111. See also Willis, *Medical Dominance*, p.113.

53 Harvey, “The Truth About Mothers and Babies?”, p.46.


56 Harvey, “The Truth About Mothers and Babies?”, pp.46-47.

have a positive effect on infant and maternal mortality.\textsuperscript{58} According to the contemporary discourse which suggested that midwives were to blame for the high rates of infant and maternal death in Australia, the shift away from the employment of empirically-trained midwives and the subsequent increase in the number of births managed by doctors and hospital-trained nurses should have had the immediate effect of lowering infant and maternal death rates. This was not the case. Not only did the maternity allowance fail to halt the decline in the birth rate, which fell sharply again in the period of economic depression between 1925 and 1935, it had little impact on maternal or infant mortality.\textsuperscript{59} As mentioned above, infant mortality figures account for the deaths of all infants to the age of one year and therefore only a proportion of these deaths can justifiably be linked to midwifery practice. Maternal mortality on the other hand, relates specifically to the deaths of women from puerperal causes and is therefore strongly linked to midwifery practice. The fact that parturient women continued to die in large numbers at a time when medical-management of birth was increasing suggests that the supposed ignorance of untrained midwives cannot be the only reason for high rates of maternal mortality in Australia during this period.

Maternal mortality: the role of puerperal fever

Up until the 1930s, maternal mortality in Australia was strongly linked to the high incidence of puerperal fever among lying-in women.\textsuperscript{60} Contemporary medical authorities from the 1880s to the 1920s highlighted that puerperal fever consistently made up a significant proportion of Australia’s total maternal mortality.\textsuperscript{61} ‘Puerperal fever’ was first formally noted by medical-men during the seventeenth century, but it has a much longer history and appears to have been prevalent in various countries and during many different time periods. It was understood to be a contagious disease from the 1840s and, after the discovery of germ theory

\textsuperscript{58} See Kewley, \textit{Social Security in Australia}, p.105.
\textsuperscript{59} Harvey, “The Truth About Mothers and Babies?”, p.45; Hicks, \textit{This Sin and Scandal}, p.158. Many historians as well as contemporary commentators have noted that the allowance had no impact on maternal or infant mortality. See for example Williamson, “‘She walked...with great purpose’”, p.8; Allan, "Report on Maternal Mortality", p.683; Willis, \textit{Medical Dominance}, p.113. See also the findings of the 1926 Royal Commission on Health, cited in Kewley, \textit{Social Security in Australia}, p.111.
in the 1860s, it was established that the disease was caused by invading bacteria which entered a woman’s body through the genital tract. In the 1920s, it was thought that the infecting agent may be one of the many streptococcus bacteria which are still very common in obstetric practice today. The discovery of antisepsis in 1867 seemed to provide the key to a reduction in puerperal fever infections, however in the 1920s, Australian medical authorities were still bemoaning the lack of improvement in maternal mortality from the disease.

Medical opinion during the late nineteenth and early twentieth centuries suggested that high puerperal fever death rates were the direct result of a lack of antiseptic precautions being taken by childbirth attendants. In the medical literature, doctors were occasionally reminded that they must share responsibility for maternal deaths in childbirth, but usually the finger was pointed directly at midwives. In 1887 Dr. James Jamieson, then Melbourne University’s Lecturer in Obstetric Medicine and Diseases of Women wrote:

> If anything in the field of practical medicine can be taken as proved, it is that puerperal fever is a preventable disease, and the means of prevention at our disposal are both more reliable and more easily accessible than in the case of almost any other of the infectious diseases...But unfortunately, it is not sufficient that medical men should exercise every care in the cases under their own charge. Very many women are attended by midwives or nurses, often possessed of little or no training or knowledge, and so long as this goes on, it is vain to expect a large measure of improvement in the mortality among women after delivery.

By the interwar years, it had become apparent to observers of Australia’s maternal mortality statistics that blame for the deaths of parturient women could not be levelled at midwives alone. In the 1920s internationally, puerperal fever accounted for nearly half of all maternal deaths, and it was acknowledged by some medical authorities that medical-men must be accountable for a proportion of these.

In 1928, Australian medical specialist Robert Marshall Allan published a comprehensive study of puerperal fever in Victoria. His statistical analysis included material from all six

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states as well as data from overseas. He established that in 1927 the Commonwealth of Australia had a puerperal fever death rate of 2.15 per 1000 births out of a total maternal mortality of 5.93 per 1000.68 These figures show what a high proportion of maternal deaths in Australia were caused by puerperal fever; in 1927 it accounted for over 36 percent of all maternal deaths. These figures compared poorly to other countries such as Japan, Italy, Norway and Holland which all had puerperal fever death rates lower than 1 per 1000 in 1927. WA performed poorly too with a puerperal fever death rate of 2.12 per 1000 in the year 1927. Of the Australian states, only Victoria and NSW had worse results, with puerperal fever mortality rates of 2.22 and 2.58 per 1000 respectively.69

While Allan makes the important point that, due to the relatively small numbers of deaths in each state, reliance on these statistics alone gives ‘an erroneous conception of the true incidence of maternal mortality’, his research also shows that puerperal fever death rates during the 1920s were underestimated and often went under-reported.70

A detailed inspection of the death certificates for the past ten years shows that in some cases no real cause is given or else the cause is stated in vague terms which preclude correct classification...Some certificates give the impression that either the medical practitioner has not diagnosed the cause of death correctly or more likely that he is unwilling to certify to the true cause...71

This was not the only occasion when deliberate misdiagnosis of puerperal fever had been raised in the medical literature. The practice had been noted in a 1913 communication to the Australian Medical Journal and was anecdotally reported in newspaper articles such as the ‘Microbe Missionaries’ piece that appeared in the Sunday Times during 1902.72 Given that identifying and recording a case of puerperal fever on a death certificate could have implications for the attendant’s future practice, it is unsurprising that some medical-men were reluctant to attribute individual maternal deaths to this preventable disease. It had been known for many decades that rigorous implementation of the principles of antisepsis would dramatically reduce the incidence of puerperal fever, evidently antisepsis was not universally

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72 “Should Puerperal Fever be Notified?”, AMJ, August 23, 1913, p.1183; “Microbe Missionaries”, Sunday Times, Sunday 9 March, 1902, p.12. In this article doctors are accused of falsifying death certificates in cases where parturient women have died from ‘septicemia’. This was often a term used to describe puerperal fever.
employed by childbirth attendants.\textsuperscript{73} In 1910 for example, R. Tate Sutherland, Honorary Surgeon at the Women’s Hospital in Melbourne noted how difficult it was to ‘impress aseptic principles upon many of those who undertake the responsibility of midwifery’.\textsuperscript{74} Nor were other precautions against puerperal fever readily and consistently employed. In 1911 Alfred Austin Lendon, then Lecturer in Obstetrics at the University of Adelaide and Consulting Obstetrician at the Queens Home (South Australia’s primary maternity hospital) suggested that, while he felt that wearing gloves during an internal examination was ‘safer’, he did not feel that he could ‘proselytise’ about the necessity for doing so in private practice. The situation was not necessarily better in hospitals. For example, Allan found in his 1928 study that only 40 percent of private hospitals in Victoria had a satisfactory system of sterilisation in place.\textsuperscript{75}

Allan’s work, as well as a similar effort from Dr. Hubert Jacobs two years earlier, identified a number of factors in relation to the spread of puerperal fever which highlighted important shortcomings in obstetrical practice. While both authors identified that medical practitioners had to bear much more responsibility for maternal mortality than had hitherto been accepted, they also shifted blame for high maternal death rates onto the general public and women themselves. One of the common findings of both investigations was that puerperal fever was linked to unnecessary interference in normal labour.\textsuperscript{76} Primary among the author’s concerns was the overuse of forceps, particularly by those GP obstetricians wishing to hasten delivery so as to ‘fulfil another engagement’.\textsuperscript{77} As Allan suggests, the busy general practitioner can be:

\begin{quote}
tempted to terminate a case as soon as possible with forceps and generally such interference is welcomed by the importunate relatives demanding immediate relief. The vicious circle is completed and the conscientious doctor often suffers defeat in the unequal struggle between his obstetrical ideals and the conditions of actual practice.\textsuperscript{78}
\end{quote}

While Allan goes on to say that medical-men in such circumstances are ‘not absolved from blame’, he concludes that ‘by their insistence on rapid deliveries regardless of the

\textsuperscript{73} See Lewis, “Maternity care and the threat of puerperal fever”, p.35.
\textsuperscript{74} R.Tate Sutherland, “Management of the Normal Puerperium”, AMJ, July 1910, p.356.
consequences, the public must bear a share of the responsibility’ for high rates of puerperal fever. Similar conclusions were reached by Jacobs, who insisted that ‘the education of the public is…essential’ in the future prevention of puerperal sepsis.  

Milton Lewis confirms that the practice of hastening deliveries by forceps was common in the first few decades of the twentieth century, suggesting that this contributed significantly to the overall maternal mortality rate. Certainly forceps were over-used by some private practice physicians, with some medical-men claiming forceps delivery rates of between 47 and 60 percent. By comparison, an account of the work of district midwives in Sydney during the years 1904-1911 reported a forceps delivery rate of only 3 percent. What is interesting, however, is that the malpractice of some GP obstetricians was framed as being a problem uniquely associated with home delivery both in the historical literature and in the contemporary analysis of maternal mortality. Lewis suggests that ‘there seems little doubt that unacceptable practices like the speeding up of labour resulted in part from the bias of the maternity care system towards private practice’. This reflects what Australian medical doctors like Hubert Jacobs were suggesting in 1926: that birth is safer for the mother in an institutionalised setting.

It has been clearly demonstrated that the statistics of maternal morbidity and mortality of women whose confinements are managed and who are delivered under hospital conditions, are very much lower than those in other circumstances.

Jacobs insisted that since 1875 maternity hospitals internationally had been implementing the principles of antisepsis and that this had resulted in a decline in maternal mortality from puerperal fever. According to Jacobs, the same decline had not been observed in private practice. Thus he concluded that private practice obstetricians were to blame for the puerperal fever death rate, insisting that ‘the methods and techniques of lying-in hospitals can be and must be generally adapted to all forms of private practice’.

81 See for example Lendon, “Modern Midwifery”, p.6.
82 This figure is based on data provided in E. Ludowich, “District Midwifery Practice”, AMJ, December 30 1911, pp.253-54. Any forceps deliveries administered as part of the scheme were conducted by medical-men, not midwives.
The suggestion that childbirth was safer in maternity hospitals was not new. In 1904 the NSW Commissioners examining the falling birth rate recommended that the state should provide maternity hospital beds for all women during childbirth because it would (among other things) allow for better control of puerperal fever outbreaks. The establishment of institutionalised care in childbirth would also lead to the provision of more extensive antenatal care which was, according to many authorities, the best way to avoid preventable maternal deaths. Jacobs, for example, insisted that such ‘supervision’ of the pregnant woman would naturally lead to a reduction in morbidity and mortality. Allan in his analysis of puerperal fever deaths recommended the establishment of antenatal clinics ‘at every centre where facilities exist’. Indeed, the 1926 Federal Royal Commission on Health recommended that the Maternity Allowance Act be amended so that no woman could be given the allowance unless she could prove that she had received antenatal supervision from a medical practitioner.

These recommendations were not implemented, but the association of a reduction in maternal mortality with increasing medical supervision of the pregnant woman became one of a number of factors in the increasing push for the establishment of maternity hospitals across Australia. The disturbing rate of puerperal fever deaths and high infant mortality rates was a source of public concern which was exacerbated by the decreasing birth rate and a perceived decline in the public commitment to marriage and family. Midwifery itself, and midwives as individuals, were under increasing community scrutiny at a time when public trust in medical doctors was on the increase.

Within this context Perth-based community groups began to lobby the state government for the establishment of a maternity hospital. The development of the facility was a long and complex process lasting over a decade and involving the work of numerous women’s groups and individual medical practitioners. King Edward Memorial Hospital first began accepting patients in 1916 and remains today as Perth’s premier specialist maternity hospital. The following chapter examines the development of this and other maternity hospital facilities in

Perth during the period to 1950 with a particular focus on the experiences of the midwives who worked in them and the mothers who birthed in them.
Chapter 6
Birthing in Maternity Hospitals

In relation to the growth of general hospital services, WA followed a similar route to other Australian states, beginning with the establishment of small hospitals specifically for the impoverished which developed into the large publicly-funded institutions which now dominate the provision of health care. In the formation of large-scale hospital-based maternity services however, WA was significantly slower than other Australian states with successive state governments reluctant to invest in maternity service provision. Perhaps unsurprisingly given their larger populations, both NSW and Victoria boasted large maternity hospitals before the end of the nineteenth century. Melbourne’s long-running and well-known obstetric hospital, The Royal Women’s, was operational from the 1850s, and Sydney had four separate institutions for maternity services during the nineteenth century, including the Women’s Hospital, Crown Street and the Royal Hospital for Women, Paddington. Even South Australia, which could be considered more like WA in its history of settlement and smaller population, had a publicly-funded maternity ward by 1901. Seven years of public pressure, specifically from Perth’s women’s groups, eventually saw the establishment of King Edward Memorial Hospital (hereafter KEMH) on state government land in 1916. The institution ultimately became Perth’s premier specialist obstetric hospital. However, the poor quality of the buildings and the pressure on the trainee midwives in the early years contrasted starkly with the hospital’s later success as both a provider of maternity services and as a training institution for pupil midwives.

Histories of this and other maternity hospitals in WA rarely touch on the personal experiences of mothers. Women’s ignorance of birth, their treatment by doctors and nurses, the routine use of anaesthesia and their enforced isolation from husbands and even their own babies were part of the reality of a hospital birth for many young WA women during the 1920s, 30s and 40s. Over this period, women were faced with new expectations of their own behaviour in relation to their role as mother and homemaker and were expected to conform to medical

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dictates in their birth choices. As women adopted their new roles as mothers of healthy, robust Australian citizens and eagerly embraced the pain-free birthing offered by the maternity hospital, the era of home birthing came to a close and the empirically-trained midwife became a relic of the past.

**Early hospitals in WA**

As was the case in other colonial settlements, the provision of institutionalised health care was very limited at the Swan River colony during the 1830s and 40s. The British government, consistent with the principle that the West Australian settlement was not to be a drain on finances, provided very little in the way of financial support for the settlers at the new colony.³ Unlike the settlements at NSW and Van Diemen’s Land, Swan River was not initially a penal colony but a place for free settlers who were expected to be independent of the government back home. Early administrators therefore found it difficult to provide much in the way of services for the pioneers, particularly in relation to health care, considered a private concern to be dealt with in the home. Those waiting on Garden Island to get to the mainland in the first year of settlement did have a tent which served as a hospital of sorts. Physicians there attended one of the first European babies born at the fledgling settlement in 1829.⁴ Other hospitals were set up throughout the colony over the early years, including a hut on St Georges Terrace which served as the Colonial Hospital from 1830, and Albany Hospital which was built on government land in 1838. Some of these early institutions were created to service military men and their families, and it is unlikely that there was much maternity work undertaken in them.⁵ During a period when almost all women were ‘confined’ at home, there would have been little call for hospital-based maternity services.

The arrival of male convicts in 1850 provided a source of cheap labour at Swan River and this resulted in an increase in the number of government buildings at the colony, including hospitals. Hospitals built after the arrival of convicts include Bunbury District Hospital, York

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⁵ WADCD, “Roads”, p.103.
District Hospital, and the Military Hospital in Fremantle. A lunatic asylum was also built at Fremantle during this period and this building later became the site of the Fremantle midwifery training school run by the Fremantle Medical Men. By 1865 there were many hospitals established in rural areas. A good number of these had originally been convict infirmaries which then developed into larger government hospitals. Rural towns such as Geraldton, Northam and Busselton all had hospital services from at least the 1860s and some, such as Albany, even earlier.

During the 1890s, the lure of gold attracted impoverished immigrants from overseas and from the eastern colonies. Typhoid outbreaks, both in Perth and on the goldfields were commonplace and there was an increasing need for hospital services. Consequently, this period saw a rise in the construction of new institutions to cater for the mounting number of indigent patients. There was also a growing acceptance of hospitals generally and this contributed to an increase in middle-class patronage of these institutions. As hospitals were increasingly frequented by patients other than the desperate and destitute, conditions improved, and the health system benefited from greater government investment. Despite this, for many in the community, colonial and state governments were not active enough. The growing public tolerance of institutionalised care led to calls for the establishment of more specialist hospitals, specifically for the treatment of children and child-bearing women. After years of campaigning, Perth Children’s Hospital was set up in 1909 on land at the edge of Subiaco and West Perth. Like the future KEMH, Perth Children’s Hospital was only established after concerted effort from members of the public, and the government only reluctantly agreed to partially fund the building and its maintenance.

