

**School of Nursing, Midwifery and Paramedicine
Faculty of Health Sciences**

**Looking Back and Moving Forward: A History and Discussion of
Privately Practising Midwives in Western Australia**

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Doctor of Philosophy
of
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Declaration

To the best of my knowledge and belief this thesis contains no material previously published by any other person except where due acknowledgment has been made.

This thesis contains no material which has been accepted for the award of any other degree or diploma in any university.

The research presented and reported in this thesis was conducted in accordance with the National Health and Medical Research Council National Statement on Ethical Conduct in Human Research (2007) – updated March 2014. The proposed research study received human research ethics approval from the Curtin University Human Research Ethics Committee (EC00262), Approval Number # RDHS-193-15.

Signature:

Date:

Abstract

The overall aim of this historical narrative research study was to fill a gap in the literature by investigating, analysing and describing the history of Privately Practising Midwives in Western Australia (WA) from colonisation to the present day (approximately 1830-2018). This study embedded within a naturalistic, feminist paradigm analysed oral history interviews from fifteen midwives and three doctors, along with archival documents to reconstruct the history and explore the experiences of Privately Practising Midwives (PPMs) in WA.

Since the beginning of recorded history midwives have assisted women in childbirth. Midwifery is recognised as one of the oldest professions; midwives are mentioned in ancient Hindu texts, featured on Egyptian papyrus and in The Bible. Up until the seventeenth century childbirth was the responsibility of midwives, but the gradual emergence of barber-surgeons, then man-midwives and obstetricians heralded a shift from women-led and community-supported birth to a patriarchal and medical model. Throughout the twentieth century childbirth practices in the Western World have continued to change, leading to a move from midwifery-led care at home to doctor-led care in the hospital.

Privately practising midwifery is thought of as a relatively new concept; however, until the early twentieth century, birth in Australia generally occurred at home with a privately practising midwife in attendance. The first non-Indigenous Australian midwives were not formally trained; they came on ships bringing convicts to Australia and are described as 'accidental' midwives, as assistance in childbirth came from whoever was available at the time. This period was followed by what was called the 'Aunt Rubina' period where older married women helped younger women in childbirth. Throughout the early 1800s untrained or 'lay' midwifery care continued alongside the more formally trained midwives who had arrived with the colonists. The decline of midwifery as an independent profession in Australia began in the early twentieth century as nursing and medicine began to encroach on traditional midwifery practice. By the 1930s in WA, midwives as practitioners became almost non-existent. However, the desire for independent midwifery care continued, with a small but stable number of women choosing to give birth with a PPM.

Today, PPMs in Western Australia offer caseload midwifery care to women. Caseload midwifery is an organisational model considered to be the gold standard of midwifery-led care. In this model, the midwife is the primary carer responsible for the planning and execution of midwifery care for an agreed number of women. With the introduction of government health care rebates which cover some of the cost, the choice of a PPM is once again becoming more widely available in Australia.

Using historical and narrative research methods, this study explored the history of PPMs in WA and discovered rich data that described the experiences of these midwives. Four main interrelated themes and subthemes emerged. The first major theme was 'Midwives in the community: the journey of the Privately Practising Midwife (PPM)' and its subthemes 'Building a relationship and providing continuity of carer' and 'Birth within the home'. This theme describes how midwives' desire to work within the community was central to their experiences of being a PPM. An important part of being a community midwife was the ability to provide care in the community, usually in the childbearing women's own homes. The midwives in this study provided care throughout the pregnancy, labour and birth and into the postnatal period, thereby providing continuity of care and building a relationship with the woman based on mutual respect and trust.

The second major theme that emerged from the qualitative analysis was 'Trusting women and birth is central to midwifery philosophy' and its subthemes 'Medicalisation of birth' and 'Midwives use of intuition and the concept of authoritative knowledge'. A component of the midwifery philosophy shared by midwives in this study, was the belief that birth was a normal physiological process, and this included the midwives trusting women's knowledge and instinct to birth their babies. The midwives rejected the medicalisation of birth, choosing to work within the community, where they were able to provide holistic, individualised midwifery care. PPMs within this study described how they use intuition as a form of authoritative knowledge and how they also value the childbearing woman's embodied knowledge and intuition.

