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An Australian history of the subordination of midwifery

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An Australian History of the Medical Subordination of Midwifery

How has it happened that medicine holds a power monopoly over a natural, rite-of-passage event like healthy childbirth? A search of the literature showed that the history of midwifery has been published in the journals for New Zealand, Scotland, Ireland, the UK and the USA (1-7). Annette Summer's published a paper that focussed on nursing's takeover of midwifery but her account was limited to the years of the takeover (5, 8). The current paper incorporates the era that Summers' reported upon and provides an historical analysis of professionalisation of medicine from the mid 19th until the early 20th century. Medical professionalisation was inextricably linked to an obedient nursing profession which in turn was the key player in the eradication of midwifery as an independent occupational group.

Ultimately social power rests with the State therefore the focus of critical analysis within this paper includes the role that the State played in supporting and legitimising medical domination. An understanding of the socio-historical medical domination and virtual obliteration of midwifery as an independent discipline is contextual to understanding the contemporary organisation of maternity services by the state. The analysis shows that medicine's power strategies are essentially the same today as they were 100 years ago. This is important because it means that midwifery can learn from history and develop more effective strategies to promote and protect for the wellbeing of women and babies.

Medicine in Britain: The UK Medical Act of 1858

Australia was founded as a British penal settlement in 1788, before the first medical act was promulgated in 1858 (5, 9, 10). The Australian history of medicine and midwifery, therefore, shares historical roots with and runs parallel to events happening in Britain (5, 7). This medical act (1858) brought together three groups: physicians, barber surgeons and apothecaries. This act

marked the beginning of the professionalisation of medicine. This was a disparate grouping of relatively unrelated occupations with divergent histories, levels of education and social classes (10). These differences are important because the lower status occupations benefited from their amalgamation with the physicians who were the smallest and the highest status group. They came from the aristocracy and had a university education (11). The barber surgeons had begun separating from barbers in 1540 but this was not complete until 1745. During those years the barber surgeons were trained by the apprenticeship system and had no university education (12). Surgery wasn't thought of very highly at that time and was considered to be more a craft than a profession. Surgeons came from the middle classes of society. The apothecaries were most numerous and in the lowest tier in the medical hierarchy in terms of class and income. Apothecaries had originally been grocers but during the 17th and 18th century, apothecaries narrowed their focus to drugs and expanded their occupational territory to include giving medical advice. Physicians, who only provided their services to the wealthy upper class, were apparently content with this. The right to provide medical advice was legitimated by the Apothecaries Act of 1815, thus apothecaries were the original general practitioners who provided low-cost service to the bulk of the population (11).

In Britain at that time there was a rapid increase in the number of GPs who were being recruited from the burgeoning capitalist class who could afford to educate their sons, at least to high school level. Medicine at the time was ranked lower than an army officer in terms of prestige. Medicine had a problem in that GPs were finding it difficult to establish a practice and compete successfully with low paid vocational health care providers such as herbalists, bone-setters and midwives. It is important to remember that, at this time, GPs and barber-surgeons were not required to have a university education. Medicine as a discipline was in a pre-scientific era because the causes of mostly disease were unknown, medical treatments were based on unproven theories and were not very effective (11). In the absence of scientific evidence, GPs had no strong claim to expert knowledge and therefore had

difficulty in gaining a competitive advantage. This led to the related problem that GPs could neither increase their incomes nor their social status. The rising numbers of GPs also created competition between doctors. Some, who couldn't establish a practice in England, decided to immigrate to Australia.

The Subordination of Midwifery in Australia

When the English GPs arrived they essentially found the same range of other health occupations that existed in England. Australia's class system, then as now, is much more open than the British one; it is based on achievement rather than family of birth. As in England, Australian doctors during the late 1800s and early 1900s were mainly middle class GPs. They were seeking to raise their incomes and social class via private practice. The number of GPs grew rapidly during the 1800's. With the help of government, GP's established themselves as a profession. This meant they were registered with the government and could exercise autonomy over their own practice. Being registered with the government meant that doctors had a monopoly over 'medical practice' and this gave doctors a legitimacy which led to increases in income and social class (11).

Initially the British doctors found that there was less medical competition in the early years of Australia settlement. The first areas of medical competition occurred in the wealthier parts of major cities. As the numbers of GPs increased, however, competition between GPs became a problem and they moved out of the city and infiltrated rural areas in order to find more paying customers. In the rural area the focus of competition became the unregulated health workers, including midwives (11).

Since the beginning of white colonisation midwives had provided the majority of maternity care. As long as labour progressed well, the birthing room belonged to the woman and her family; the midwife was an invited guest. The woman's control over her own birthing, with the support of a midwife, continued largely

unchallenged in Australia until the late 1800s (11). Midwives were working class, mainly uneducated women (13). Being unable to read and write would have created a huge power differential when it came to challenging medicine's claims that they were safer practitioners than midwives. This lack of education was related to being female as much as to being working class. It has been convincingly argued that the takeover of midwifery by medicine was an example of gender-based oppression; an oppression from which women and midwives are still suffering (14-16).