6 WACD, “Roads”, p.103.
7 J.H. Stubbe, Medical Background: Being a History of Fremantle Hospitals and Doctors, 1969, University of Western Australia Press, Perth, p.18.
8 WACD, “Roads”, pp.103-04.
13 Stannage, The People of Perth, pp.259-60.
The question of government involvement in maternity care

The unwillingness of governments and officials to recognise the public appetite for greater investment in and regulation of WA’s health services generally was an ongoing barrier to change in this area. This was particularly the case in regard to the provision of maternity-related services which, in the minds of many parliamentarians and officials, was still a private concern. Thus in 1909 the new Principal Medical Officer, Dr. James William Hope, suggested that mothers ‘would not for a moment entertain the idea of going from their family’ during childbirth. In this, he was out of touch with many medical practitioners and with a good number of women. Even some doctors were initially suspicious of change particularly if it meant that government regulation might limit medical control over the running and management of hospitals. Nevertheless, in the Australian Medical Journal of January 1911 Dr. John Howard Lidgett Cumpston suggested that full state control of hospitals was only a matter of time. Cumpston, a well-known and respected Australian physician who was also Hope’s deputy in 1911, ultimately became an advocate of greater Commonwealth government control over public health, particularly in relation to immunisation and disease quarantine.

Even after much of the legislation relating to the regulation of health services was in place in WA and when institutionalised maternity care was well-established, some parliamentarians remained ambivalent about the need for any government involvement in the regulation of maternity services. In a 1921 debate on a bill for the examination and registration of nurses in WA, some male members of the Legislative Assembly showed how out of touch they were with public attitudes by querying the need for the regulation of the profession. Even at a time when medical management of childbirth was becoming the new norm, some members questioned the view that training was needed to deliver a baby. While reluctantly supporting the bill, the National Labor member for Pilbara, Henry Underwood, voiced his dissatisfaction at what he saw as excessive government meddling in private affairs. In stark contrast to this, the Nationalist member for West Perth, Mrs. Edith Cowan, Australia’s first female

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15 “Australian Branches: Western Australia”, Australian Medical Journal (hereafter AMJ), January 1911, p.36.

parliamentarian, insisted on the necessity and importance of nursing training to women and children, highlighting the loss of life which had resulted from what she perceived as a lack of expert assistance at childbirth in past generations. An extract from the debate shows the different opinions at play during this period:

Mr. Underwood (Pilbara) [6.2]: …We are apt to become somewhat hysterical in regard to nurses and their training. I remember that 50 years ago we had no nurses. We lived through those days without any of these regulations. We are all the time regulating, regulating, regulating. As one of a large family reared in the bush, I ask what are we going to achieve as the result of all these regulations? The young husband of the present day has to work his soul case out to get a doctor and a nurse. I lived through it without either.

Mrs. Cowan (West Perth): But a good many [women and children] have died.

Mr. Underwood: Our family did not. I remember that many years ago a woman just came in and helped her neighbor.

Mrs. Cowan: She still does so.¹⁷

The conflicting ideologies in this debate give an insight into the past and future of maternity service provision in WA. They also highlight the important role of ‘progressive’ thought during this period of significant social change, particularly the popularity of eugenicist ideas in relation to national health.¹⁸ As Mr. Underwood continues:

I was one of a family of nine born and reared without the assistance of either doctor or nurse…We are becoming too highly technical, and by our regulations employing huge numbers of people who could be doing more useful work. That some child should die because it has not had proper attention is worthy of consideration; but then we have to take the evidence of the member for West Perth…before the Education Commission, where they told us that we are breeding a lot of weaklings, and suggested that those weaklings, mental or physical, should be sterilised.

The Minister for Works: So they should.

Mr. Underwood: Those who lived through as we lived through, did not require sterilising.¹⁹

Despite these protestations from many of the male parliamentarians, Mrs. Cowan persisted in emphasising the necessity of registration and training for nurses, even highlighting the male parliamentarians’ lack of personal experience in this area:

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¹⁸ Eugenicist thinking was popular in WA and throughout Australia during this period, particularly in the years leading up to World War I. Both Principal Medical Officer J.W. Hope and his medical officer to the WA Central Board of Health John Howard Lidgett Cumpston were eugenicists as was William Hughes who served as Australia’s Prime Minister between 1916 and 1923. See Roe, *Nine Australian Progressives*, pp.119, 122.

¹⁹ West Australian Legislative Assembly Debate, Registration of Nurses, October 1921, in Aveling, *Westralian Voices*, p.256.
Mrs Cowan: I support the Bill because it is the earnest desire of different sections of trained nurses that it should be passed. The nurses are of such importance to the community that their wishes deserve every consideration…

Mr. Teesdale: Any motherly woman can deliver a child just as well as a certificated nurse.

Mrs. Cowan: Perhaps, in certain circumstances, but abnormal conditions are likely to arise. Some of us have had experience which the honourable member could never have, and so we appreciate trained help.20

This debate shines a light on the challenges that were faced by those seeking the establishment of a dedicated public maternity hospital in WA. During a period when even the necessity of midwifery and nursing training was still being questioned by some in positions of power, it is not surprising that successive governments baulked at the commitments associated with a public maternity hospital. Indeed, from the initial attempt to organise publicly-funded institutionalised maternity care in WA, government officials were resistant to the concept. According to feminist and social historian Irene Greenwood, the Kalgoorlie Municipal Council approached the Perth Medical Department in 1905 requesting that a maternity ward be added to Kalgoorlie Hospital. The application was rejected on the grounds that surgical and midwifery cases should not be dealt with close together.21

This and other similar points were made by government officials over the following decade as women’s groups, doctors and nursing professionals fought a campaign to establish a maternity hospital in Perth. At one point the government considered adding a maternity ward to Royal Perth Hospital rather than fund a specialist maternity hospital, suggesting that much of the official posturing over this period was based not on legitimate concerns about infection, but on the belief that a dedicated maternity hospital was not necessary given the current level of population in WA. In his annual report for 1909, Principal Medical Officer Hope reiterated the relevance and value of home-birthing internationally, associating the practice with low maternal mortality. If midwives could be trained through other avenues

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20 West Australian Legislative Assembly Debate, Registration of Nurses, October 1921, in Aveling, Westralian Voices, p.257.
21 Irene Greenwood, unpublished history of the establishment of King Edward Memorial Hospital, n.d., The Irene Greenwood Collection, Murdoch University Library, Murdoch, Western Australia, p.5.
such as the Fremantle Midwifery School which was then up and running, Hope felt that the need for a maternity hospital was significantly lessened.²²

Campaigning for a maternity hospital: the important role of women

In many cases in Australia, the establishment of and the agitation for hospital accommodation for child-bearing women had been initiated by women themselves. The Royal Women’s Hospital in Melbourne was established through the work of a women’s committee during the 1850s.²³ Sydney’s Benevolent Society lying-in department which in 1904 became the Royal Hospital for Women, Paddington was set up by a women’s committee during the 1820s.²⁴ Perth’s House of Mercy was established and run by a women’s committee as were some of the other smaller hospitals throughout WA. Indeed, women’s groups, as well as individual women, were often at the forefront of campaigns to ‘modernise’ and further medicalise childbirth.²⁵ During the 1930s the National Council of Women of Australia which acted as an umbrella organisation for state-based women’s councils, strongly supported medical doctors who called for improved obstetrical training and the suppression of untrained midwives.²⁶ In 1905 at the inaugural meeting of the WA-based Labor Women’s Organisation, those present spoke passionately of the need for institutionalised maternity care in Western Australia.²⁷ Similarly, the formation of the Women’s Service Guilds of Western Australia and the Western Australian branch of the National Council of Women in 1909 gave powerful impetus to the campaign for better infant health and in turn the establishment of a maternity hospital.²⁸

The increasing social importance of motherhood created the broader context for the involvement of the Australian women’s movement in debates around maternity services.

²³ McCalman, Sex and Suffering, p.6.
²⁷ Greenwood, unpublished history of the establishment of King Edward Memorial Hospital, p.25.
²⁸ Annette Davis, “Infant Mortality and Child Saving: The Campaign of Women’s Organizations in Western Australia, 1900-1922”, in Penelope Hetherington (ed.), Childhood and Society in Western Australia, 1988, University of Western Australia Press, Nedlands, pp.167-68.
Indeed, the identity of ‘mother’ was central to the Australian feminist movement during the late nineteenth and early twentieth centuries. During this period, mothering and motherhood became the cornerstone of a broader political and economic push by women for greater autonomy and control over their own lives. As women, citizens and mothers, feminists insisted that they had rights which needed to be recognised in law and supported by governments.\(^{29}\) Outrage at women’s lack of legal rights over their own children was one of the primary reasons for the establishment of early women’s groups. Early feminists, members of organisations such as the Women’s Service Guild, defended their mothering role against the intrusion of men and the state through their pursuit of fairer custody laws in divorce courts and through their articulation of the right of all women to motherhood, regardless of class status.\(^{30}\) In their agitation for infant and maternal welfare legislation, the women’s movements of the 1910s, 20s and 30s highlighted the centrality of the mothering role to the success of the nation as a whole.\(^{31}\) This was a maternalist vision of feminism which emphasised motherhood as women’s defining role and insisted on the rights of women as ‘mother citizens’.\(^{32}\)

It was in this broader context that a committed group of Perth’s doctors and nurses along with numerous members of WA’s women’s organisations worked together to build support for a publicly-funded maternity hospital. At the forefront of these groups were women like Edith Cowan and Lady Edeline Strickland, the wife of WA’s new Governor Sir Gerald Strickland who arrived from Tasmania in 1909.\(^{33}\) Lady Strickland brought with her invaluable experience in the setting up of a women’s hospital after her central role in the establishment of the Alexandra Maternity Home in Hobart. Her involvement in the campaign for the creation of a Perth-based maternity hospital ‘brought vice-regal pressure to bear’ on WA officials and soon after her arrival in Perth she sought a meeting with Principal Medical Officer Hope to highlight the great need for institutionalised maternity care in the state.\(^ {34}\) Unsurprisingly this meeting had very few direct results, as the state government was firm in its view that a maternity hospital was unnecessary at this time. Decent married women, so

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\(^{32}\) This is a term used by the Australian women’s movement of the 1920s. See Lake, *Getting Equal*, p.10.

\(^{33}\) Davis, ‘“Infant Mortality and Child Saving’”, p.168.

\(^{34}\) Greenwood, unpublished history of the establishment of King Edward Memorial Hospital, p.12.
Hope assumed, were able to pay for their own confinements at home while unmarried women were catered for at the House of Mercy.\textsuperscript{35}

Undeterred, Lady Strickland wrote to WA Premier Newton Moore later in 1909, reiterating her request for government funding for a maternity hospital.\textsuperscript{36} Moore was reluctant, citing financial strain on the state budget, but he did agree to put aside an area of land near the Children’s Hospital in reserve, should a maternity hospital ever be set up.\textsuperscript{37} This information was delivered by Lady Strickland to a group of around four hundred people at a now-famous meeting held in the Government House Ballroom in November 1909.\textsuperscript{38} The gathering was attended by a number of parliamentarians as well as medical practitioners, representatives of the ATNA and members of Perth’s various women’s organisations, and all were united in their belief that a maternity hospital was a necessity for the state.\textsuperscript{39}

Perhaps the most important thing to come out of this meeting was the agreement that the new hospital should cater for both married and unmarried women. Early in the evening, Mrs. Ruffy-Hill of the Women’s Service Guild moved an amendment to the original motion to establish a maternity hospital, insisting that the words ‘and the hospital shall be for both married and single women’ should be added. A good proportion of the meeting was spent discussing this important question and some of the responses to the suggestion reflect a community still grappling with both the idea of out-of-home maternity care and the social implications of a changing class system. Dr. Ellis suggested that if the hospital were to admit both married and unmarried women, the sensitivities of one group would prevent the other from using the hospital at all. On the other hand, Dr. Haynes insisted that there was a moral obligation to admit unmarried women to the hospital as not allowing them admittance would be tantamount to murder in some cases. Reflecting Principal Medical Officer Hope’s position, one delegate suggested that married women would naturally not want to leave their homes at all for their confinements and that the majority of the women using the hospital would therefore be unmarried. The proposal that the whole debate should be put off to be

\textsuperscript{35} James W. Hope, 22 October 1909, Colonial Secretary’s Office, Correspondence Files, 1883-1983, SROWA, Item no.1909/760, Cons.1003.
\textsuperscript{36} Greenwood, unpublished history of the establishment of King Edward Memorial Hospital, p.27.
\textsuperscript{37} Newton Moore, letter to Lady Strickland, November 1909, Colonial Secretary’s Office, Correspondence Files, 1883-1983, SROWA, Item no.1909/760, Cons.1003.
\textsuperscript{38} “Proposed Maternity Hospital”, \textit{The West Australian}, Tuesday 9 November, 1909, p.7, Accessed via TROVE archive, 25/02/2014.
\textsuperscript{39} “Proposed Maternity Hospital”, \textit{The West Australian}, Tuesday 9 November, 1909, p.7.
resolved by a sub-committee at a later date was soundly rejected by the majority of attendants. Some women’s groups felt very strongly on the matter, with their representatives insisting that they would do absolutely nothing to assist the project unless the principle of admitting all women regardless of marital status was agreed to right there and then.\textsuperscript{40} Suggestions that the amendment was out of order and should be abandoned were also ignored, with Mrs. Ruffy-Hill refusing to withdraw it and insisting the amendment be put to a vote.

When a vote was finally taken, the vast majority was clearly in support of allowing both married and unmarried women to attend the proposed hospital. While this open-door policy was not altogether unusual in Australian maternity care facilities, it was still a significant decision for the time, as a number of hospitals in other Australian states still distinguished between these two groups of women.\textsuperscript{41} Adelaide’s Queen’s Home, although established in 1901, did not admit unmarried women until 1917.\textsuperscript{42} Similarly, Hobart’s Alexandra Maternity Home, established in 1905, was set up exclusively for married women.\textsuperscript{43} This decision to admit all women, regardless of marital status, was certainly a break with tradition and reflected the changing social conditions of the time. It was not, however, what Lady Strickland had intended for the new hospital, a point which was made the following day in an editorial in \textit{The West Australian} where it was claimed that Lady Strickland had been ‘misled’ by others into thinking that the community would support ‘a hospital wholly intended for married women, or one with the thinnest sprinkling of the unmarried’.\textsuperscript{44} Indeed, Lady Strickland was not part of the committee which was formed to carry the project forward after

\textsuperscript{40} “Proposed Maternity Hospital”, \textit{The West Australian}, Tuesday 9 November, 1909, p.7.
\textsuperscript{41} There were a number of exceptions to this. Melbourne’s Royal Women’s Hospital which was established during the 1850s had always admitted unmarried women. This was due mainly to the insistence of the obstetricians who conducted the births there that the institution should be open to all women regardless of marital status. Interestingly, the ladies committee which managed the affairs of the hospital was resistant to this open door policy and it remained a source of conflict for many years. See McCalman, \textit{Sex and Suffering}, pp.16-18. Some of Sydney’s larger women’s hospitals also reluctantly accepted single women as patients. See Lewis, “Hospitalization for Childbirth”, p.200. See also, Australian Government, Find and Connect, “Crown Street Women’s Hospital (1893-1983)”, n.d. Australian Government, Canberra, http://www.findandconnect.gov.au/guide/nsw/NE00446, accessed 31/03/2014.
\textsuperscript{43} Lady Edeline Strickland notes this in a letter to Premier Newton Moore. See Greenwood, unpublished history of the establishment of King Edward Memorial Hospital, p.27.
\textsuperscript{44} “Vigilans et aduax: The Proposed Maternity Hospital”, \textit{The West Australian}, Tuesday 9 November, 1909, p.4. Accessed via TROVE archive, 25/02/2014.
the November 1909 public meeting although she did continue to lend her support to the scheme over the coming years.  