The third major theme identified in this study, 'Power and control of the Institutions' describes how the interviewees felt that the mainstream maternity system in Western Australia, which they defined as a collection of 'patriarchal' institutions, sought to control women and midwives. The subtheme 'persecution and reporting of midwives' explores how the PPMs had either had experience of being persecuted and reported to their governing bodies themselves or had witnessed the persecution of other PPMs. The subtheme

'Legislation: jumping through the hoops and all the red tape' explores the PPMs concerns that the increasing restrictions on their scope of practice was reducing women's autonomy and access to PPMs.

The final theme explored within the study 'Breaking through the fear: continuing to support women and each other' included two sub themes, 'Collaboration' and 'Getting educated and gaining power'. 'Breaking through the fear: continuing to support women and each other' describes how the PPMs and doctors in this study were at times persecuted, faced vexatious reporting and were often marginalised. Some had ceased practice altogether due to the stress and increasing legislation. However, despite these challenges they were adamant that they would continue to support women and each other to enable current PPMs to provide midwifery care that aligned with their philosophy. 'Collaboration' explored how the participants in this study felt that collaboration was an essential element of safe care for women and babies. The final subtheme in this study, 'getting educated and gaining power' describes how the PPMs and doctors had always been involved in education, both officially and unofficially.

Understanding the development and evolution of the midwifery profession can help future directions of the profession. The findings of this WA study, therefore, make an important and original contribution to midwifery knowledge by giving a unique insight into the experiences of PPMs in WA. This thesis fills a gap in the literature by providing an in-depth understanding of the challenges and triumphs of these midwives, and the doctors who supported them. The key finding of this thesis is that there are reoccurring themes throughout the history of midwifery in WA which have ongoing impacts on autonomous midwifery practice. The suppression of independent midwifery is not a new phenomenon and continues to lead to a reduction in women's autonomy during the childbearing period.

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Glossary and Abbreviations

Australian Medical Association (AMA): The Australian Medical Association (AMA) is the most influential membership organisation representing registered medical practitioners and medical students of Australia.

Artificial rupture of the membranes (ARM): artificial rupture of the amniotic sac.

Armadale hospital: general hospital with maternity services approximately 30kms south east of Perth.

Augmentation: Acceleration of labour once it has commenced. It involves carrying out an ARM and/or an intravenous syntocinon infusion.

Assisted birth: a vaginal birth with the use of forceps or vacuum.

Australian College of Midwives (ACM) – the peak professional organisation for registered midwives in Australia.

Australian Health Practitioners Regulation Agency (AHPRA): is the national regulatory body for health professionals, including midwives, in Australia formed in 2010.

Australian Nursing and Midwifery Federation (ANMF): The Australian Nursing and Midwifery Federation is the largest union in Australia, with 238,144 members in 2018. The union is run by nurses, midwives and assistants in nursing to advance the industrial, political and professional interests of its members.

Bachelor of Midwifery (BMid): a direct entry university course that leads to midwifery registration.

Breech presentation: when a baby is lying bottom down or feet down in the uterus instead of the more common head down position.

Birth Centre: Birth centres are midwifery-led units providing home-like birth environments, they can be freestanding or on the grounds of a hospital.

Broome Hospital: general hospital with maternity services in the north west of WA approximately 2,250Kms from Perth.

Bunbury General Hospital: general hospital in the south west of WA approximately 175Kms from Perth.

Busselton General Hospital: general hospital in the south west of WA approximately 225Kms from Perth.

Caesarean: the surgical delivery of a baby via the mother's abdomen. Also referred to as a c-section, caesarean section and caesar.

Cardiotocograph (CTG): a machine used for monitoring the foetal heart rate and maternal contractions. It provides a graphic representation of the correlation between foetal heart rate patterns and uterine contractions during labour and birth.

Clinical Facilitator: Registered Midwife employed by a hospital or university to provide clinical support to midwifery students during their clinical practicum.

Community Midwifery Program (CMP): initially started by PPMs (Theresa Clifford, Enid facer and Bronwyn Key) to enable women access to free continuity of midwifery care and homebirth. The CMP is now a government-funded, midwifery-led model for low risk (meeting a strict criteria) women choosing home birth or domino births. The midwives are employed by the health department.