As the number of GPs expanded midwives were increasingly seen as a problem. Writing in the Australian Medical Journal, doctors informed each other that the fastest way to build up a general practice was to establish a relationship with the women during pregnancy; build up her trust and then become the doctor for the whole family; thus the midwife stood in the way of medical income and status (11). In order to wrest the childbearing women away from the midwives GPs had to find a way to justify their involvement in all labours and births, not just the complicated ones. The basis for the initial medical insurgence into the birth room was the development of the oobstetrical forceps by the Chamberlain family of barber-surgeons in the 17th century (12). In Australia as in Britain, barber-surgeons were called to pull out the babies in cases where the labour was blocked. At the turn of the century about 1:200 women were dying of sepsis related to childbirth. Although there was no evidence that this was related to the midwives, medicine began to claim that midwives were dirty and were the cause of the infections (11). At the time, hand washing to reduce sepsis, advocated by Semmelweiss in the 17th century was not yet commonly taught to doctors and, of course, antibiotics had not yet been developed. Thus, as in Europe, rather than the midwives being the cause of puerperal sepsis, it is more plausible that doctors carried the infection from women to women. Notions of cleanliness and dirtiness, however, were strongly class-based which made the midwives vulnerable to being stigmatised (17).

For many years, however, midwives provided stiff competition for doctors. They were known within the community and were generally held in high regard. Midwives charged much lower fees than doctors (8). The community generally thought midwives were as effective as medicine or even more so (11). One doctor, David Browne, who had a rural practice in the 1920s, wrote that after his arrival he wanted to take over the births. He tried to raise funds from the local community to build a maternity hospital but to no avail. When a public meeting was called he found out why: At the meeting people resisted the doctor taking over normal birth. They said ‘what about the poor midwife being done out of a living and she being an old resident working in the village before this young doctor was born’” (11). Given the competitive advantage and community support medicine needed help to overthrow midwifery and they turned to nursing for help.

Nursing and Medicine’s Strategic Alliance

During the late 1800s and the early 1900s nursing was evolving as an occupation and seeking to assert itself as a profession. Nursing emerged as an occupational group from the Crimean war 1854-56 where Florence Nightingale and her nurses provided care for wounded soldiers. In designing nursing to fit with medicine, Nightingale was influenced by the way the military operated and made sure that nurses were formally subordinate to medicine. From the beginning nurses were taught to follow ‘doctors orders’ (18). Over the first 30 years of the nineteenth century the Australian Trained Nurses Association, (ATNA) used medicine as a model of how to professionalise. ATNA set up a register, started a professional journal, formed a professional society, advocated standards for nursing training and sought legal support for the registration of nurses (8). Observing nursing’s attempts to professionalise and consistent with their own goal to eliminate midwives from practice, medicine saw a strategic opportunity to get rid of vocational midwives. Medicine and nursing formed an alliance that served the interests of both parties because nursing wanted to claim an occupational territory that included the whole life cycle. The incorporation of midwifery into nursing was seen as desirable by ATNA (8, 11).

In 1888 the first course in midwifery was commenced at the Women's hospital in Melbourne. This was in response to government and community pressure to try to improve birth outcomes for women and babies (11). Both medicine and nursing opposed the training of independent midwives. These two groups used their power to ensure that the Diploma of Midwifery could be taken only by women who had completed their general nursing training (8). Nursing sought to have power over midwives through incorporation, medicine sought power through subordination. Nursing benefited by having an expanded occupational territory and medicine benefited by being in control of midwives. Although the government continually pressured the Women's Hospital to provide some training to currently practising vocational midwives both medicine and nursing resisted. Deliberately withholding knowledge that medicine believed was important for saving women's lives was a power strategy designed to protect the financial interests of medicine. This resistance to training vocational midwives made the medical claims that they were most concerned about the welfare of women rather hollow. Their refusal to train midwives adds weight to the idea that the real concern of medicine was to eliminate the midwife as a source of occupational competition (11). These power plays were occurring within a context of there not being enough midwives, or doctors for birth, particularly for the poorer parts of town and the rural areas.

A Midwives Registration Bill was passed by parliament in 1915 although it was resisted by both medicine and nursing (11). The state at this time supported the need for midwives, mainly because of unmet needs in rural areas. This bill ensured the establishment of a Midwives Board to govern practice and to register midwives. Both vocational midwives and nurses with formal midwifery qualifications were entered on the register. In 1916 a government inquiry, no doubt informed by medical ideology, recommended that only a trained and medically supervised nurse or midwife be allowed to give care during the lying in period (11). This demonstrates that medical authority; conferred by specialised knowledge and by social class, was sufficient for the government to confer legitimacy on medicine as having sovereignty over health care matters.