The membership of the working committee, which took on the task of fundraising and lobbying for the hospital, is notable both for the preponderance of ATNA-affiliated doctors and nurses and the inclusion of a number of now well-known Western Australians such as Edith Cowan, then Vice-president of the Women’s Service Guild, and Dr. J.S. Battye, WA state librarian. Other members of note included Mary Molloy, the wife of the then Perth Mayor Thomas Molloy and Deborah Hackett, wife of John Hackett, a Member of Parliament and newspaper proprietor. There were six ATNA delegates to the committee including Antoinette Harris, matron of the House of Mercy, Miss K. Ryan, ATNA council vice-president and matron of Perth Public Hospital, and Dr. E.A. Officer, ATNA council president.  

Of the 22 members of the committee, 17 were women, and a significant proportion of those were trained nurses or members of women’s organisations. As such, they had a personal interest in women’s affairs and in maternity care specifically. The make up of this first committee reinforced the role that women had played in the establishment of institutionalised maternity care in Australia to that point. As time went on and subsequent committees were formed to raise funds for the hospital, the particular role of women in the project became further evident. The 1910 committee which established the ‘Shilling a Brick Fund’ for the hospital was made up entirely of women, and representatives of women’s groups remained a feature of all subsequent committees working towards the establishment of the hospital.  

Despite the commitment and efforts of such individuals, progress was slow. Early in 1910 a deputation to the Colonial Secretary was told that there was simply no money in the current budget for a maternity hospital and that the matter would need to be put off until the following budget. By May of that year a government promise to contribute financially to the establishment of the hospital had been confirmed with the proviso that the committee

45 In 1910 for example the committee held a fundraiser for the hospital at His Majesty’s Theatre under the patronage of Lady Strickland. See Greenwood, unpublished history of the establishment of King Edward Memorial Hospital, p.35.  
46 Greenwood, unpublished history of the establishment of King Edward Memorial Hospital, pp.33-34. See also Hobbs, But Westward Look, p.45.  
47 Greenwood, unpublished history of the establishment of King Edward Memorial Hospital, p.34.  
48 Greenwood, unpublished history of the establishment of King Edward Memorial Hospital, p.34.
needed to raise the first £1,500 of the £4000 required to build and equip the institution.\textsuperscript{49} The name King Edward Memorial Hospital was chosen around this time in memory of the late King, and a public appeal for funds for the hospital was made in his name. This and other fundraising efforts for the new hospital resulted in the accumulation of £900 over the five years to 1915.\textsuperscript{50}

While Principal Medical Officer Hope and other government officials were less than convinced about the necessity of a maternity hospital for the care of child-bearing women in WA, they were aware of the need for appropriate training facilities for maternity nurses. The establishment of a WA branch of the ATNA in mid-1908 brought considerable pressure to bear on the government as medical practitioners began to agitate for a maternity hospital where nurses could receive ATNA-accredited midwifery training. In his inaugural address as President of the WA branch of the ATNA, Dr. Athelstan Saw insisted that a maternity hospital was of vital importance to the state, not only for the poor to receive proper treatment but also to prevent WA-trained nurses travelling interstate to attain their midwifery qualifications. He called on the government to provide such an institution and expressed disappointment at the current lack of progress on the issue.\textsuperscript{51} Saw reiterated his frustration during the 1909 public meeting in support of a maternity hospital where he challenged the government to provide a pound for pound subsidy to assist in the building of the hospital.\textsuperscript{52} Three years later, Miss K. Ryan, matron of Perth Public Hospital and ATNA council vice-president, spoke at the Western Australian Public Health Congress, insisting on the necessity of a maternity hospital where nurses could be trained in midwifery.\textsuperscript{53}

Despite the lack of any government commitment to a proposed maternity hospital, in 1909 Hope was instructed by the Health Minister to draw up three alternative plans for a maternity hospital which would address both the issue of midwifery training and the concerns of the


\textsuperscript{50} Johnston, \textit{Looking backward fifty years}, p.2; Greenwood, unpublished history of the establishment of King Edward Memorial Hospital, pp.34-35.


\textsuperscript{52} “Proposed Maternity Hospital”, \textit{The West Australian}, Tuesday 9 November, 1909, p.7.

\textsuperscript{53} Greenwood, unpublished history of the establishment of King Edward Memorial Hospital, p.35.
The results of this endeavour indicate the degree of government reluctance to embark on the maternity hospital project. Financial constraints were evidently a significant factor, as the costs associated with any of Hope’s potential plans were considerable. His first suggestion was to offer the House of Mercy £3000 to build and outfit a new ward with accommodation for 18 lying-in cases. This new facility would comprise part of the existing House of Mercy building and could be managed and run by the present House of Mercy committee. Alternatively, the new wing could be built and managed by the Medical Department with the supervision of the Principal Medical Officer, the Minister for Public Health and the Superintendent of Public Charities. The second option was the establishment of a separate institution, run by a ‘committee of ladies’. This hospital would again have only 18 beds and while the government would shoulder the expense of building and equipping it, most ongoing costs would be the responsibility of the committee. This scheme was costed at £4000, with the state to contribute an additional £25 per month towards the salary of a matron. In both proposed plans, the new institution was to be a training school for midwives.\footnote{Greenwood, unpublished history of the establishment of King Edward Memorial Hospital, p.12.} At no point did Hope ever seriously consider actually building a large publicly-funded maternity hospital, even though this is what would have most obviously addressed the concerns of those campaigning for improved maternity care.

Neither the Cabinet of the Moore government nor the House of Mercy committee approved of Hope’s first plan and while the Colonial Secretary gave support to the second of Hope’s schemes, it too was dismissed by the Cabinet as being too expensive.\footnote{James W. Hope, 5 July 1909, Colonial Secretary’s Office, Correspondence Files, 1883-1983, SROWA, Item no.1909/760, Cons.1003.} Despite this, Hope was asked to ‘bring the matter up for consideration later’ when the government’s financial position was better.\footnote{John Connolly, 7 and 8 July 1909, Colonial Secretary’s Office, Correspondence Files, 1883-1983, SROWA, Item no.1909/760, Cons.1003.} In the light of this, and with the pressure for a midwifery training facility still very apparent, Hope and other government officials pursued a third option, the establishment of a midwifery training program at the Fremantle Women’s Home, previously the Lunatic Asylum.\footnote{Greenwood, unpublished history of the establishment of King Edward Memorial Hospital, p.13. For further details of this training scheme see the previous chapter.} In itself, this institution (discussed in the previous chapter) did not address the need for a publicly-funded maternity hospital, as its primary focus was on...
midwifery training, not on providing midwifery care to all classes of women. The patients who became the case studies in the training course were residents of ‘Hopetoun’ (later Hillcrest), the charity lying-in home run by the Salvation Army and situated in North Fremantle.\(^5^9\) As such, the Fremantle Women’s Home provided no actual extra accommodation for midwifery cases.

**Social pressure and the establishment of KEMH**

While the Fremantle midwifery training school produced a trickle of trained midwives over the coming years, very little else was done to address the need for a publicly-funded maternity hospital. In the meantime, two much-publicised incidents further highlighted the need for a specialist maternity hospital. The first occurred in August 1909 when a young woman, on her way to a charity woman’s home, gave birth en route and was subsequently refused access to the home. The matron at the Cornelie Home where the woman had intended giving birth insisted that as the institution was registered as a rescue home it was not equipped for maternity cases.\(^6^0\) The woman was then referred to the House of Mercy, where she was again refused access. Having never met the mother before, the matron of the home was reluctant to provide her with care, particularly as she may have been carrying an infection. The woman found some temporary assistance at the private Topham hospital in West Perth run by Dr. E.J.A. Haynes and was later transferred to the home of Dr. Tanner in Lincoln Street where she received care for a number of hours. The woman was finally given more permanent accommodation at the House of Mercy after being interviewed by the matron.\(^6^1\)

The *Sunday Times* was outraged by the conduct of the matrons of both the Cornelie Home and the House of Mercy, claiming that the latter institution had ‘lost every shred of claim it ever possessed on the philanthropy of the public’.\(^6^2\)

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\(^5^9\) Central Board of Health, Files – General, 1899-1987, SROWA, Item no.1910/0158, Cons.1003.
\(^6^1\) “Shocking Inhumanity”, *Sunday Times*, Sunday 22 August, 1909, p.3
\(^6^2\) “Shocking Inhumanity”, *Sunday Times*, Sunday 22 August, 1909, p.3
sorts of contemptible excuses and subterfuges were made use of... The case is cruel, callous, and barbarous beyond compare. It stands alone in its Satanic inhumanity.63

While most of the community anger was directed at the House of Mercy, the need for a public maternity hospital where such cases could be accommodated was clear. This point was again highlighted in June 1914 when a woman died in childbirth at the House of Mercy after being turned away from the Perth Public Hospital. The ‘Bellevue Case’ became a source of significant angst for the medical practitioners and midwives involved in the incident.64 The Sunday Times again took issue with officials over the case in a lengthy article in which the editor called for a maternity wing to be added to Perth Public Hospital:

What really is wanted and what must be done – there must be absolutely no more tomfoolery about it – is that a maternity ward must be erected in connection with the Perth Public Hospital. If that had been in existence a week ago there would have been no absurd turning-up of regulations when an emergency cropped up...65

However, after completing an investigation into the ‘Bellevue Case’, Principal Medical Officer Hope was satisfied that there had been no wrong-doing and was at some pains to demonstrate that the current systems were more than adequate:

There are four medical men living in the vicinity of the residence of the patient, and there are five licensed midwifery premises, containing 29 beds. Had any medical man been called into the case a fee is specified in the Midwifery Regulations and is paid by the Government for such assistance.66

Despite Hope’s confidence in the existing services, the community was angered and frustrated by the case and an editorial in The West Australian reflected the public feeling.

Every city the size of Perth should, undoubtedly, be provided with a maternity hospital, and probably no other capital in the Commonwealth is totally unequipped for dealing with indigent and urgent maternity cases...The Public Hospital should be able to meet all the genuine demands with which it is faced. But it is even more essential that facilities for the treatment of urgent maternity cases should be provided in Perth at the earliest possible moment.67

63 “Shocking Inhumanity”, Sunday Times, Sunday 22 August, 1909, p.3
While the addition of a maternity ward at Perth Public Hospital as suggested by the *Sunday Times* would not have satisfied the committee of women who were then working for the establishment of a separate maternity hospital, the publicity accorded to the KEMH project by these two cases was significant. From 1910 the committee of women working on the scheme had met intermittently at Lady Hackett’s home in St Georges Terrace. Through their efforts and the generosity of the public they were able to raise a significant amount of money, although not enough to spark the government into fulfilling its promise to contribute financially to the project. Even as late as 1914 and after the tragedy of the ‘Bellevue Case’, it was still felt by some health department officials that the state had enough facilities for maternity care and that a separate, dedicated maternity hospital was not necessary. For example, in his annual report for that year Principal Medical Officer Hope noted that, while there was an increasing tendency among women to ‘seek institutional care’, there were more than enough lying-in homes to accommodate them. He triumphantly concluded that, given a three-week period for each confinement, the 581 lying-in home beds available throughout the state could each accommodate 17 cases per year, providing for a total of 9,877 births annually. In Hope’s mind, as this figure was more than the 9,206 births in WA for 1914, there must be more than enough maternity accommodation available in the state already.

Hope’s calculations are misleading and do not take into account seasonal variations in births nor the geographic and financial limitations on access to lying-in homes for some women. Yet despite this simplistic interpretation of the figures, both Hope and the government were aware of the growing public disquiet on the issue of maternity care. In 1913, a year before Hope made his unsophisticated analysis of maternity bed numbers, the then Scaddan Labor government proposed a new plan which it was hoped would address both the lack of an appropriate midwifery training facility and provide the much sought after maternity hospital service. A new wing would be added to Perth Public Hospital where maternity and

68 Greenwood, unpublished history of the establishment of King Edward Memorial Hospital, p.35.
71 Hope’s calculations presume that all women would have been able to afford to access medical or midwifery care in private hospitals or lying in homes. His figures also ignore the fact that births are not spaced evenly over the year, meaning that at any one time there could be either a significant oversupply of beds in lying-in facilities or a significant undersupply. Nor were lying-in homes evenly distributed throughout the state, meaning that access to these facilities would have been limited for some women. All of these factors necessitated the provision of low-cost and easily accessible maternity care for women who could not afford or who were not able to access lying-in homes.
gynaecology patients could be provided for. As Principal Medical Officer Hope’s annual report for 1913 stated, this scheme would have a number of advantages:

Central situation, economic management, all the administration facilities are already there, the opportunity for nurses who are receiving general medical and surgical training to continue there and qualify in midwifery and diseases of women, whereas many now go to the other States for this course of study…At least for some years this plan will answer all requirements.

The Women’s Service Guild and some other women’s organisations felt differently and there was an immediate outcry about what was seen as a breach of the original promise to build a separate maternity hospital. The idea was temporarily shelved, but it made an appearance again in early 1915 when the government, citing the financial strains of the war effort, officially retracted its promise to build a separate maternity hospital. Members of the Women’s Service Guild and the hospital committee were outraged and a public protest meeting was called. Over one hundred people attended including representatives of various women’s groups along with members of the Farmers & Settlers Association, the Liberal League, the Council of Churches and the WA Alliance. During the meeting, Edith Cowan made the important point that £900 had already been raised for the hospital and that if this money were actually put towards starting the building, more money would no doubt be forthcoming from the public. She went on to suggest that the site of the old Industrial School in Subiaco could be used as a temporary hospital facility while a more appropriate site was being organised. This suggestion was keenly embraced by all at the meeting including the then Minister for Health Rufus Underwood who, according to one member of the Women’s Service Guild, ‘immediately said the hospital would be established’.

From this point, the facility which was to become KEMH was set up relatively quickly. By April 1916, the buildings of the old Industrial School had been converted for the use of the hospital and an advisory committee had been established to oversee the running of the institution. A matron, Miss Eleanor Harvey, was appointed, and on 14 July 1916 the hospital

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72 Greenwood, unpublished history of the establishment of King Edward Memorial Hospital, p.37.
74 Greenwood, unpublished history of the establishment of King Edward Memorial Hospital, pp.37-38.
75 Johnston, Looking backward fifty years, p.3; Greenwood, unpublished history of the establishment of King Edward Memorial Hospital, p.38.
76 Cohen, A History of the King Edward Memorial Hospital, p.6; Isabel Johnston, letter to Hon. Minister Panton, 9 December 1939, cited in Greenwood, unpublished history of the establishment of King Edward Memorial Hospital, p.39.
opened and received its first patients.77 Despite early predictions that the hospital would ‘never be filled’ the response from the public was overwhelmingly enthusiastic and the 20-bed hospital was generally full.78 The 1916 report of the then Commissioner of Public Health, Dr. Atkinson, describes the success of the hospital in its first six months:

The institution, judging by the popularity it has attained, is already a great success and there has hardly been a vacant bed since its inception. The hospital has been availed of by numerous women from both town and country and for the latter has frequently proved a veritable godsend. Without exception, all have spoken in terms of the highest praise of the care and treatment bestowed upon them…The fee of 3.3.0 for confinement and fourteen days’ care thereafter has enabled many a mother to pass through this trying period in unwonted comfort and has provided for her the best of medical and nursing care.79

Early newspaper reports were equally enthusiastic and heralded the immediate success of the institution.80 Patients were variously described as being ‘delighted with the place’ and ‘thoroughly satisfied with the treatment accorded to them’.81

The early years of hospital management at KEMH

At least externally, this honeymoon period for the hospital continued for many years. Newspaper reports were always positive and spoke highly of the staff and of the facility’s excellent record on maternal mortality.82 Indeed, the statistics for the early years of the hospital are good, particularly for a new institution, managing with a limited staff and with the added pressure of needing to train probationer nurses. Initially, outcomes were challenging. For the first six months from 14 July 1916 to 31 December 1916 there were 101 confinements undertaken at the hospital, 60 boys and 41 girls. Of these there were seven stillbirths and three infant deaths. One maternal death was also recorded.83 However, by 1920

77 Cohen and Hutchinson, *A History of the King Edward Memorial Hospital*, pp.7-8.
78 Isabel Johnston notes that this comment was made privately by the Hon W.C. Angwin to Mrs Amelia Macdonald (Johnston’s aunt) just before the hospital opened. See Johnston, *Looking backward fifty years*, p.3.
82 See for example “For Mothers and Babies: Magnificent Record of the King Edward Hospital”, *The West Australian*, Friday 30 March, 1923, p.6; “King Edward Hospital: Birthplace of 10,000 West Australians”, *The West Australian*, Tuesday 19 June, 1934, p.3; “Perth Hospital’s Fine Record”, *The Advertiser*, Saturday 26 January, 1935, p.15. Accessed online via TROVE archive 19/06/2013.
the hospital was accommodating many more patients annually, 565 in that one year alone, and with only 2 maternal deaths recorded.\footnote{Cohen, \textit{A History of the King Edward Memorial Hospital}, p.13.}

The popularity of the hospital was clear from its inception, and admissions grew steadily every year. In 1922, 587 women were admitted, in 1923, 795 and in 1924, 928.\footnote{Cohen, \textit{A History of the King Edward Memorial Hospital}, p.17.} The hospital treated over one thousand women in 1927 and even though the hospital had by this time been significantly enlarged, the matron complained of a lack of accommodation in her annual report for that year.\footnote{In 1922, a grant from the British Red Cross had made it possible for KEMH to double its original patient capacity with the addition of 20 new beds across 4 new wards. See Cohen and Hutchinson, \textit{A History of the King Edward Memorial Hospital}, p.14; Agnes Walsh, “Matron’s Annual Report”, KEMH, 1927, cited in Cohen and Hutchinson, \textit{A History of the King Edward Memorial Hospital}, p.22.}

At this point, the hospital was also providing antenatal care in pregnancy, so the number of women using the institution’s services had increased dramatically since its establishment in 1916, just 11 years earlier. In 1927, as in many previous years, the figures on maternal and infant mortality were good; there had been only 4 mortalities out of the 900 babies born at the hospital and only 2 maternal deaths. This result was, according to the matron, quite a significant achievement given that during this period an average loss of 1 in 250 mothers was ‘considered unavoidable in all maternity hospitals’.