Continuous electronic monitoring: the use of a cardiotocograph machine to monitor the foetal heart continuously throughout labour.

Council of Australian Governments (COAG): The COAG Health Council (CHC) and its advisory body, the Australian Health Ministers' Advisory Council (AHMAC), provide a mechanism for the Australian Government and state and territory governments to discuss matters of mutual interest concerning health policy, services and programs.

Doppler: a hand held device that is used to listen to the foetal heart rate through the maternal abdomen.

Doula: A person who provides support during pregnancy, labour and birth and the postnatal period. A doula is not considered a healthcare professional, however they may some training in supporting women during childbirth.

Edith Cowan University (ECU): University in Perth WA offering midwifery education for undergraduates and postgraduate students (four year dual degree, Bachelor of Science

(nursing) and Bachelor of Science (Midwifery) and two year Master degree for Registered Nurses).

Educated: empirically trained midwives (midwives trained through experience rather than formally educated) also referred to as Granny or Lay midwives.

Empirically trained midwife: A midwife who has informal training through experience or apprenticeship with another midwife.

Employed midwife: registered midwife employed by the health department.

Epidural analgesia: a form of anaesthetic or pain relief administered via an injection into the epidural space around the spinal cord.

Episiotomy: a surgical incision into the perineum during birth.

Family Birth Centre (FBC, The Birth Centre): there is one birth centre in WA located in site at King Edward Maternity Hospital providing government-funded, midwifery-led care for low risk women who meet the strict criteria.

Fiona Stanley Hospital: established in 2014, public maternity hospital providing services to the Fremantle area of WA.

Foetal distress: the clinical manifestation of foetal hypoxia. It may be suspected in labour if the foetal heart rate is abnormal or there is meconium stained liquor.

Foetal heart rate auscultation: listening to the foetal heart (can be done with a pinnard, a handheld doppler or a CTG).

Forceps: metal instruments used by an obstetrician to deliver a baby via the vagina. They are used if the foetus is malpositioned, not descending, and/or there is suspected foetal distress.

Freebirth: a planned unassisted homebirth, whereby there is no midwife or medically trained birth professional in attendance. (Also used as a verb: to freebirth)

Homebirth Australia (HBA) – the peak national body for homebirth in Australia.

Induction: the process of starting labour artificially.

Instrumental birth: a vaginal birth with the use of forceps or vacuum.

Intrapartum: labour.

King Edward Memorial Hospital/King Eddies/KEMH: established in 1916, King Edward Memorial Hospital is the only tertiary level maternity hospital in WA.

Lay midwife: prior to registration the lay midwife was an informally or empirically trained midwife. Can also refer to a formally trained midwife who is unregistered.

Lithotomy: A birth position with the woman lies on her back with her legs held up and out, usually in stirrups.

Liquor: the amniotic fluid around the foetus contained in the amniotic sac.

Maternal observations (maternal obs): clinical assessments including blood pressure, pulse, temperature and other assessments in pregnancy, labour and birth or the postnatal period.

MIGA/medical Insurance Group Australia: a specialist insurer offering a range of insurance products and associated services to the health care profession across Australia. It is the only insurance company offering antenatal, intrapartum (only for hospital births NOT for homebirths) and postnatal insurance to PPMs in Australia.

Medicare: a publicly funded universal health care system in Australia. Medicare provides free or subsidised access to healthcare services for Australian citizens and permanent residents in public hospitals and from a range of care professionals such as medical practitioners, nurses and midwives who have been provided with a Medicare provider number.

Medicare Benefits Schedule (MBS): a listing of the Medicare services subsidised by the Australian government.

Medicare Provider Number (MPN): a number used for Medicare claims processing. It is used to identify the practitioner and their practice location when processing claims.

Midwifery Practice Review (MPR): a formal, transparent, nationally consistent peer review mechanism that supports midwives to reflect on their professional portfolio, their midwifery practice, and their professional development.

Meconium liquor: when the foetus has opened his/her bowels into the amniotic fluid. This can occur as the baby's digestive system matures, or in some cases of foetal distress.

Medicare Eligible Private Midwife: is a midwife who has met the requirements to be eligible for a Medicare provider number. This allows their clients to claim back a portion of the fees for their services through Medicare.