In 1923 nurses got their own act and were specifically excluded from providing care in childbirth unless also registered as a midwife (8). Nurse-midwives were restricted to the practice of midwifery to rural areas where there was a shortage of doctors wishing to provide obstetric care. In 1928, a further nurse's act was passed which formally abolished the Midwives Board and brought midwifery under the control of nursing (8). Because nursing was already subordinated to medicine the nurses act of 1928 effectively ended midwifery as an independent occupation.

Populate or Perish

Free convict labour had played a crucial role in the development of the Australia economy. Only 6% of Australia's convicts were kept behind bars so, when the last of the convict ships landed in 1868, the plentiful source of free labor dried up. This led to widespread anxiety about the future development of the country (9). By the turn of the century the Anglo-Saxon population was about 4 million (the indigenous people were not counted) (19). This low number of white people, compared with the vastness of the land created fear for governments about the national security. In 1900s, the federal government decided that it needed to increase the birth rate. The government's primary objective was to increase the white population quickly as a source of labour (11). Following a Royal Commission into the declining birth rate (1904) the government introduced a baby bonus of 5 pounds in 1912 (11). I offer a personal note here to link my history to that of Australia. My grand mothers, on both sides of my family, were having babies at this time. Both grandmothers had 11 children. They had all their babies at home with a midwife in attendance. I know from my parents' stories that financially times were tough for them and I deduce that at least in part, my grand-parents were motivated to have a lot of children because of the baby bonus. Australia has again introduced a baby bonus and the birth rate is going up.

In the decade following the introduction of the baby bonus the proportion of births attended by midwives halved as the five pound allowed women to select a doctor to attend them; no doubt because the women believed that midwives carried puerperal sepsis? These social and economic factors, coupled with the dominance of the medically asserted belief that midwives were the chief cause of puerperal sepsis, created the last nail in the lid of the coffin of independent midwifery (11).

Medical Victory

By the 1920s antenatal clinics, under the control of medicine, had been established and nurse-midwives worked under medical orders and supervision; thus medicine was in control of birth. There was no decrease in infant mortality, however under medical care. Further, even though medicine was firmly in charge of births across Australia, the death rate from puerperal sepsis did not decrease until the 1930s and 40s when antibiotics became widely available (11, 20). The involvement with medicine was not benign. With medical attendance at what would have been normal childbirths the use of anaesthesia and forceps became much more common. This resulted in a proliferation of birth injuries to both mothers and infants; this was no doubt a major factor in doctors being unable to lower the mortality and morbidity during this time (11). One doctor, writing in the Medical Journal of Australia in 1929, boasted that he used forceps for every one of his 768 deliveries as a way of preventing complications (11). This type of ideological logic persists today in the elective caesarean section or the vaginal breech birth debate. It is difficult to accept this type of argument because then, as now, the supposedly beneficial intervention is in the interests of the doctor performing the surgery and whilst the woman and baby take all the risks of complications.

Discussion

The most powerful strategies that medicine used in the takeover of midwifery were; stigmatising midwives as unsafe practitioners; aligning with capitalism and the state to shore up medical power and aligning with nursing to takeover

midwifery. Support for medicine, even today, is expressed through state initiated law, policy and actions. An example of a law that protects and supports medical interest is that Medicare rebates are essentially limited to medical treatments. An example of a government policy was when the Federal government decided in 2004 to provide support for medical indemnity insurance for birth whilst refusing to do the same for midwives. Government actions that benefit medical interests occur daily and include decisions about who gets to sit on health related committees. Both federal and state governments place doctors, in dominant numbers and in chairing roles on the committees that plan and manage health services, including maternity care. Some committees have one or two midwives and possibly a consumer. The committee chairs are invariably medical; thus the outcomes of the committees usually have a heavy weighting towards medical interests. This committee composition is replicated at the health service level. Thus, policy and planning related to maternity services occur by committee thus the composition of each committee is usually weighted towards medicine.

Conclusion

The tide of medical domination is turning. The state health departments have heard of the safety, satisfaction and cost-effectiveness of midwifery led care. Midwives and women are asking for woman centred birthing and they are being heard on radio, television and read in the newspapers. In the context of an Australia-wide shortage of obstetricians and GP obstetricians, governments are motivated to provide maternity services close to where the voters live. Thus there is a synergy of interests between maternity consumers, midwives and government. In the state of New South Wales, Australia, at the time of writing the government has committed to extending midwifery-led models of care; including publicly funded homebirth.

Thus, at the state and national level the struggle over maternity services continues. Thanks to feminism, women and midwives are more powerful than they were 100 years ago. Thanks to government decisions to provide university education for midwives we now have a voice that is being heard. Midwives and women can now challenge anti-midwife ideology by countering with research

evidence. These advances for women and midwives have levelled the occupational playing field somewhat. Issues of capitalism, state patronage, class and gender continue to be sources of a medical power that need to be countered in order for women to be able to have the kind of birth they want.

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