Also of note was the fact that there had been no cases of puerperal fever (also known at the time as septicaemia) recorded at the hospital that year.\footnote{Walsh, “Matron’s Annual Report”, KEMH, 1927, cited in Cohen and Hutchinson, \textit{A History of the King Edward Memorial Hospital}, p.23.} In fact throughout the hospital’s first six years there were only five cases of puerperal sepsis and only one proved fatal.\footnote{“For Mothers and Babies”, \textit{The West Australian}, Friday 30 March, 1923, p.6} During a period when puerperal fever was still a major killer of child-bearing women, this outcome was certainly testament to the efforts of the midwives, nurses and doctors working at the hospital over the early years.\footnote{Numerous medical authorities note the prevalence of puerperal fever as a killer of child-bearing women in Australia during the 1910s and 1920s. See for example “Vital Statistics”, \textit{AMJ}, Aug 1911, p.61; Robert Marshall Allan, “Report on Maternal Mortality and Morbidity in the State of Victoria”, \textit{Medical Journal of Australia} (hereafter \textit{MJA}), June 1928, pp.668-85 and Hubert Jacobs, “The Causes and Prevention of Maternal Morbidity and Mortality”, \textit{MJA}, Vol.1, No.22, 1926, pp.593-611.}

In 1920, the hospital appointed nurse Agnes Walsh to the staff.\footnote{Cohen and Hutchinson, \textit{A History of the King Edward Memorial Hospital}, p.12.} Walsh would later become the matron of KEMH and her influence on the hospital during her 32 years as matron was significant. Walsh’s recollections of the hospital during the early years contrast with the
glowing representations of the institution which appeared in the press during the 1920s. According to Walsh the early KEMH was ‘a shocking place’ and the nature of the converted buildings meant that many basic conveniences of a modern maternity hospital were not available to the staff.  

As Walsh notes:

> like most buildings that are converted, it was hard to run…Everything, from pantries to bowls for scrubbing up, seemed to be of the makeshift variety. The inconveniences were dreadful. Even most of the important things, like septic tanks and drainage, were either obsolete or missing altogether. We had no such thing as a seterilising plant, for instance, nor did we enjoy the luxury of sterile sheets…In fact, there was very little provision for asepsis at all.

These recollections further highlight the significance of the hospital’s good record on maternal mortality and illustrate the dedication of the nurses, midwives and doctors in an environment where antisepsis was not easily achieved. Indeed, it appears that many aspects of the running of the hospital were substandard during this time. For example, during 1922 one of the wards became infected with fleas and needed to be completely disinfected. It was later found that the infected ward had been built on top of the old fowl yards. In one particularly shocking incident, Agnes Walsh describes going to an outside storage room for linen, only to find that the next-door shelf was being used to temporarily store two stillborn babies awaiting removal.

Life for the pupil midwives was challenging at the new hospital. Initially, the fee for training was 10 guineas, to be paid in advance. For a time, this fee was increased to 15 guineas but was significantly reduced in 1934 to £1. The course was run over 6 months for nurses with a general certificate and 12 months for students with no nursing training. Like most midwifery or nursing training courses, prospective students needed to provide a medical certificate confirming their good health and be free of vision or hearing impairment. As well as being required to pay the fee for training, pupil midwives were expected to provide their own regulation uniform and they did this while receiving no pay for their work. Most trainees

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93 Ruth Bottle, transcript of oral history interview conducted by Victoria Hobbs, 1975, State Library of Western Australia (hereafter SLWA), OH139.

94 Cohen and Hutchinson attribute this story to Walsh. See Cohen and Hutchinson, *A History of the King Edward Memorial Hospital*, p.13.

lived in at the hospital in accommodation which was in 1916 deemed ‘somewhat limited’ by the Commissioner of Health.\textsuperscript{96}

According to some of the early pupil nurses at KEMH, conditions for the trainees at the hospital were substandard. Nurse Greaves, who trained at the hospital in 1918, reported that there was generally not enough food for the staff and the pupils were often hungry. Because they had no money, they had to scrounge eggs and milk from the patient supplies or raid the hospital vegetable garden.\textsuperscript{97} Some trainees did not have the required discipline for hospital work. An excerpt from Matron Harvey’s monthly report reflects the level of scrutiny and oversight of the pupil nurses in the early years:

\begin{quote}
Nurse N… Untidy, not improved. Unmethodical, slight improvement. Irritable in manner, friction with patient, examined patient without Matron’s supervision, impertinent and taken out of Labour Ward.\textsuperscript{98}
\end{quote}

Despite these challenges, this trainee successfully completed the course and did well in her final examinations.\textsuperscript{99} Indeed, the hospital developed a good reputation for midwifery training during the 1920s. The institution graduated 123 trained midwives in its first six years, and in 1927, the matron reported that KEMH was found by the Australian Nursing Federation to be the only hospital in the Commonwealth giving nurses the full, specified training in midwifery.\textsuperscript{100}

The KEMH casebook: midwives as primary carers

An examination of the KEMH casebook for the period 1916-1931 is useful when seeking information on the experiences of patients, the roles of the resident midwives and the flavour of the institution itself. The list of delivery room instruments for example, which were in use at the hospital during 1916, has some disturbing overtones which reinforce the representation of these early hospitals as unpleasant places for new mothers. The list features five different types of forceps, a number of razors (presumably for shaving pubic hair), a cephalotribe used

\textsuperscript{96} Atkinson, in Cohen and Hutchinson, \textit{A History of the King Edward Memorial Hospital}, p.8.
\textsuperscript{97} See Cohen, \textit{A History of the King Edward Memorial Hospital}, p.12.
\textsuperscript{99} Cohen and Hutchinson, \textit{A History of the King Edward Memorial Hospital}, p.9.
\textsuperscript{100} “For Mothers and Babies”, \textit{The West Australian}, Friday 30 March, 1923, p.6; Walsh, “Matron’s Annual Report”, KEMH, 1927, cited in Cohen and Hutchinson, \textit{A history of the King Edward Memorial Hospital}, p.24.
for crushing a foetus’ skull if a successful birth was impossible, a perforator for ‘breaking the waters’ pre-delivery, a dilator for manual vaginal dilation and a mouth gag. Thankfully, the casebook also shows that many of these instruments were rarely, if ever, used. There were craniotomies performed at the hospital, and the first caesarean section occurred in September of 1916, but both of these operations appear only rarely in the list of deliveries throughout the whole 15 year period. Similarly, forceps procedures were performed on only 18 occasions out of over six hundred births during the two years between July 1916 to July 1918, indicating that forceps were only used sparingly and as a last resort.

The casebook also shows that in the early years at KEMH the midwives did the vast majority of the deliveries themselves, in stark contrast to other smaller private hospitals in operation in Perth at the time. Just three medical men – doctors Couch, Clement and Officer – appear in the register and they conducted deliveries only occasionally. In fact in the first 2 years of the hospital’s operation, less than 7 percent of over 650 births were conducted or assisted by a doctor. In this way, KEMH followed the traditional model of midwifery care in which the female midwife was the primary carer of the patient with obstetrical staff only being deemed necessary in emergency situations. In the first three years of the hospital’s operation, doctors were called in to a number of emergency cases including two cases of ruptured uterus, one case of preeclampsia and three caesarean sections. Obstetricians were also involved in cases where the baby needed to be turned or where forceps were required. However these cases were rare and the vast majority of deliveries were conducted safely by the midwives, some of whom were trainees.

While the presentation of the baby is not always recorded in the casebook, when it is noted, the vertex or crown presentation dominates, confirming again that despite common representations of birth in the past as being fraught with difficulties and complications, a significant majority of births proceeded normally, at least in terms of their presentation. Breech births were also conducted safely by the midwives, showing the extent of their skills.

103 KEMH Casebook July 1916 - May 1931. See period 01/07/1916-01/07/1918.
104 See the ‘delivered by’ section of the KEMH Casebook July 1916 - May 1931.
105 KEMH Casebook July 1916 - May 1931. See period 01/07/16-01/07/19.
as managers of normal vaginal birth. 106 The occurrence of a ‘footling’ or foot presentation is recorded on four occasions and on all of these, the delivery was conducted by a midwife. 107 A case of face presentation in 1921 and an instance of umbilical cord presentation in the same year were both managed by the midwife on duty. 108 It was not uncommon for the midwives at KEMH to deliver twins and this occurred on multiple occasions. 109 The trainees also worked very long hours and some midwives delivered multiple babies during their shift. On one occasion in 1921, one midwife delivered five babies to four different mothers over a single twenty-four hour period. 110

Attending midwives and doctors often noted anything out of the ordinary in the casebook, and these entries provide some insights into some of the potential challenges faced by women giving birth during the 1910s and 20s. One woman, a victim of preeclampsia, lay in a coma for three days after the birth of her baby in 1922 before being able to get up and feed her child. 111 Many victims of preeclampsia died either during the birth or within a few days of it and the deaths of these women and their children are generally briefly noted. 112 The remark ‘unavoidable haemorrhage’ appears from time to time, indicating that a mother bled out after birth. 113 There were a number of cases of malformed infants at the hospital during the period covered in the casebook and these were usually recorded. An infant with a cleft palate was born in October 1923 and died soon after. 114 In early 1924 a child with two malformed hands was born. 115 In 1922 the case of a ‘Blue Baby’ – a child with a congenital heart problem which prevents proper oxygenation of the blood – was recorded for the first time. 116 The remark ‘accidental harm, stillborn’ occurs quite often, which may imply that mother and baby met with an accident or violence before birth, resulting in the death of the baby. 117 It is also possible that this remark could have been used to conceal harm to mother and baby sustained

106 This is significant because breech presentation is now considered justification for obstetrical intervention including caesarean section. Midwives of the past were able to deliver these babies without medical assistance of any kind.
109 KEMH Casebook July 1916 - May 1931. See for example p.02/08/21-12/09/21
113 See for example KEMH Casebook July 1916 - May 1931, p.15/1/22-21/2/22.
during the birth itself. Most unusual childbirth events occurred rarely however. For example, the birth of a baby to a thirteen-year-old mother was noted in the casebook in 1921, but the fact that such an event is recorded only once in the whole book, suggests that particularly young mothers were not common at the hospital.\textsuperscript{118}

Abnormal childbirth outcomes were also logged in the casebook and these make for interesting reading. Extremely large babies were noted, as were unusually long umbilical cords. In 1922, two umbilical cords measuring over 50 inches each were documented and in that same year, an extremely short 8 inch cord was also noted.\textsuperscript{119} The acronym B.B.A. indicates that a baby was born before arrival at the hospital and in a number of these cases the actual birth location is noted. One such child, logged in 1922, was born in a rowing boat, while another in 1924 has the note ‘born in a taxi’.\textsuperscript{120} The claim that a case of ‘superfoetation’ had occurred at the hospital is recorded in the casebook in July 1922. This very rare event takes place when a second foetus is conceived days or weeks after the conception of a first foetus and two babies are born at distinctly different stages of physical development. As this event has only been recorded a handful of times in humans, it is more likely that the children noted in the KEMH casebook were twins, but the suggestion itself is interesting and attests to the variety of cases which the midwives and doctors were handling during this period of the hospital’s history.

Women’s childbirth experiences in maternity hospitals: silences in the sources

While KEMH was WA’s first publically-funded maternity hospital, the growing popularity of institutionalised care for childbirth saw the establishment of a number of other well-known private and public maternity hospitals in metropolitan Perth over the 1920s, 30s and 40s. Woodside Maternity Hospital was established in 1925 in East Fremantle.\textsuperscript{121} Originally a private institution, it was publically-funded from 1953 to 2006 when it was shut down and maternity services for the area transferred to Kaleeya Hospital.\textsuperscript{122} Hawthorn Hospital was set up in 1933 and became known as Osborne Park Hospital from the 1960s. This institution was the site of over one thousand births in 1974 and is still a significant part of WA’s public

\textsuperscript{119} KEMH Casebook July 1916 - May 1931, see pp.15/1/22-21/2/22, 19/8/22-24/9/22, and 22/2/22-5/4/22.
\textsuperscript{121} WADCD, “Roads”, p.68.
\textsuperscript{122} WADCD, “Roads”, pp.68, 109.
maternity services today. St John of God hospital in Subiaco established a maternity ward in 1937 and during the 1940s, the facility had 35 beds available for private, fee-paying patients. The St John of God facility at Subiaco along with other branches in Murdoch, Geraldton and Bunbury still provide private maternity care today. St Anne’s Maternity Hospital in Mount Lawley was established in 1938. St Anne’s went on to become one of the best-known private maternity institutions in the state and remains part of Perth’s modern-day maternity service as St John of God Hospital, Mount Lawley.

While the histories of many of these institutions are well-researched and understood, the experiences of the women who worked and gave birth in them, particularly in the early years of institutionalised care, have been almost lost to history. Certainly, the expectation of mothers who had their children in these hospitals during the 1920s, 30s, and 40s was that they should appreciate the effort and time being invested in them by the nurses and doctors. In the case of KEMH, many women were treated free of charge or were able to use their federally-funded maternity allowance as payment and this reinforced the notion that all women should feel grateful for the service being provided to them. Indeed, references to ‘happy patients’ and ‘expressions of appreciation’ from mothers are so common in newspaper articles relating to KEMH that they appear to have been an obligatory part of the reporting: an effort to assist in the promotion of the hospital. As such, it is unclear to what extent patients were genuinely ‘happy’ with the service provided at the hospital.