Midwifery: Lay midwife: prior to registration the lay midwife was an informally or empirically-trained midwife (midwives trained through experience rather than formally educated).

Midwives: Empirically-trained midwives (midwives trained through experience rather than formally educated).

Multiparous (multi): a woman who has given birth more than once.

National Registration and Accreditation Scheme (NRAS): a registration and accreditation scheme for health practitioners that commenced on 1 July 2010 and was established by state and territory governments through the introduction of consistent legislation in all jurisdictions.

Nursing and Midwifery Board of Australia (NMBA): the regulatory board for Nurses and Midwives in Australia Nursing and Midwifery Board of Australia (NMBA).

National Maternity Services Review (MSR): was conducted in 2009 and sought submissions from the public and interest groups on maternity services in Australia. The aim was to identify gaps and changes need and inform priorities for national action.

Oxytocin: the natural hormone that initiates contractions of the uterus during labour.

Pharmaceutical Benefits Schedule (PBS): the PBS provides timely, reliable and affordable access to necessary medicines for Australians. The PBS is part of the Australian Government's broader National Medicines Policy.

Postpartum Haemorrhage (PPH): the traditional definition of primary PPH is the loss of 500 ml or more of blood from the genital tract within 24 hours of the birth of a baby.

Post-Traumatic Stress Disorder (PTSD): a type of anxiety disorder. Some people develop PTSD after experiencing a traumatic event.

Princess Margaret Children's Hospital (PMH) - Perth's children's hospital.

Privately Practising Midwives (PPM): midwives who are self-employed. They are not employed by a health service but employed directly by the woman. Most PPMs provide

continuity of care across the full scope of midwifery practice and provide homebirth services.

Professional Indemnity Insurance (PII): arrangements that secure, for the practitioner's professional practice, insurance from civil liability incurred by, or loss arising from, a claim that is made as a result of a negligent act, error or omission in the conduct of the practitioner.

Perineum: The area of the body between the anus and the vagina.

Physiological third stage: The physiological birth of the placenta and membranes (without any synthetic hormone administration or intervention).

Pinnard: an instrument shaped like a trumpet that can be applied to the maternal abdomen to hear the foetal heart.

Pre-eclampsia: a complication of pregnancy involving increased blood pressure and proteinuria.

Primiparous (primip): a woman who is having her first baby.

Pudendal block: local analgesia is injected into the pudendal nerves in the pelvis via the vagina. This is occasionally performed to provide pain relief during an instrumental birth.

Royal College of Midwives (RCM): The United Kingdom's professional organisation and trade union for Registered Midwives.

Royal College of Obstetricians and Gynaecologists (RCOG): The United Kingdom's professional organisation for obstetricians and gynaecologists.

Royal College of Australian and New Zealand Obstetricians and Gynaecologists (RCANZOG): The Australian and New Zealand professional organisation for obstetricians and gynaecologists.

Registered midwife: Midwife who is registered to meet legal requirements.

Shoulder dystocia: A complication that occurs when the baby's head has birthed but the shoulders are stuck behind the pelvic brim and therefore the baby is not born spontaneously. This is an emergency situation.

St Anne’s Hospital: Maternity hospital established in 1937 by the Sisters of Mercy, became Mercy Hospital in 1996, then became St John of God Mt Lawley Hospital located on the banks of the Swan River, in Mount Lawley a suburb of Perth, Western Australia.

St John of God Hospitals (SJOG): Group of private hospitals in WA. There are currently seven SJOG hospitals offering obstetric-led private maternity services, three in the Perth metropolitan area, one in the south west of WA in Bunbury (175Kms south west of Perth) and one in the Pilbara (700Kms north of Perth).

Syntocinon (synto): a synthetic version of oxytocin, the hormone that initiates contractions of the uterus during labour. It is used to augment and induce labour and following a post birth haemorrhage.

The exemption: an exemption to the requirement of insurance provided under section 284 of the National Law from PII for PPMs providing intrapartum care in the home in Australia.

Ultrasound: An ultrasound scan creates a real-time picture of the inside of the body using sound waves.

Unregulated Birth Worker (UBW): a person who attends women planning a homebirth but is not a registered midwife or doctor. They may have experience or knowledge of childbirth and may be a doula, childbirth educator, lay midwife or have previously held midwifery registration in Australia or another country.

Unassisted Birth –see Freebirth.

Vacuum Birth: an assisted vaginal birth using a suction cup placed on the foetal head with applied traction to deliver the baby. It is used if birth is not progressing and/or there is suspected foetal distress. Performed by an obstetrician.

Vaginal birth after caesarean (VBAC): when a baby is born vaginally after the mother has had at least one previous caesarean section.

Vaginal Examination (VE): a digital examination attended by a midwife or doctor to determine cervical dilatation and descent of the presenting part of a foetus.

Vero Insurance: Vero Insurance is an Australian insurance company. Founded in 2003, it is one of the largest insurance companies in Australia. Vero provided PII to PPMs but ceased to offer this insurance in 2015.

Woodside Hospital: In 1926 the stately home 'Woodside' in East Fremantle became a private hospital. In 1953 it became Woodside Maternity Hospital. In 2006 maternity services for the Fremantle area were transferred from the Woodside Hospital to Kaleeya Hospital. Kaleeya hospital closed in 2014 and maternity services were transferred to the newly built Fiona Stanley Hospital.

Chapter One – Introduction to the Thesis

*You are a midwife, assisting at someone else's birth. Do good without show or fuss.
Facilitate what is happening rather than what you think ought to be happening. If you
must take the lead, do so that the mother is helped, yet still free and in charge. When the
baby is born, the mother will very rightly say: "We did it ourselves!"*

From The Tao Te Ching ¹

Chapter Overview

This historical narrative research study involved an investigation into the experiences of Privately Practising Midwives (PPMs) in Western Australia (WA) from the period 1830-2018. This thesis makes a unique contribution to midwifery knowledge by exploring the untold stories of these Western Australian midwives through analysis of archival documents and oral history interviews. The author acknowledges and pays her respects to the past Indigenous midwives of Australia; however, this research will not discuss their experiences or practices and recognises that there is a gap in this knowledge, which unfortunately is beyond the scope of this thesis.

Chapter One will begin with a brief description of the author's background and decision-making process around the research topic. A brief history of midwifery, maternity care and Privately Practising Midwives (PPMs) in WA is then provided. The context of the research and an overview of the study setting in WA is offered. The aim and objectives of the study plus its unique significance and contribution is outlined, and the chosen methodology presented. This chapter will conclude with an overview of the thesis and a brief explanation of each thesis chapter.

Background

Since the beginning of recorded history, midwives have assisted women in childbirth. Midwifery is recognised as one of the oldest professions; midwives are mentioned in ancient Hindu texts, featured on Egyptian papyrus and in The Bible.² Up until the

¹ Heider, J. 1985. *The Tao of Leadership: Lao Tzu's Tao Te Ching Adapted for a New Age*, Atlanta, Georgia: Humanics Limited.

² Donnison, Jean. 1977. *Midwives and Medical Men: A History of Inter-Professional Rivalries and Women's Rights*, London: Heinemann Educational Books; Ehrenreich, Barbara and Deirdre

seventeenth century childbirth was the responsibility of midwives, but the gradual emergence of barber-surgeons, then man-midwives and obstetricians heralded a shift from the women-led and community supported role to the more patriarchal medical model.³ Throughout the twentieth century childbirth practices in the Western World have continued to change, contributing to a move from midwifery-led care at home to doctor-led care in the hospital.⁴

Autonomous independent midwives—now referred to as Privately Practising Midwives (PPM) — are thought of as a relatively new concept; however, until the early twentieth century, birth in Australia generally occurred at home with a midwife in attendance. The first non-Indigenous Australian midwives were untrained; they came on ships bringing convicts to Australia and are described as accidental midwives, as assistance in childbirth came from whoever was available at the time.⁵ This practice was followed by what was called the ‘Aunt Rubina’ period where older married women helped younger women in childbirth. Throughout the early 1800s untrained or ‘lay’ midwifery care continued alongside the more formally trained (both empirically and hospital trained) midwives who had arrived with the colonists.⁶ Throughout the nineteenth and early twentieth centuries in Australia, the majority of women still gave birth at home with a midwife, however, the lying-in house was another option for some women.⁷

English. 2010. *Witches, Midwives and Nurses: A History of Women Healers*, 2nd ed. New York: The Feminist Press.