Most revisionist representations of early twentieth century maternity hospitals in other parts of Australia suggest that patients were certainly not ‘happy’ during their stay there. Anne Blood for example suggests that in South Australia in 1938:

[b]eing in hospital to have a baby was not a particularly pleasant experience for the majority of mothers. After the ordeal of labour, assisted by narcotic "twilight sleep" and nitrous oxide gas which, although it dulled the pains of labour, also dulled the senses and left behind a massive twenty-four hour

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124 Central Board of Health, Files – General, 1899-1987, SROWA, Item no.1944/1116, Cons.1003.
127 There are many references to women being sent home from KEMH with their full maternity allowance. Although this did not happen in every case, it was a regular enough occurrence for it to be noted more than once. See “Baby Mix-up ‘Impossible’ at K.E.M.H.”, The West Australian, Tuesday 18 October, 1949, p.11; “Perth Hospital’s Fine Record”, The Advertiser, Saturday 26 January 1935, p.15 and “King Edward Hospital: Birthplace of 10,000 West Australians”, The West Australian, Tuesday 19 June, 1934, p.3.
"hangover", a woman would be confined to a narrow, hard, iron bed in a sterile ward, with little privacy and little contact with her new born baby. Surrounded by crisply starched efficient and 'bossy' nurse-midwives, she would be instructed to breast feed her child at strict four hourly intervals. There would be no visitors apart from her husband for six days during which time she was not permitted to get out of bed at all.\textsuperscript{128}

Large public maternity hospitals such as that described by Blood certainly would have been oppressive and challenging for many women, at least by modern standards. In these institutions, the use of anaesthesia and sedation during labour was routine and went unquestioned by patients and medical staff. Husbands were not permitted to attend births and babies were systematically removed from their mothers, to be temporarily returned only at feeding time.\textsuperscript{129} Fear of upsetting the nurses or of doing the wrong thing is a common motif of oral histories taken from women who gave birth in Australian maternity hospitals during the 1920s and 1930s.\textsuperscript{130}

Despite insights such as these, attempts to understand or fully appreciate women’s experiences of childbirth in early hospital institutions in Australia and internationally have been hampered by a number of factors. Perhaps the most important is that both traditional historians of obstetrics and women themselves did not see mothers’ personal childbirth experiences as worthy of recording. Anne Misson touches on this when she highlights the use of positive birth stories in modern-day alternative birthing manuals. According to such accounts ‘[t]he proof of any [birthing] system or any alternative in the end must be in the feelings of the women, the satisfied customers’.\textsuperscript{131} While this acceptance of women’s birth stories as a valid and informative aspect of childbirth research has been common from the 1970s onwards, it was unheard of in the early twentieth century. As Misson points out, women’s ‘feelings and experiences, so prized and respected today, do not appear relevant in that earlier period’.\textsuperscript{132} Consequently older women, describing their childbirth experiences from the 1920s, 30s and 40s tend to downplay their own involvement in the process, packaging their experience into a few short phrases.\textsuperscript{133}

\textsuperscript{130} See for example Blood, Birth in South Australia, p.39.
\textsuperscript{132} Misson, “Mentioning the Unmentionable”, p.134.
\textsuperscript{133} There are many examples of this. See Misson, “Mentioning the Unmentionable”, p.137.
One important factor which helped to create this silence from women was the practice of routine anaesthetisation. In early twentieth century maternity hospitals use of anaesthetisation during childbirth worked to deny women the ability to describe their experiences of birthing: many simply could not remember what had happened.\textsuperscript{134} Women’s inability to describe their experiences is further explained by the moral and social restrictions on talking about reproduction or sexuality which existed well into the twentieth century, and by their consequent lack of appropriate language in which to explain the events surrounding the births of their children. As Misson points out:

\begin{quote}
the language in which to describe the actual experience of birth was not generally available to women at this time. Sex education and childbirth preparation were still very much reliant on hearsay, with little of a specific nature heard.\textsuperscript{135}
\end{quote}

For these reasons, while it is desirable to seek out and explain women’s own personal experiences of hospital birthing during the 1920s, 30s and 40s, it is incredibly difficult to do so, as sources are limited or non-existent. It is possible however to piece together a picture of what women’s experiences in these early public and private institutions would have been like based on some limited information from women themselves, and from a knowledge of the workings of these early hospitals.

KEMH is of particular interest because there is more historical material pertaining to this institution than there is to most other maternity hospitals in WA.\textsuperscript{136} Unfortunately, women’s own experiences do not make up any significant proportion of this material, though some aspects of the running of the hospital itself can help to illustrate how women may have felt about their time there. For example, it was common practice during the 1920s at KEMH for unmarried mothers to be denied visitors. While one of the significant achievements of the hospital had been its commitment to provide care to both married and unmarried women, single mothers were discriminated against in this way due to their moral status. The hospital staff made a special effort to disguise the identity of single mothers from the married women, referring to them as ‘Mrs Blank’ or using their last name, making sure never to call them

\begin{footnotesize}
\begin{enumerate}
\item[\textsuperscript{135}] Misson, “Mentioning the Unmentionable”, p.135.
\item[\textsuperscript{136}] It is noteworthy that a significant proportion of the historical documents produced by KEHM during its early years have recently been lost and remain accessible only through the work of earlier historians such as Cohen and Hutchinson.
\end{enumerate}
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‘Miss’. Unmarried mothers’ lack of visitors was explained by reference to the mother’s health: ‘Mrs Blank doesn’t feel well enough to receive visitors’. How single mothers felt about not being allowed visitors is impossible to determine; however for some women it would have doubtless made the hospital experience more isolating and difficult.

The physical space of the early KEMH can give the historian further insights into how women may have experienced this institution. One important factor to consider is the building itself. Pictures of the old Industrial School show a long single-storey building displaying traditional nineteenth century architecture. The building had a distinctly institutional feeling, no doubt a remnant of its time as a school for orphan and delinquent children. It was certainly an imposing structure and nothing like the lying-in homes with which many women would have been familiar. Some trainee-midwives recalled the physical space of the early KEMH in a less-than-positive light. According to Ruth Bottle who worked at the hospital during 1919, the reformatory style of the buildings remained a feature of the new institution:

The building was almost in the same condition…as [when] it was a Reformatory. It was just divided into Wards that use [sic] to be dormitories. There was Ward 1, 2 and 3 that’s all it was. The third one was a building that was removed from Coolgardie, it was a T.B. Hospital in Coolgardie and they moved it complete, most of it corrugated iron, down to King Edward to convert it into [a] Midwifery Hospital….The Labour Ward was in a very exposed condition and very near the entrance, which was a rather unsatisfactory position…

A schematic of KEMH from 1922 illustrating the positioning of new walls after a renovation, shows that the original building was quite open. The delivery ward was directly in front as a person entered, an inappropriate position which obviously worried midwives like Bottle. There were four beds in the delivery room, suggesting that it was usual for a number of women to be birthing at the same time. The challenges that this situation could create for mothers and attendants can be imagined. A lack of privacy, stress and anxiety were likely in an environment where as many as four women were going through the physical and emotional strains of childbirth all together in a single room. The ward’s positioning at the entrance also seems strange, given that visitors and new patients would have been arriving fairly regularly. The delivery ward remained in this less-than-satisfactory position even after

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137 This practice was discussed at length by Agnes Walsh in Allen, *Life in Her Hands*, pp.44-45. See also Bottle, transcript of oral history interview.
138 Bottle, transcript of oral history interview.
the 1922 renovation, although it appears to have been shut off a little more from the other wards through the addition of some internal walls.\textsuperscript{139}

Through the renovation work done in 1922 the hospital gained an examination room for the assessment of antenatal patients as well as a preparation room for those women about to go into the delivery ward. In addition to these spaces there were two wards, one with four and the other with six beds which housed the women waiting and those having given birth in the last few days and weeks. Newspaper photographs from the time show that patients slept in specially designed cots with a bassinet attachment at the foot which allowed mothers to attend to their babies when needed.\textsuperscript{140} In keeping mother and baby so close together and allowing women to attend to their children in the night, KEMH deviated from the usual approach in many maternity hospitals, where babies were taken away from their mothers and only returned to them temporarily at feeding time. This factor in itself could have made life in KEMH more pleasant for some women; being able to be close to their babies without any other distractions or tasks to perform may have been welcomed by some mothers. On the other hand, sharing a room with five other women and their babies could mean that no one was able to sleep for long, suggesting that this arrangement may have also had its disadvantages.

A lack of privacy for mothers is an obvious problem associated with early maternity hospitals. These institutions were often very open, and in the case of KEMH, the space was designed for dormitory-style living and was not altogether conducive to the intimate nature of childbirth. The modern concept of ‘surveillance room’ is appropriate in this context because the space facilitated the easy observation of the patient by staff. Large open rooms with multiple beds and multiple occupants removed any semblance of privacy and allowed for the monitoring of women from a physical distance. The clinical aspects of the hospital space also support the suggestion that women at KEMH gave birth and slept in ‘surveillance rooms’. The transition made from the waiting ward to the preparation room and finally to the delivery ward was a function of hospital policy, including the routine use of anaesthetisation, the administration of which, for obvious reasons, could not be performed in front of other

\textsuperscript{139} This schematic diagram of KEMH after the 1922 renovation was provided privately by Jennie and Bevan Carter.
\textsuperscript{140} See “King Edward Memorial Hospital”, \textit{Western Mail}, Friday 14 July, 1916, p.27 and “Helping the Babies: Work at King Edward Memorial Hospital”, \textit{Western Mail}, Thursday 24 May, 1928, p.3. Accessed via TROVE archive 27/03/2015.
‘waiting’ mothers. The focus on institutional policy and procedure at the expense of women’s own feelings and needs in childbirth is another reason why these early hospital environments fit the model of ‘surveillance rooms’. Some women may have preferred not to be moved during labour, to be left alone, not to be observed by others, not to be anaesthetised, but these were not aspects of the birthing process that were within a mother’s control.

Twilight Sleep: the lure of ‘painless’ childbirth

Sedation of the patient during labour was routine in most maternity hospitals from the 1920s onward, and the ‘twilight sleep’ method along with chloroform were used at KEMH from the very first months of its opening to the public.141 Indeed it is interesting to note that anaesthesia in labour was so routine at KEMH that its use was not even noted in the delivery casebook during the period 1916-1931.142 Twilight sleep had been regularly used in private practice in Perth from the early 1910s, though its use in hospitals seems to have been limited before the establishment of KEMH.143 In 1916 the Sunday Times ran a series of promotional articles on the drug and suggestions that a ‘twilight sleep hospital’ should be established in Perth were put forward by the newspaper.144 The West Australian responded to this by emphasising the fact that KEMH was already using the method and insisted that its employment would be ‘greatly increased’ once a resident medical officer was employed.145 From this time on, it appears that the use of twilight sleep for all first time mothers became a matter of routine at KEMH and this policy continued well into the 1940s.146 Indeed a 1941 Sunday Times article insisted that ‘where once it was optional, merciful “twilight sleep” as an

142 The use of chloroform is occasionally recorded, but only if it was used in connection with the use of forceps. For example see KEMH Casebook July 1916 - May 1931, p. 21/1/1920-10/03/1920.
145 See “News and Notes”, The West Australian, Friday 6 October, 1916, p.6
146 This is noted in many newspaper articles promoting the hospital during the 1920s, 30s and 40s. See for example “For Mothers and Babies”, The West Australian, Friday 30 March, 1923, p.6; “Perth Hospital’s Fine Record”, The Advertiser, Saturday 26 January, 1935, p.15 and “Baby Mix-up ‘Impossible’ at K.E.M.H.”, The West Australian, Tuesday 18 October, 1949, p.11.
aid to childbirth, is now administered to all patients at the King Edward Maternity Hospital, unless expressly stipulated otherwise’.147

In theory, the appeal of twilight sleep was in the drug’s ability to erase the memory of the birth for the mother while rendering the patient completely conscious and able to respond to the commands of the doctor and nurses. In the words of Mary Boyd, an American pro-twilight sleep campaigner active in the 1910s, the drugs ‘raise the function of childbirth from a gross and primitive physical agony to a normal, unimpeded, muscular process which can be entirely directed by the obstetrician’.148 The drug was popular in hospitals internationally during the 1910s and 1920s because it allowed for the promotion of ‘painless childbirth’. Births under the effect of twilight sleep were ‘painless’ to the extent that all memory of the birth had been erased for the mother.149 Australian medical literature for this period makes little reference to twilight sleep, though it is clear that medical attitudes to the drug varied widely. At the same time as twilight sleep was being administered to mothers at KEMH and was in widespread use in private obstetric practice in WA, some medical authorities were talking of the drugs as a ‘so-called advance’ and a source of medical ‘charlatanry’.150 Despite this, there was no widespread condemnation of twilight sleep by Australia’s medical fraternity and its use continued in Australia well into the 1940s.

While there is limited material which shines a light on women’s own personal experiences under the effects of twilight sleep, some general observations on its use in the hospital context during the 1910s, 20s, and 30s can be made. According to early promotional material, the particular combination of scopolamine and morphine which constituted twilight sleep produced in the mother ‘a sense of drowsiness’, ‘a pleasant feeling of don’t-care-ness’ and

147 “‘Twilight Sleep’ at King Edward”, Sunday Times, Sunday 2 March, 1941, p.8. See also matron of KEMH Agnes Walsh’s response to a correspondent to The Daily News in “They have ‘twilight’”, The Daily News, Friday 2 April, 1948, p.2. Access via TROVE archive 12/05/2014.
149 Rion, Painless Childbirth in Twilight Sleep, p.16. See also Leavitt, “Birthing and Anesthesia”, p.149.
eventually ‘overpowering sleepiness’.

For observers and attendants, the effect of the drugs on the mother were somewhat different for, as historian Judith Walzer Leavitt describes it, ‘women’s bodies experienced their labors, even if their minds did not remember them’. Witnesses to twilight sleep births saw ‘women screaming in pain during contractions, thrashing about, and giving all the outward signs of “acute suffering”’. Yet as journalist Hannah Rion, author of a 1915 promotional book on twilight sleep, suggests:

> it will be found after the birth is over that [the patient] has retained no memory whatever of the events which have taken place since the injections began to take effect. In other words, the drugs have obliterated memory for the time being...

In addition, and more importantly, the mother who was given twilight sleep was cooperative with hospital staff and obeyed the doctors and nurses. As Rion notes:

> the most remarkable quality of this narcotic is that whilst the mother retains her normal muscular functions, and is in such possession of her mental faculties that she can obey the doctor’s and nurse’s requests – can, in fact, co-operate in the entire birth process, she afterward retains no memory of what she has done or of what has occurred...

The level of control which the use of twilight sleep gave obstetricians during childbirth was one of the drug’s great appeals for medical professionals. In theory, the treatment gave the physician ‘complete control of everything’ including ‘absolute control over your patient at all stages of the game’.

The amnesia associated with twilight sleep allowed doctors and nurses to treat patients in ways which would have been unacceptable had the women been fully conscious. In some American hospitals, patients under the effects of twilight sleep were placed in specially designed crib beds which restricted their movements and from where all outside noise and light could be eliminated. Some patients were dressed in a ‘continuous sleeve’ vest which limited their physical movements and prevented them from interfering with the sterile

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151 These descriptions of the effects of twilight sleep come from Rion’s *Painless Childbirth in Twilight Sleep* (1915) which strongly promoted the continued use of the method. See Rion, *Painless Childbirth in Twilight Sleep*, p.15.

152 Leavitt, “Birthing and Anesthesia”, p.149.

153 Rion, *Painless Childbirth in Twilight Sleep*, p.16.

154 Misson notes that all types of anaesthesia and sedation had this ‘beneficial’ effect of making the patient more compliant at the birth. See Misson, “Mentioning the Unmentionable”, p.138.

155 Rion, *Painless Childbirth in Twilight Sleep*, p.16.

environment. Despite the fact that twilight sleep theoretically gave obstetricians more control over their patients, in practice some women under the effects of the drugs became difficult to manage and the forced limitation of their movements was deemed necessary by hospital staff. Indeed, Agnes Walsh reported in her autobiography that women who had been given twilight sleep at KEMH were sometimes hard to control and were often getting out of their beds during labour. Some women who had been administered ‘hyacine’ (an alternative to scopolamine) had hallucinations and imaginary conversations.

Reports from employees of other Australian maternity hospitals using twilight sleep during the 1930s confirm that patients were difficult to manage while under the effects of the drugs. At the Royal Women’s Hospital Melbourne, mothers who had been administered with twilight sleep were often found ‘crawling around the floor’. One woman interviewed by Misson, reported being picked up from a hospital corridor the day after the birth of her baby, still in a dazed state after the effects of the anaesthesia administered by doctors. Indeed, the suggestion that combining scopolamine and morphine was dangerous to patient health was put forward as early as 1921 in the *Medical Journal of Australia* where a doctor reported that three of this patients had stayed asleep for 24 hours after being administered the drugs. Some women claimed to have been unconscious or dazed for as long as 48 hours after the birth of their baby with many women being unaware of the existence of the child for 2 to 3 days.

Women under the effects of twilight sleep generally retained no memory of these events or the birth itself and for many mothers this amnesia was a blessing. While this conflicts with modern-day childbirth philosophies which emphasise the importance of women’s conscious autonomy and control over the birthing process, in the past the sanctioned use of pain-relieving drugs during labour may have allowed women to possess for themselves what they

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159 This was reported by Jean Crameri, deputy matron of the Royal Women’s Hospital during the 1930s. Jean Crameri, cited in Misson, “Mentioning the Unmentionable”, p.138.
160 Misson, Protected and Directed, p.106.
161 “Minutes of the meeting of the NSW branch of the British Medical Association”, *MJA*, June 1921, p.491.
162 Misson, Protected and Directed, p.106.
163 Rion quotes many instances of twilight sleep mothers retaining no memory of the birth of their babies and subsequently expressing great relief that the birth was completed without their knowledge. See Rion, *Painless Childbirth in Twilight Sleep*, pp.25-41.
perceived as a degree of control over childbirth which they had never before experienced. As Leavitt notes in relation to the popularity of twilight sleep amongst women:

Although women were out of control during twilight sleep births...this loss of control was less important to them than their determination to control the decision about what kind of labor and delivery they would have.\textsuperscript{164}

Despite what is now known about the dangers of twilight sleep, the method was very popular with mothers internationally during its early usage in the 1910s and 1920s. Many women in both Europe and the US campaigned for the approach to be offered to all mothers during childbirth and their efforts spawned a national movement in the US resulting in the formation of the National Twilight Sleep Association.\textsuperscript{165} In this way, the twilight sleep movement and the method’s attractiveness to women generally during the early decades of the twentieth century shares something in common with other great shifts in birthing philosophy such as the modern re-popularising of home birth.

There was no equivalent of the National Twilight Sleep Association formed in WA during this period; however many mothers in Perth, particularly those accessing KEMH and the other maternity hospitals, had the expectation that the drugs should be made available to them during childbirth.\textsuperscript{166} While the administration of twilight sleep at KEMH was supposed to be free and, from the 1940s, available to \textit{all} mothers, there were some women who missed out. In 1946, a series of letters to \textit{The Daily News} complained of a lack of care at KEMH, including the withholding of twilight sleep from mothers.\textsuperscript{167} The editor of the newspaper took it upon himself to investigate the issue and upon speaking to some of the KEMH nursing staff found that ‘seldom is twilight sleep given to public patients’.\textsuperscript{168} This was in direct opposition to the stance put by the hospital’s then matron Agnes Walsh who had insisted on more than one occasion that all mothers at the hospital were administered with twilight sleep, regardless of their status.\textsuperscript{169} The problem persisted however. In 1948, another correspondent to \textit{The

\textsuperscript{165} Leavitt, “Birthing and Anesthesia”, p.153.
\textsuperscript{166} One woman even asked that twilight sleep be subsidised by the government to promote painless childbirth and increase the birth rate. See “New Deal Suggested for Large Families on Small Incomes”, \textit{Sunday Times}, Sunday 9 April, 1944, p.5. Accessed via TROVE archive, 12/05/2014.
\textsuperscript{168} “Opinion: KEMH Complaint”, \textit{The Daily News}, Friday 30 August, 1946, p.4.
\textsuperscript{169} Quotes from Matron Walsh about the use of twilight sleep at the hospital appear regularly. See for example “Woman’s Realm: Maternal Health”, \textit{The West Australian}, Thursday 23 May, 1935, p.6; “Opinion. KEMH
Daily News was frustrated that she did not receive twilight sleep while having her baby at KEMH:

This makes the clinic scheme second-rate. Rather than risk repeating my experience, I would find £20 to cover costs of private hospital another time.170

Material such as this highlights the significant role that women themselves played in agitating for universal access to anaesthesia during childbirth both in WA and internationally. Analysis of birthing practices during this period shows that women were, in many cases, actively requesting the use of anaesthesia during childbirth.171 Indeed, anaesthesia was an important aspect of the ‘Safety Model’ of childbirth to which the majority of women now subscribed. Childbirth in a hospital, under the management of a team of medical professionals, was merely ‘what you did’ and the administration of anaesthesia was part of this ‘safe’ process.172 Thus, many women giving birth in Perth’s hospitals during this period had an expectation that some form of anaesthesia would be available to them and the perceived withholding of this pain relief was seen by some as being unjust and worthy of complaint.

Despite this it must be emphasised that in most cases, women giving birth in Australian hospitals during the first half of the twentieth century were not consulted about their personal preferences for pain relief. These decisions remained entirely with the medical professionals who managed the birth. Choice in the use of anaesthesia as it might be understood by modern day consumers of maternity care, did not exist in the same way for women giving birth during the early twentieth century in maternity hospitals. Women’s understanding of childbirth itself and their own ‘control’ over the process as it unfolded was so limited as to make notions of ‘choice’ somewhat irrelevant. For example, the use of twilight sleep at KEMH was initially reserved for first time mothers only, highlighting one of the ways in which women’s own perceived ‘control’ over their birthing experience could be quickly usurped by the obstetrician. Over the years, the use of twilight sleep at KEMH became routine for all births, at least in theory, again highlighting how women’s ‘choice’ about the use of anaesthesia during childbirth was significantly limited by hospital policy. What this example demonstrates is that, depending on the period in which a birth took place at KEMH,

172 Misson, Protected and Directed, p.102.
women who actively wanted a twilight sleep birth may not have been able to access one, while women who would have preferred to remain aware during the birth of their baby may have had anaesthesia forced on them in the name of hospital policy.

Mothers’ attitudes to doctors: ‘a superior race of people’

To understand fully women’s acceptance and enthusiasm for hospital birthing, it is important to examine how mothers related to medical practitioners. By the 1930s, the authority of doctors and nurses over the processes of childbirth was almost universally taken for granted and their decisions generally went unquestioned by patients. During this time, women were socially conditioned not to question the knowledge or actions of hospital staff, despite their own personal desires. For example, despite being a doctor herself, Effie Hone did not ask what drugs were being used during the deliveries of her four children in Perth’s private hospitals during the 1930s. The role of the doctor and the patient was so clearly defined that Hone believed as the patient it was ‘not her business’ to enquire. Oral history projects conducted during the 1980s show that this attitude to the use of anaesthesia and other drugs during labour was common amongst women giving birth in Australian maternity hospitals during the 1920s and 1930s. As one Victorian woman interviewed in 1986 about her childbirth experiences stated, ‘I was given anaesthetics. I don’t know why. I didn’t make any enquiries it just seemed to be the procedure.’

This complete acceptance of hospital policies was driven in part by women’s almost universal reverence for the role of the doctor as manager of the birthing process. This outlook was a reflection of societal attitudes generally and was influenced by the perception of medical practitioners as ‘a superior race of people’ who possessed highly important knowledge which was inaccessible to the lay person. Obstetricians rarely shared any of this information with patients, compounding women’s lack of understanding about childbirth and reinforcing their compliance in the hospital setting. Ironically, this refusal to provide information to women did not translate to a distrust of doctors but:

177 This interviewee is cited in Pyke, “‘But nothing interesting ever happened to us’”, p.56.
178 Misson, Protected and Directed, pp.92, 100.
greatly enhanced their image as supermen who held the keys to life and death and threw into high relief crumbs that were offered by more forthcoming doctors from time to time.  

In relation to her doctor who managed the birth of her daughter in a Victorian hospital in 1936, one woman noted that:

> he never enlightened me, he didn’t tell me one little thing…He’d say ‘You’re doing fine, come in another four weeks’, but there was no discussion, no friendliness, he was an aloof professional man, I accepted he was a brilliant man.

Women of the time, ‘held the doctor in awe’ and received any advice he did offer ‘as Gospel’. Within this context, women accepted the complex and intrusive array of procedures and interventions which were administered to them in the hospital as being part of a process of which they knew very little and which was managed by professionals they implicitly trusted. The criteria for successful motherhood as projected by the maternity hospital required that women not ‘make a fuss’ during childbirth and that patients must subvert their own needs and prioritise the needs of medical staff. Women of the time absorbed this message wholeheartedly and understood hospital processes as being modern and safe. As Misson notes, the childbirth process at this time was ‘[m]ysterious, scientific, embodied in large and well-established institutions [and] promoted by printed texts, the system became ‘what you did’ and no one questioned it’.

Despite this, some other aspects of hospital procedure in Australia during the 1920s and 30s did surprise patients. The shaving of pubic hair before the birth was a great shock to many women, with some expressing their horror about this experience many years later. In some cases, patients also needed to conform to the doctors’ and nurses’ expectations in their behavior during labour, keeping strong feelings to a minimum and never expressing dissatisfaction with the process. The removal of babies from their mothers shortly after the birth was considered best practice in these early twentieth century maternity hospitals, particularly if the baby were ill. Women were seldom informed about their baby’s progress.

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177 Misson, Protected and Directed, p.99.
178 Mrs Brennan, cited in Misson, Protected and Directed, p.91.
179 Misson, Protected and Directed, pp.99-100.
180 Misson, Protected and Directed, p.93.
181 Misson, Protected and Directed, p.102.
182 A number of interviewees from Pyke’s study mentioned the shaving of pubic hair. See Pyke, “‘But nothing interesting ever happened to us’”, p.60.
183 See Pyke, “‘But nothing interesting ever happened to us’”, p.60.
One Victorian woman, who had been administered with twilight sleep and whose baby had had difficulty breathing as a result, did not see her child for 48 hours after the birth. While she did ‘wonder’ where the baby was, she never thought to ask the nursing staff: ‘they didn’t tell you anything, you were there and you just did what they told you’.184

For some women, the abdication of control and autonomy to the medical staff at the hospital was a relief from their daily responsibilities. Frances Shea, a well-off woman who had a son at a private Fremantle hospital in 1938, recalled that she ‘thoroughly enjoyed’ her time in the hospital, noting ‘that was my holiday…I always had someone nice in the ward…and we really had good fun’.185 Other women also remember the efforts of the nurses and staff in a positive light:

They looked after you, I don’t remember any problems or worries…you took their advice and everything was alright.186

[N]urses at the hospital were very good, and they told you what to do and if you did the right thing you made it all the easier for yourself.187

Reflections such as these, along with women’s support and enthusiasm for the use of anaesthetics and amnesia-inducing drugs during labour, demonstrate how complex and multifaceted women’s own feelings about their hospital experiences could be. They also highlight the way in which contemporary notions of ‘control’ and ‘choice’ in childbirth cannot easily be transposed onto this earlier period in history. It appears that for many women giving birth in the early twentieth century, the feeling of being ‘in control’ of their childbirth experience was of limited importance.

While it will never be possible to determine each woman’s individual experience of birthing in early twentieth century maternity hospitals, the pursuit of this knowledge is vitally important nonetheless. The information gleaned from items like the KEMH casebook, along with the material found in newspaper articles and interviews with child-bearing women, highlight the great variety of potential experiences which mothers could have had in these maternity hospitals. Women in Perth and elsewhere actively campaigned for the

184 This interviewee is cited in Pyke, “‘But nothing interesting ever happened to us’”, p.60.
186 Cited in Pyke, “‘But nothing interesting ever happened to us’”, p.60.
187 Cited in Pyke, “‘But nothing interesting ever happened to us’”, p.56.
establishment of maternity hospitals such as KEMH and they faced significant opposition from governments in doing so. The culture of institutionalised childbirth was not uniformly accepted or promoted by health department officials or members of parliament in WA during the 1910s and 20s and the expectation that existing maternity services were sufficient was a barrier to the establishment of government funded maternity hospitals during the early years of the twentieth century. Once maternity hospitals were established, women’s personal experiences in them are hard to accurately determine. In the revisionist tradition of the 1970s and 80s, these early twentieth century institutions were almost uniformly represented as oppressive and dangerous to women and babies, and elements of this portrayal certainly ring true in this analysis of Perth’s early maternity hospitals. However women’s own enthusiasm for certain aspects of the hospital experience – the access to anaesthesia, the potential to forget the birth entirely and the break from the cares of home life – all hint at another, more complex narrative.
Chapter 7
Conclusions: Linking the Past to the Present

The primary goal of this research has been to bring to light a number of aspects of Western Australia’s experiences of maternity service provision from the beginning of European colonisation to 1950. There are currently a number of gaps in the historical literature related to childbirth in Australia and this study seeks to fill one of them through an analysis of the unique Western Australian experience. Bringing to light the hitherto unwritten history of WA’s birthing services is an important contribution to broader understandings of Australia’s childbirth history. While exploring this material has been vital, this research has also highlighted a number of supplementary themes which have significant relevance in the contemporary context. In this way, the empirical study focusing on Western Australia has been a vehicle for exploring more universal themes related to childbirth location, to choice in childbirth and to the process of history writing itself.

This research has adopted a post-revisionist approach to childbirth history which has necessitated a focus on the voices of women, both midwives as service providers and mothers as recipients of that service. As a post-revisionist study, this work seeks to rebut traditional criticisms of empirically-trained midwives and aims to reposition the home historically as an important, safe and worthwhile birthing space for women in the past. This has necessitated a review of revisionist approaches themselves to highlight the many ways in which women in the past helped to bring about the increasing medicalisation of birthing practices. Mothers’ relationships to childbirth, their attitudes to medical-men and midwives as well as their reactions to birthing spaces have all been shown to be complex and multifaceted. In many respects, women’s attitudes to childbirth in the past have reflected an ambiguity which has challenged contemporary understandings of the importance of the childbirth event.

The location of birth, and how this changed over time, has been shown to have significantly altered women’s personal experiences of birth in the past. Linked to this theme of birth location is the notion of women’s choices in childbirth. This study has problematised the idea of ‘choice’ by highlighting the various ways in which women’s decisions around childbirth in the past were dictated to them by their socioeconomic position and geographic location. Overlying these factors was the important role of the medical profession and the state in
determining what services would be available to child-bearing women and importantly, who would deliver those services. Most women were not able to choose where they gave birth or who would attend them during this time because these aspects of the birthing process were, in many cases, predetermined by factors beyond mothers’ control.

Both the issue of birthing location and the problematic notion of ‘choice’ highlight the challenges of transposing some aspects of existing contemporary understandings of childbirth into the historical narrative. One part of this is that choices themselves are difficult to see from an historical distance. While ‘choice’ in childbirth was no doubt a reality for some women, it is almost impossible to see these choices in the historical sources. The notion of choice is further undermined here by the recognition that early twentieth century mothers did not prioritise choices in childbirth in the same way that modern women often do. Being ‘in control’ of the birth and feeling personally empowered were not necessarily concepts which these women recognised as relevant to their experience. Similarly, the changing location of birth, the transition from the ‘sanctuary’ of the home to the ‘surveillance room’ of the hospital, cannot be understood in simple binary terms. In the modern era, the repopularisation of home birthing along with the contemporary focus on the importance of particular birthing spaces to the wellbeing of mother and baby have refocused attention on birth location. However, the birthing spaces of the past and how women felt about them highlight an underlying ambiguity in the narrative of birthing location change which resists historical analysis. While it is possible to identify the ‘sanctuaries’ or ‘surveillance rooms’ of the past, it is much more difficult to understand women’s reactions to these spaces.

The final theme explored in this study of Western Australian maternity services has been the seeking out of the ‘normal’ birth in the historical sources. This has been a challenging exercise, primarily because most of the material related to childbirth in the past is a record of the abnormal. A significant proportion of the primary sources on childbirth have been created by medical-men, a group which invested heavily in establishing birth as a pathological event which required medical, rather than midwifery, expertise. Despite its absence from the historical record, the existence of the normal birth is unquestionable. A lack of records which describe normal birthing does not suggest that all births were traumatic or deadly; in fact, it is self-evident that the majority of births were normal and very much a part of everyday life. In the context of this research, it has been important to emphasise the normal in birthing through a rebuttal of the negative representations of empirically-trained midwives and through the use
of sources which have made it possible to describe a normal birth at home in the colonial period.

**Reviewing the Revisionist Narrative**

The processes of reproduction, including the act of birthing, are in one sense purely biological in nature. Women are inherently linked to these processes as only their physiological make up allows for the development and birth of babies. In this sense then, childbirth is inherently ‘natural’, a process which allows for the survival of the human race. Yet childbirth is also quite obviously social in nature; it is both a biological and cultural undertaking which is of great interest to writers and researchers and of lasting social significance. As Oakley notes:

> reproduction is a cultural activity: it has far-reaching consequences for the life of a society. Particular childbirths create or break families, establish the ownership of property and entitlements to poverty or privilege; they may alter the statuses, rights and responsibilities of persons, communities and nations.

The importance of childbirth as a cultural as well as a biological activity necessitates the recognition of women as central players in this area of historical writing. Women ‘personify the union of nature (biological reproducer) and culture (social person) directly’ and are thus the true and rightful focus of childbirth.