³ Donnison, Jean. 1988. *Midwives and Medical Men: A History of Inter-Professional Rivalries and Women's Rights*, 2nd ed. London: Historical Publications; Katz Rothman, Barbara. 1989. *Recreating Motherhood: Ideology and Technology in a Patriarchal Society*, New York: W.W. Norton & Company.

⁴ Katz Rothman, Barbara. 1982. *In Labour: Women and Power in the Birth Place*. London: Junction Books; Katz Rothman, *Recreating Motherhood: Ideology and Technology in a Patriarchal Society*; Donnison, *Midwives and Medical Men: A History of Inter-Professional Rivalries and Women's Rights*.

⁵ Barclay, Lesley M. 2008. "A Feminist History of Australian Midwifery from Colonisation until the 1980s." *Women and Birth* 21 (1): 3-8.

⁶ Ibid.; Grehan Madonna. 2009. "Heroes or Villains? Midwives, Nurses, and Maternity Care in Mid-Nineteenth Century Australia.," *The Free Library*; McKenzie, Briony. 2015. "Place and Power: A History of Maternity Service Provision in Western Australia, 1829-1950" Murdoch University.

⁷ Flanagan, May. 1997. "Lying-in (or Maternity) Homes in Western Australia from About 1860-1960." *Early Days*, 11 (3): 338-353; McKenzie, "Place and Power: A History of Maternity Service Provision in Western Australia, 1829-1950."

The Western Australia Context

In his 1875 annual report, the Colonial Surgeon, Dr Waylen, considered the infant death rate in WA to be very high.⁸ In 1875, the infant death rate was 114 deaths per 1000 births which was less than the infant death rate in England during the same period (160 deaths per 1000 birth)⁹; however, Dr Waylen considered the lack of formal training of birth attendants to be one of the causes of the high infant mortality rate.¹⁰ Although the infant mortality rate was more likely due to the health of the pioneer women and their living conditions, rather than problems associated with the actual birth. Childbirth itself was generally uneventful and considered a part of everyday life in the colony.¹¹ As the population of the colony expanded, the demand for assistance during birth increased. It is not known if there were any trained midwives in the colony until the 1860s, when advertisements placed by trained midwives started to appear in the newspapers; therefore the empirically trained midwives (midwives trained through experience rather than formally educated¹²) and the 'Aunt Rubinas' continued to provide midwifery care along with the trained midwives until the early twentieth century.

Midwifery training had commenced in Australia in the late 1800s in other states; although the demand for midwifery care was higher than the number of trained midwives, so lay midwifery care continued in all states.¹³ Midwifery¹⁴ training commenced in Fremantle, WA, in 1909 and, as in other states was completely controlled by medical practitioners and nurses, however, unlike the Eastern States, the Fremantle course did not require formal nursing training prior to admission.¹⁵ To be eligible for admission to the course, applicants must meet a strict criteria, which ruled out many of the existing

⁸ *Western Australian Times, The*. 1876. Health Report. March 21, 1876.

⁹ Donnison, *Midwives and Medical Men: A History of Inter-Professional Rivalries and Women's Rights*. 85.

¹⁰ *Western Australian Times, The*, "Health Report."

¹¹ McKenzie, "Place and Power: A History of Maternity Service Provision in Western Australia, 1829-1950."

¹² Empirically trained midwives (midwives trained through experience rather than formally educated) also referred to as Granny or Lay midwives. (Please see Glossary)

¹³ Fahy, Kathleen. 2007. "An Australian History of the Subordination of Midwifery," *Women and Birth* 20 (1): 25-29.

¹⁴ Lay midwife: prior to registration the lay midwife was an informally or empirically-trained midwife (midwives trained through experience rather than formally educated). (Please see Glossary)

¹⁵ *West Australian, The*. 1909. "The West Australian Trained Nurses Association, Letter to the Editor." August 19, 1909.