This acknowledgement of women as both reproducers of the human race and social persons with desires, needs and emotions drives the pursuit of a revisionist historical narrative for childbirth, one which will bring women’s voices to the forefront and highlight the injustices of the past. It was not so long ago that childbirth, in the hands of male medical professionals, was reduced to a purely biological exercise. Informed by sexist and patriarchal understandings which subordinated women’s knowledge of their own bodies to the ‘scientific’ knowledge of the medical profession, male obstetricians developed childbirth processes which effectively by passed mothers and turned childbirth into a surgical procedure. Nowhere is this more clearly illustrated than in the work of American obstetrician Jospeh B. DeLee who developed and carried out the Prophylactic Forceps Operation on many

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women at the Chicago Lying-In Hospital during the 1910s and 20s. DeLee’s approach necessitated giving the patient a number of different anaesthetic agents in succession over the first and second stages of labour. First, a modified twilight sleep was given which was sometimes followed by the rectal administration of chloral (a sedative and hypnotic drug) and sodium bromide. When the baby’s head had descended and was minutes from being born, ether was given to the patient and she was rendered unconscious. An episiotomy – a cut in the perineum designed to enlarge the opening of the vagina – was then performed and forceps completed the delivery of the baby. A number of injections were then administered to the mother before the placenta was manually removed.\(^4\) The final stage is described here by DeLee:

The woman is now given ¼ grain of morphine and gr.1/200 of scopolamine to reduce the amount of ether required for the repair work, to prolong the narcosis for many hours postpartum, and to abolish the memory of the labor as much as possible.\(^5\)

The description of the stitching up of the mother’s damaged perineum as ‘repair work’ and the desire to ‘prolong narcosis’ and ‘abolish’ her memories of the event all speak volumes about the attitude many medical-men had to women and their bodies during the early twentieth century. Many physicians of this period held their female patients in low regard, constructing the female body as a broken machine in need of ‘repair’. At the same time, doctors represented childbirth as terrifying and painful, thus reinforcing its apparent pathology and the need for medical intervention in the process. As Oakley notes:

through its ideological construction of the uterus as the controlling organ of womanhood, [the medical profession] effectively demoted reproduction as woman’s unique achievement to the status of a pitiable handicap. Such a construction presented women essentially as reproductive machines, subject to a direct biological input. It enabled physicians to assert a role in the mechanical management of female disorder, thus justifying the particular techniques of drastic gynaecological surgery and obstetrical intervention, and therefore establishing the ‘need’ for male medical ascendency over the whole domain of reproductive care.\(^6\)

While this overtly mechanistic approach to childbirth is no longer so obviously present in modern maternity care, medical approaches to childbirth still emphasise the technological and ‘scientific’ aspects of birthing. Indeed, in the modern era our own understandings of our

bodies are such that the medical mechanistic approach to ‘machine management’ has become natural and unquestioned. As Rothman suggests:

[w]e treat our bodies as machines, hooking them up to other machines, monitoring and managing bodily functions. When a doctor manages a woman’s labor, controlling her body with drugs and even surgery, it is to make her labor more efficient, predictable, rational.\(^7\)

Murphy-Lawless points out that one of the great strengths of traditional and pre-obstetric approaches to childbirth is their ability to encompass the physical, emotional and spiritual aspects of birthing as they pertain to mothers, something that modern medicine fails to do.\(^8\)

Medicine today relates to women and childbirth in a way which emphasises the physical and downplays the importance of the emotional, psychological and social. ‘Success’ in childbirth is determined by quantitative measures and ignores the very real issue of quality of life for mother and baby.\(^9\)

Through the long history of childbirth medicalisation, medical dictates which define the ‘right’ way for childbirth to proceed have become ubiquitous and appear ideologically neutral. However, as Oakley so accurately describes, ‘in becoming a repository of ‘knowledge’ about reproduction, medical science is not some kind of ultimate truth. It hides an ideological face’.\(^10\) One measure of this is the way in which medicalised approaches to birthing seek to separate the act of childbirth from its social and cultural implications. As Rothman notes:

people often think that biology is beyond culture, beyond ideology. The “mechanism” of contraception, the “mechanics” of labour, the “programming” of genetic development – these things are often seen as simple biological givens with which we must cope. But remember, that is the nature of ideology: the constructs look like common sense, the ideas are obvious, the descriptions are simply how things are, “naturally”.\(^11\)

Medicine is often so effective at achieving this separation of childbirth from its social and cultural aspects because it represents itself as having achieved the ultimate in obstetric science: the ability to predict and prevent death in childbirth. Murphy-Lawless highlights this

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when she questions the ways obstetrics has represented its approach to birthing as purely scientific and rational. Within society medical expectations around how childbirth should be managed are represented as being the result of an accumulation of scientific knowledge and obstetric understandings are therefore considered to be a true reflection of ‘the world as it is’. In this way, obstetrics seeks to justify its place as the sole manager of childbirth by asserting that its seemingly scientific approach is rationally superior to non-scientific or traditional approaches. Importantly, obstetrics:

“does not present itself to the larger community as a human activity that is as much subject to competing local agendas, irate concerns, and a desire to control as other human undertakings. Rather obstetrics argues that its power to determine what ought to be done in childbirth is founded on its authority as a form of scientific rationality and it is not amenable to accepting as expert any voice from outside that community.”

In the contemporary context when women question obstetric power by seeking alternatives or challenging obstetric personnel the spectre of women’s ‘threatened destiny’ materialises. As Murphy-Lawless writes:

“irrational response[s] emerge... pretty rapidly whenever we query obstetrics and it always turns on the same issue, the risk of death in childbirth whether to woman or baby. Despite the fact that we have become increasingly incisive in the way we challenge obstetrics, its reaction to us, that we do not sufficiently comprehend the threat of death which hangs over us, remains unchanged.”

Such pressures are incredibly effective at limiting women’s own agency within the context of birthing. However, the apparent desire and need to ‘rescue women from death’ – a remit which obstetrics reserves solely for itself – is really a reflection of a broader fear that women may seek to regain control of their own birthing. These contemporary understandings of how medical ideology operates in modern maternity care have their roots in history, highlighting how essential it has become to revise traditional historical representations of childbirth. Through historical analyses of childbirth in the past, the cultural and social significance of this event can be explored with women at the centre of the narrative.

For most of the last two hundred years, the approaches and qualities of traditional empiricist midwives, representatives of a much more traditional and social approach to birthing, have

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12 Murphy-Lawless, Reading Birth and Death, p.17.
13 Murphy-Lawless, Reading Birth and Death, p.17.
14 Murphy-Lawless, Reading Birth and Death, p.17.
15 Murphy-Lawless, Reading Birth and Death, p.19.
been denigrated by childbirth historians, many of whom were themselves integrally linked to
the medical profession. The repression of midwifery as an independent profession and the
concurrent rise of obstetricians has, until recently, been represented by writers and
researchers as a universal good for childbearing women; a phenomenon to be accepted; a
narrative to be repeated and regurgitated for decades. Revisionist historians working from the
1970s onwards have exposed many of the misrepresentations and manipulations of the
medical profession, pointing out among other things that independent empirically-trained
midwives were, in many instances, competent and appropriate managers of childbirth in the
past. This history of Western Australia’s maternity services supports this position and argues
that if midwives at their worst were ignorant and dangerous, so too were many of the
medical-men working in midwifery in the past. During colonial times, WA’s medical-men
were not well trained in the specialist field of midwifery and there is no evidence to suggest
that they provided a better or safer service than empirically-trained midwives. Nor does the
historical record, as it relates to WA, suggest that maternity hospital services were safer for
mothers and babies than birthing at home. Records dating from the 1910s show the true
nature of early hospital services such as KEMH, which was, by the admission of a long
serving matron of that institution, ‘a shocking place’. As such, the focus of historical debate
should justifiably now be shifted onto a critical examination of the quality of services
provided by doctors and research should be conducted into the power structures at play
during a time when obstetric technology was developed and introduced into routine use
before its efficacy could be properly tested.

One of the key points to emerge from this analysis of WA’s maternity services is that both
common and revisionist ideas about midwives, women, mothers and childbirth in the past are
oversimplified. What the Western Australian material shows, somewhat strangely for those
conversant in modern-day debates on childbirth politics, is that women in the past were at the
forefront of the initial efforts to institutionalise birthing in this state. As the history of KEMH
demonstrates, not all maternity hospitals were the domain of male medical doctors and not all
women experienced the hospital setting as repressive and frightening. Some women actively
campaigned for more interventionist approaches to birth including the universal availability
of anaesthetics during labour. The ability to completely forget the birth, to experience a
‘painless’ birth through access to drugs like twilight sleep was empowering for some women,
and represented a significant leap forward in how childbirth was managed. While these
factors challenge the accepted revisionist narrative which stresses the role of the medical
profession in subverting childbirth from a normal, natural event into a highly medicalised operation, they remain very important to a full and complete understanding of childbirth in times gone by. In the past just as now, how women conceptualised the childbirth process and how they understood their own relationship to it was complex and contradictory.

Revisionist historians as well as writers involved in the debates around modern-day childbirth politics have long emphasised the importance of recording and truly hearing women’s own reactions to the childbirth event, thus illustrating the social and cultural facets of birthing which medicine ignores. Yet these efforts to record and understand women’s experiences, at least from an historical perspective, have often encountered unforeseen challenges. As the work of Anne Misson shows, women giving birth in the early part of the twentieth century, when given the opportunity to discuss their experiences, were unable or unwilling to fully explain their emotional and psychological reaction to childbirth. Some were anaesthetised and thus unable to remember their experience; others, influenced by nineteenth century taboos, were unwilling to discuss reproduction at all. Most importantly, Misson found that the underlying assumptions of revisionist writers and childbirth reformers came into direct conflict with the attitudes of those she interviewed. Unlike contemporary mothers, women giving birth during this earlier period were not overly focused on the childbirth event itself and their representations of it seem to undermine its presumed value as a life-changing event.\(^\text{16}\) Through their perceived acquiescence to the medical dictates of the time, mothers of the early twentieth century appear to have accepted childbirth as a purely biological event, without social or cultural meaning.

It is unclear what historians should make of this challenge to the underlying framework of revisionist theories. Certainly it cannot simply be ignored. It is undeniable that women’s attitudes to childbirth during the early twentieth century were heavily influenced by patriarchal medical ideologies. Women’s attachment to the ‘Safety Model’, their implicit trust in the knowledge and skills of medical professionals, as well the dominance of a male-orientated ideology in political and economic life, worked to limit women’s views of themselves. Motherhood was all-important and yet the events which made motherhood possible were of limited concern. Just as in many other aspects of daily life, women of the

early twentieth century had learned to subjugate their own needs and feelings to that of a higher authority which claimed to possess specialised knowledge and which, so it seemed, had their best interests at heart. Yet the claim that mothers were simply tricked into accepting a system which, in many cases, worked to dehumanise childbirth and subjugate women is ultimately unsatisfying. Nor is the idea that women had a significant degree of control over the direction and ideology of medicalised approaches to childbirth supported by evidence. Mothers were clearly not in control of any aspect of the birthing of their own babies in early twentieth century maternity hospitals and yet broadly speaking, they failed to object to their treatment there. Women were obviously at the bottom of an institutionalised hierarchy which prioritised the practical needs of medical staff and emphasised the ‘correctness’ of technological intervention in childbirth, yet few women resisted these impositions. It is important to understand more fully these seeming contradictions in the historical narrative of childbirth. Women’s unique contribution to childbirth medicalisation must now form a more significant part of the revisionist story.

Childbirth location in the past: power structures at home and away

An analysis of how women interacted with and understood different childbirth locations in the past forms one of the central themes of this thesis. Over the period in question, WA women gave birth in one of three locations: in their own home, in a lying-in home (which could take a number of forms) or in a maternity hospital. Understanding and assessing women’s experiences of childbirth in these places is difficult and complicated, primarily because there is so little evidence which directly shows women’s reactions to different birthing locations in the past. Importantly also, it is challenging to both accurately describe as well as critically analyse mothers’ childbirth experiences. Nonetheless, I have attempted to do this here and the results have demonstrated that in the past women’s reactions to different birthing spaces, while difficult ever to understand or document completely, were certainly much more complex and multifaceted than may first be thought.

Using the contemporary analytical tools of ‘sanctum’ and ‘surveillance room’ as espoused by Fahy and Paratt, along with Goffman’s image of the ‘total institution’, it has been possible to reimagine the birthing spaces experienced by colonial and early twentieth century women and

come to a better understanding of the power structures at play in various childbirth locations in the past. While these modern conceptions of childbirth locations are useful, they can never give a full picture of how women experienced different birthing places in the past. Firstly, many women never ‘chose’ to give birth in a particular location but simply followed the expectations and limitations imposed on them by their socioeconomic or geographic situation. Thus women in colonial times did not ‘choose’ to give birth at home as contemporary women might do, but saw their home as the obvious and only location in which to give birth. Perhaps more importantly, modern understandings of childbirth practices which emphasise the great significance of childbirth location to the wellbeing of the mother, are difficult to transpose into the historical narrative. Just as notions of ‘choice’ in childbirth are problematic when applied to the past, so too are understandings of the importance of childbirth location. From the contemporary perspective, when recounting history, it is of course essential to focus on the differences between childbirth locations of the past, highlighting women’s different experiences in each. However, it is not at all clear that the way these different spaces are conceptualised today would have had relevance to women in the past. During the period in question, the childbirth event was not the primary focus for many women, it was merely the inevitable process which led to the more important and identity-defining task of motherhood.

Despite these caveats, the rightful attention paid to childbirth location in modern debates on maternity care necessitates an analysis of birthing spaces in historical writing. I have argued that in the past, just as now, the home was a safe and supportive environment for childbirth and that this was the case in both midwife and doctor-managed births. It is possible, I believe, to imagine a woman’s home in the past as a ‘sanctum’ to her during childbirth. At home, women had access to their familiar personal items and were surrounded, in the main, by people they knew. Access to the outdoors, the ability to move around, familiar food and the inclusion of husbands during childbirth were all aspects of a woman’s potential experience in a home setting. These small considerations may seem irrelevant, but they come into sharp focus when compared to the hospital or lying-in home experience where women’s activities were limited in a variety of ways during childbirth and the period immediately after. Certainly there is no guarantee that women in the past experienced their homes as ‘sanctums’. During parturition the place of birth was part of a network of potential factors which were dictated to women by external expectations, socio-economic issues, and geographic location. Nevertheless, the unique relationship which women had and still have to their homes suggests
that this is a context in which women had the best chance of feeling supported at a psychological and emotional level during childbirth.

The importance of the home as a birthing location does not fit neatly into existing frameworks which explain women’s relationships to the domestic sphere. Feminist theorists have often positioned ‘the home’ as a source of women’s economic and political disenfranchisement. Women’s homes have been viewed as their prisons, as a limiting factor in women’s lives. Within this understanding, the exterior spaces, the world outside the home, is populated by men who are antagonistic to women’s entry into this external space, which itself represents all the sources of societal power. The expectation – imposed from the patriarchal outside – that women belong within the home, and that this is their natural place, has rightly been viewed with contempt by feminist theorists across time, and resisted by women themselves. As feminist historians Suzanne Mackenzie and Damaris Rose state:

[M]any women have challenged the “naturalization” of the domestic sphere as the place where they should reproduce labour-power in a form suitable for the continuance of capitalist production. Feminists have demonstrated that, for women in their domestic role, the ideal single-family home has always been primarily a workplace for their reproductive work, and often a very oppressive and isolating one, rather than a haven.18

Yet, as Mackenzie and Rose note, the internal space of the home has also been representative of safety and comfort for women, as an escape from the male dominated harshness of the external world. This contradictory and conflicting stance is illustrated by author Valerie Henitiuk:

Writers and readers have frequently been taught to consider the exterior, peopled by men, as hostile to the female half of the species, which helps to explain why women have tended to turn their attention to the interior, domestic sphere. Of course, the equation “home = refuge” does not preclude the simultaneous associations of the life-sentence that must be served there.19

Here Henitiuk reinforces the established idea of home as prison. In exchange for the home providing a refuge from the outside, women must serve a life-sentence on the inside, isolated and disempowered, limited and confined.

The particular circumstances created by the childbirth event subvert these ideas. In the past as much as now, birthing within the home provided women with an array of choices and a degree of control unknown to those birthing in the hospital during the same period and into the twentieth century. The childbirth event necessitated the entry of skilled assistance into a woman’s home, but significantly, these skilled individuals were invited in and as such lost a degree of their control. By operating within a woman’s home, and more specifically in a woman’s bedroom – a place which all present acknowledged as her domain – childbirth attendants had to adopt a more accommodating position when it came to making decisions during childbirth. This does not necessarily mean that birthing women were allowed or encouraged to make decisions themselves, although some certainly would have made their opinions known, but birthing in the home did require that the midwife or doctor attending had to clear decisions if not with the woman herself, with husbands, friends and relatives.

This contrasts sharply with how women may have experienced the lying-in home or maternity hospital setting where privacy was not guaranteed and where a patient’s movements could be restricted. In lying-in homes and hospitals women did not have free access to their personal items, had to eat unfamiliar food and were attended on by strangers. Decisions about childbirth in lying-in homes were determined by the relevant midwife or doctor, policies and rules dictated the running of such homes and mothers, as patients, were expected to comply. Indeed, the control dynamic explained above was inverted in the lying-in home context. In these places it was the midwife or doctor who had the power within the home and the mother, as patient, who was invited into the space. It was therefore the mother who needed to accommodate the wishes and needs of the attendants, the mother who abdicated some of her power to those who rightfully ‘owned’ the space.

This dynamic was even more evident in early maternity hospitals, where the veneer of ‘home’ was not present and there were many more patients to accommodate. The management of large numbers of people within these institutions necessitated the development of strict policies and rules which women as patients accepted. Just as today, maternity hospitals of the past were run for the convenience of nurses, midwives and doctors and were not designed to accommodate the personal needs and desires of patients. Childbirth approaches in such institutions were generally routinised and inflexible; women were unable to freely access the outdoors, could be confined to their beds, had only limited access to
relatives and friends and were surrounded by strangers throughout their stay. The recorded experiences of women in these early maternity hospitals demonstrates that the position of ‘patient’ was at the bottom of the institutionalised hierarchy and that, as such, mothers were expected to comply with midwives’ and doctors’ expectations of correct maternal behavior during their stay.

Just as homes of the past can be viewed as ‘sanctums’ for women during childbirth, it is possible to see other contemporary conceptualisations of birthing spaces in the historical material. The maternity hospital setting as it manifested itself during the 1910s, 20s and 30s reflected Fahy and Parratt’s negative image of the ‘surveillance room’. The immediate environment for birthing was undoubtedly a clinical one. Labour wards were separate to the lying-in or waiting wards and were set up to facilitate the implementation of routine anaesthetisation during labour. These spaces were thus equipped with the necessary instruments and technology needed to carry out a highly interventionist style of birthing and were physically very distinct from the bedrooms used for birthing at home. The physical spaces of the early maternity hospital were designed to optimise the convenience of birth attendants and facilitate the consistent observation of birthing women, again highlighting how these spaces reflected the model of a ‘surveillance room’. It is also possible to see the ‘total institution’ model at work in Perth’s charity lying-in home the House of Mercy. Women who were housed in the home were expected to commit to being there for six-months and as ‘fallen women’ were required to work in the institution’s laundry during their stay. Their personal possessions and money were taken away upon entry, their daily movements were managed by the supervisory staff and they had to obey strict rules which dictated expectations of their behavior during their time in the home. Mothers who lived at the home were identified as ‘inmates’ in need of moral retraining. These women were expected to reform their character and to emerge from their stay at the home as ‘good’ mothers and citizens.

While applying these contemporary models of different birthing locations is a useful exercise, it does not necessarily tell us how women at the time experienced these locations as birthing spaces. The ‘surveillance room’ of the early twentieth century maternity hospital may have in fact served as a ‘sanctuary’ for some women, an escape from the home which was, for most mothers, the site of hard, family-focused labour. Indeed, women’s experiences of birth were so varied and their attitudes so seemingly ambiguous that it is impossible to ascertain any
pattern in their reactions to these places as birthing locations, to the extent that their reactions were ever recorded. The available records consisting of the many interesting interviews conducted by researchers during the 1980s, suggest that women had a range of reactions to their encounters with the maternity hospital system. Some were enthusiastic about their experiences and grateful for the care of medical staff. Others were somewhat perplexed by what had happened to them at the hospital but appear to have acquiesced, seemingly with little complaint. A smaller group were more reflective and occasionally negative in their representations of their time as patients in maternity hospitals. These women were aware of feeling powerless and ignorant in the face of medical ‘expertise’ and questioned, to a limited extent, their treatment in these large, impersonal institutions.

The complex and multifaceted nature of women’s reactions to different birthing locations in the past suggests the need for further research into this area of historical study. Using sources in more creative ways, reading into silences and hunting out new potential sources of information on women’s experiences is vital to understanding the role of mothers in the story of childbirth. However, the voices of women during this period will always be difficult to hear. As Misson has noted, mothers giving birth during the early decades of the twentieth century did not have the language to communicate their experiences of childbirth and, as a result of their anaesthetised state, a good number of women were completely unable to remember what had happened to them. It is therefore refreshing to know that much valuable work is currently going on which seeks to record modern-day women’s encounters with childbirth, both through the recording of birth stories, but also through the analysis and recording of interactions between medical staff and mothers. Researchers of the future will have much less difficulty establishing what women of today wanted from their childbirth experiences and will have access to records which give a relatively unmediated view of how doctors and mothers interacted in the complex and fraught world of medicalised birthing.

The problem with choice

In the contemporary context, it has been acknowledged both at a clinical and social level that women have better childbirth experiences when they play a part in decision making. In many maternity hospitals internationally greater emphasis is currently being placed on women-centred care, which puts maternal decision-making at the forefront of efforts to improve women’s experiences of birthing. The importance placed on notions of choice in modern birthing practices highlights the need for an exploration of women’s childbirth choices in the past. This study has therefore sought to investigate the extent to which WA women had a role in decision-making in relation to childbirth, specifically with reference to childbirth location, childbirth attendant and the use of anaesthesia.

Choice, as a concept, is not something that easily transfers into retrospective analysis. Indeed, it could be argued that the decision to apply any modern understanding to representations of the past may be viewed with skepticism as this suggests an inattention to the challenges presented by the subjectivity of the historian. An historian’s current place in the world, their personal experiences, their understandings and biases are an inevitable part of the way history is researched and written. Even so, historians aim to avoid subjectivity in their research and writing and make every effort to remain ‘objective’ in their representations of past events. As Susan A. Crane writes:

> Historians pride themselves on their efforts to render the past legible in a responsible manner, and they realize that although they can never be completely “objective” in their accounts, they nonetheless value the sustained effort.

However, all historical writing is necessarily subjective and therefore brings baggage from the present into historical representations of the past. Indeed, this is unavoidable, for as Crane emphasises:

> Historical subjectivity begins with the individual scholar's perception of her connection to, and distance from, the past, and it is sustained through the historian's decision to make that perception integral to her scholarship. In other words, historical subjectivity is an expression of an individual's historical consciousness.

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24 Crane, “Historical Subjectivity”, p.434.
Modern understandings and discourses, such as that presented by the difficult idea of ‘choice’, still have a legitimate place in historical scholarship. Despite the challenges of reading individual choices into the primary material and the various ways in which women’s choices in childbirth in the past can be understood as problematic, the notion of ‘choice’ still remains relevant to this historical study because it informs both past and present understandings of decision making in childbirth. The inevitability of subjectivity in historical writing including the transfer of ideas from the contemporary context into historical narratives may seem confronting, but it speaks to some of the reasons history is written in the first place. If there is no place for the present in representations of the past, one may ask why such representations are relevant at all.

This analysis of past women’s childbirth choices has been hampered by a lack of material which shows women actively making choices about their maternity care. While individual women did have some choices about where they gave birth and who attended them, these choices are impossible to see clearly in the sources. An exploration of childbirth choices from an historical perspective has other problematic aspects too, for it is clear that even though some choices were available to some women in the past, these choices were always limited by socioeconomic and geographic factors as well as by socionormative expectations of what childbirth was and who should manage it. It therefore becomes difficult to understand women’s experiences of childbirth in the past with reference to their lack of choice as all possible choices were constrained by existing hierarchical and patriarchal social structures. As feminist author Meagan Tyler has claimed, for women in the modern context:

Yes, we make choices, but these are shaped and constrained by the unequal conditions in which we live. It would only make sense to uncritically celebrate choice in a post-patriarchal world.26

Consequently, women’s childbirth choices in the past, while relevant, cannot easily be understood within the contemporary discourses of choice in childbirth, particularly when the very legitimacy of the concept of ‘choice’ itself remains in question.

While making choices in childbirth is highly important to modern-day women there is much to suggest that being able to choose their childbirth experience was not something which women of the past necessarily valued. Women giving birth in WA in the colonial period and into the early decades of the twentieth century were not focused on ‘choice’ in childbirth as it is understood in the modern context. For these women, giving birth at home was not a choice, but was simply ‘what you did’. Even as birthing locations changed, women did not seem to support the provision of these new services with reference to ‘greater choice’ but saw them as positive and progressive steps toward ‘better’ and ‘safer’ birthing. Indeed, in the Australian context, the increasing medicalisation of childbirth led not to more choices for childbirth location but to the continued restriction of those choices through the normalisation of institutionalised birthing. Many women in the past understood childbirth merely as a pathway to motherhood, an inevitable part of life over which they had little or no control. Within this context, choice may become somewhat irrelevant.

Despite the difficulties associated with any study which seeks to understand and analyse women’s choices in the past, such efforts have great relevance in the modern context. Notions of ‘choice’ in contemporary society are always problematic for women. In the modern reimagining of traditional feminism, ‘choice’ is king and yet as Miranda Kiraly and Meagan Tyler highlight, this overemphasis on women’s supposed ‘choices’:

strips women’s lives of context and makes it sound as though our ‘choices’ are made in a political and cultural vacuum... there can be no freedom, no liberation, when the available choices are only constructed on the basis of gross inequity. More ‘choice’, or even a greater ability to choose, does not necessarily mean greater freedom.27

It is in this uncomfortable context that contemporary women’s childbirth choices sit. While women giving birth today have many more choices than women of the past, these choices are still dramatically constrained by existing social, cultural and gendered understandings of who should manage childbirth and where it should take place. Women’s apparent ability to choose alternatives in childbirth including the professed aim of maternity hospitals to focus on maternal decision-making, all take place within a long-established discourse which prioritises medical and technological approaches to birthing. There is no real ‘freedom of choice’ within this context. Women can only choose what they are allowed to choose.

Clinical research into how the new focus on maternal decision making is affecting women’s experiences of birthing in the modern maternity hospital suggests that women’s real choices within this context are limited by a number of factors. As J. Jomeen found in her study of ten women who gave birth in British hospitals in 2006:

 [...]he key themes that emerged revealed that choice is not an equitable concept for women, it is constrained by inequalities but also by the health care professionals that women are in contact with, the social discourses that surround pregnancy and birth and obstetric complications.28

The emphasis on choice in childbirth may even be ‘dangerous’ for, as Jomeen suggests, it creates unrealistic expectations from women:

Models of care which offer choice need to be designed to take into consideration the dangers of offering choices that may not be fulfilled…Above all choice needs to be presented in an honest and realistic manner.29

Thus, women must be ‘realistic’ in their childbirth choices and not expect to be allowed choices which sit outside accepted medical protocols. It is the profession of medicine, not women themselves, that makes the real choices about how childbirth can and should be managed both at an individual level and in the broader context. Childbirth therefore becomes another facet of modern life in which the celebration of ‘choice’ demonstrates a fundamental misunderstanding of the power relations between women themselves and the sociocultural discourses within which women exist. For women today, just as it was for women in the past, choice in childbirth remains a problematic concept.

Normalising Birthing: past and present

It has been a priority of this study that women’s voices, both as mothers and midwives, are heard and understood within their own context. This approach has necessitated the bringing together of many different types of primary sources including letters, diaries, newspapers, journal articles and oral histories. What is missing from the picture that is created by this patchwork of material is a representation of normal, successful childbirth in which both mother and baby emerge from the experience safe, whole and happy. Indeed, descriptions of

childbirth in the past very rarely uncover this image of normal birth primarily because it seldom appears in the sources. As historian Lisa Featherstone notes:


[i]n the end, the absence of this tale tells us more about childbearing than might be expected. The medical profession's silence on the topic of the normal birth reveals that few medical sources ever attempted to record this event.30

This lack of emphasis on the ‘normal’ in descriptions of childbirth in the past and the dualistic representations of ‘high risk’ and ‘low risk’ pregnancies which dominate modern obstetrics, undermine the discourses which seek to empower modern-day women through the normalisation of childbirth as a natural life event. This thesis has therefore focused attention on the experiences of everyday women and asserts the continued relevance of normal, uneventful birthing to historic representations of childbirth.

Before the revisionist histories of the 1970s, childbirth historians had always portrayed childbirth in the past as inherently dangerous. Without the aid of modern medicine and at the mercy of the midwife, women of the past were represented as victims of a broken system which allowed untrained women to manage what was considered to be an innately complex and risky process.31 Such representations of past birthing necessitated the inclusion of the childbirth horror story in which the medical-man, called in much too late by the ignorant midwife, arrives just in time, either to save the mother’s life or to perform necessary surgery to restore her to full health.32 Interesting and informative as these horror stories of birth gone wrong may be, these events were the exception, not the rule. The vast majority of births in the past were uneventful and required no intervention from childbirth attendants. This is not to suggest that women of the past, usually burdened by multiple recurrent pregnancies and births, were always healthy and happy following childbirth events. Indeed, many women died during childbirth and some carried permanent disabilities from the mishandling of childbirth by both midwives and medical-men. However, the suggestion put forward by traditional medical historians, that all births in the past were inherently dangerous to mother and baby,

misrepresents reality by ignoring the self-evident existence of successful, uneventful births. The very continuation of small towns and communities attests to the existence of normal, uneventful birthing over generations and highlights the successes of traditional midwifery-managed childbirth. The fact that records of ‘normal’ birthing are limited suggest not that these events did not occur, but that such instances were common enough for them not to be considered worthy of record.

While normal birth was a part of everyday social existence in times gone by, it is, in the modern context, very much a ‘thing of the past’. The huge variation across countries and across different care providers in what can and should be considered ‘normal’ in childbirth demonstrates the degree to which childbirth intervention has literally become ‘the new normal’. For some professionals, any vaginal birth, regardless of the degree of intervention in the process, can be considered normal. However, medical ideology dictates that care for child-bearing women cannot begin from the premise that birth itself is a ‘normal’ natural process which women’s bodies are uniquely designed to carry out. In the contemporary maternity hospital, the location of the vast majority of births in Australia, births can only be considered ‘normal’ in retrospect. All births are treated as potentially abnormal and this is emphasised through the routine use of clinical interventions, pharmaceutical products and machine-monitoring. The routinisation of these procedures in hospitals is one way in which the hegemony of biomedicine is maintained. As Oakley points out:

To reserve such procedures for a small proportion of maternity cases would emphasise the probability of normality; to use them for the majority of patients stresses the probability of abnormality, and the need for women to be dependent on medical care.

The notion that childbirth is a natural and normal physiological process is not compatible with modern technology-driven medicalised birthing. In the medical frame of reference, childbirth can never be considered ‘normal’ because it is, by definition, risky and dangerous. Asserting the possibility that birthing itself is not pathological and can be conducted safely without medical intervention challenges the medical hegemony which currently dominates maternity care. Reimagining and representing birth as a natural and normal activity, both in the past and in the contemporary context, is therefore becoming more and more important.

Through this historical analysis of WA’s maternity services, it has been possible to explore some important themes associated with contemporary debates on childbirth. In this way, the past begins to have greater relevance in the present and the links between women’s past experiences and the experiences of modern-day mothers can be seen more clearly. It would be wrong to suggest that nothing has changed in the sphere of maternity service provision; that the management of childbirth has not progressed or developed. Certainly, maternal and infant mortality in Western countries has dramatically improved from the rates of one hundred years ago. However as Murphy-Lawless has suggested, these seemingly positive changes disguise a growing unease within the business of maternity care, one that relates to the claims medicine makes about its ability to protect women from the apparent dangers of childbirth.

[W]e…sense…that the ‘disinterested scientific approach’ which presents itself as ‘superior heroism’ is actually a form of cowardice, a distancing, a kind of human untruth, far removed from the heroism of the woman who on becoming pregnant must engage immediately with the possibility of profound loss, because there can never be guaranteed outcomes.\(^{35}\)

Women and researchers of today must question specifically what it is that has been gained, for surely we are now past the point where a ‘good birth’ can be defined merely by the survival of mother and child. As Sheila Kitzinger wrote in 1978:

\[
\text{it is not necessarily pervers to question whether our present priority should be to reach minimum figures for perinatal mortality at any price when this includes giving up things which free human beings have often felt to be more important than their own survival – such as freedom to live their own lives their own way and to make individual choices in line with their own sense of values.}^{36}\]

The choices which Kitzinger refers to here are still elusive for mothers in the twenty-first century. Women are still confined and limited in their decision making by socionormative expectations of their behaviour in relation to childbirth. Only through a deconstruction of the powerful medical discourses which dominate maternity care can these challenges for modern-day women be overcome and to do this there is no better place to start than the past.

\(^{35}\) Murphy-Lawless, Reading Birth and Death, pp.10-11.

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