empirically-trained midwives.¹⁶ The *Health Act of 1911* was the first legislation aimed at controlling and regulating midwives' practice in WA. Included as part of the Health Act, under the title 'protection of life', was the introduction of legislation requiring midwives to be registered.¹⁷ Registration required the midwife to prove her qualifications and training and pay a fee. Trained midwives were required to have undergone at least 12 months training at an approved institution and provide evidence that they had attended a prescribed number of midwifery cases.¹⁸ The 'grandmother' clause allowed 'unqualified' midwives to register. These women did not have formal qualifications but were empirically trained.¹⁹ Following the legislation requiring the registration of midwives, the West Australian Midwifery Board was established in 1911 and was dominated by medical men from the beginning. The Board attained the right to remove a midwife from the register and to "make regulations for supervising, regulating, and restricting within due limits the practice of midwives, and for any other purpose tending to protect the lives of mothers and infants".²⁰ Following the introduction of these laws and legislation in the early twentieth century, the decline of midwifery as an independent profession in Australia began as nursing and medicine began to encroach on traditional midwifery practice.²¹ By the 1930s, the increased legislation, the requirement for formal training to be able to practise as a midwife and the changing social expectations of women, led to midwives as independent practitioners becoming almost non-existent. However, the desire for independent midwifery care continued, with a small but stable number of women choosing to give birth with a PPM.

In Australia today, midwives work in a variety of settings including private hospitals, public hospitals, birth centres and the community. The majority of women in Australia give birth in a hospital setting with care directed by an obstetrician and midwives providing clinical care. In 2015, 97% of Australian women gave birth in hospital, 1.8% gave birth in birth centres and 0.3% gave birth at home.²² It could, however, be argued that these statistics may reflect the maternity care options available rather than women's choices to

¹⁶ McKenzie, "Place and Power: A History of Maternity Service Provision in Western Australia, 1829-1950."

¹⁷ *Health Act of 1911 (WA)*, ed. Government of Western Australia.

¹⁸ *Ibid.*

¹⁹ *Ibid.*

²⁰ *Ibid.*262.

²¹ Fahy, "An Australian History of the Subordination of Midwifery."

²² Australian Institute of Health and Welfare.2015b. "Australia's Mothers and Babies 2015–in Brief. Perinatal Statistics Series No. 33.

birth in these settings. In 2015, only 50% of Australian women experienced a spontaneous labour, 29% had their labour induced and 21% did not experience labour at all.²³ Labour was augmented for 16% of women which means that only 32% of mothers had a spontaneous onset of labour. In 2015, only 54% of women experienced a spontaneous vaginal birth (although the birth may have been spontaneous, labour may have been induced and augmented). Of women having a vaginal birth, 12% were assisted by either vacuum extraction or by forceps. Over 30% of women in Australia give birth by caesarean section.²⁴ As demonstrated by these statistics, the majority of women give birth within hospitals, therefore most midwives are employed within the hospital setting. Some midwives, however, choose to work outside of the mainstream maternity setting and practice within the community as privately practising midwives, employed directly by child-bearing women.

Privately Practising Midwives (PPM) in WA offer caseload midwifery care to women. Caseload midwifery is an organisational model considered to be the gold standard of midwifery-led care, whereby the midwife is the primary care giver and is responsible for the planning and execution of midwifery care for an agreed number of women. This model of care has benefits for both women and midwives. Research demonstrates that women receiving caseload midwifery have fewer childbirth interventions during labour and birth and increased maternal satisfaction; midwives report increased satisfaction and less burnout rates.²⁵ Both midwives and women report more positive experiences when the opportunity to build a relationship is present.²⁶

²³ Australian Institute of Health and Welfare. 2015b. "Australia's Mothers and Babies 2015—in Brief. Perinatal Statistics Series No. 33.; Davison Clare. 2018 "Is the Midwife's Belief in Normal Birth Becoming Extinct?," *Australian Midwifery News* 18 (1): 19-20.

²⁴ Australian Institute of Health and Welfare. "Australia's Mothers and Babies 2015—in Brief. Perinatal Statistics Series No. 33"; Davison, "Is the Midwife's Belief in Normal Birth Becoming Extinct?"

²⁵ Dawson et al., 2015. "Caseload Midwifery in Australia: What Access Do Women Have?" *Women and Birth* 28 (1): S12; Dawson et al., 2017. "Operationalising Caseload Midwifery in the Australia Public Maternity System: Findings from a National Cross-Sectional Survey of Maternity Managers," 31 (3): 194-201; Sandall et al., 2016. "Midwife-Led Continuity Models of Care Compared with Other Models of Care for Women During Pregnancy, Birth and Early Parenting," *The Cochrane Library*; McLachlan et al., 2013. "The Effect of Caseload Midwifery on Women's Experience of Labour and Birth: Results from the Cosmos Randomised Controlled Trial," *Women and Birth*, 26 (1): S13; Tracy et al., 2013. "Caseload Midwifery Care versus Standard Maternity Care for Women of Any Risk: M@Ngo, a Randomised Controlled Trial." *The Lancet* 382 (9906): 1723-1732.

²⁶ Davison, Clare. 2014. "The Relationship is Everything: Women's Reasons for, and Experience of Maternity Care with a Privately Practising Midwife in Western Australia", Master of Philosophy (Nursing and Midwifery), Curtin University; Bradfield et al., 2019a. "'It's What Midwifery Is All About'; Western Australian Midwives' Experiences of Being 'with Woman' During Labour and

Self-employed Privately Practising Midwives in WA offer continuity of carer antenatally, during labour and birth and for up to 6 weeks postnatally. The midwife works autonomously and must practice according to the accepted standards of the profession; however, she is not bound by hospital policies as she is not employed by any specific hospital as she is engaged by the woman to provide one to one individualised midwifery care. With the introduction of Medicare rebates for some of the cost associated with employing a PPM, the choice of a PPM is once again becoming more widely available in Australia. Little is known about the WA midwives who have provided this care through history; therefore, this study is timely and warranted.

The Study's Setting, Western Australia



Figure 1: Map of Australia²⁷

Australia is the largest island in the world, covering an area of 7.69 million square kilometres (see Figure 1). To put this into context Australia's land mass is almost the same as that of the United States of America, about fifty per cent bigger than Europe, and thirty two times bigger than the United Kingdom.²⁸ Australia was invaded and colonised by the

Birth in the Known Midwife Model." *BMC Pregnancy and Childbirth* 19 (29); Bradfield et al., 2018. "Midwives Being 'with Woman': An Integrative Review," *Women and Birth* 31 (2) 143-152.

²⁷ Lonely Planet. Map of Australia.

²⁸ Australian Government, "The Australian Continent."

British in 1788, when the 'First Fleet' arrived in Botany Bay on the east coast of Australia.²⁹ In June 1829, Captain James Stirling established the Swan River Colony in Western Australia (WA). This site became known as Fremantle Port. Swan River was the first colony to be established by free settlers —people who chose to travel to Australia and had the means to support themselves— rather than the convicts, who were transported as punishment to the eastern colonies. The Swan River Colony eventually became Perth, WA's capital city.

Today, Australia's population is approximately twenty-three million, and of this number over eighty percent live within one hundred kilometres of the ocean.³⁰ Australia is divided into six states and two territories. Western Australia (WA) has the largest landmass of the states and territories with a population of 2.59 million people. Of this number three quarters of the population live in Perth, the capital and the surrounding metropolitan area.³¹ Western Australia has a diverse landscape from forests in the south to the tropical north and desert areas of the east. Western Australia consists of eight regions (see Figure 2) the Kimberly, Pilbara, Goldfields, Midwest, Wheatbelt, Southwest, Great Southern and the Perth metropolitan area running 160kms from North to South.



Figure 2: Regions of Western Australia with the Perth metropolitan area identified in black³²

²⁹ Peel, Mark. 2011. *History of Australia*, ed. Christina Twomey, Palgrave Macmillan.

³⁰ Australian Government, "The Australian Continent."

³¹ Australian Bureau of Statistics, Western Australia.

³² Australian Government, "The Australian Continent". Regions of Western Australia with the Perth metropolitan area identified in black.

The history of midwifery has been researched by a small number of Australian midwives and historians with most of this research focused on the Eastern States of Australia. This research will be covered in more detail in Chapter Two, which provides an extensive review of the literature, under the section 'Revisionist histories of independent midwifery in Australia'.³³ Unlike some of the other Australian States, very little has been written about the history of midwifery in Western Australia.³⁴

Researcher Background and Decision-making Process Relating to the Study

My interest in this topic comes from my own story. I am a woman, a mother, a midwife and a feminist. I am passionate about women having their choice of midwife to provide continuity of care throughout the childbirth continuum. I am originally from the United Kingdom (UK), and grew up expecting care during pregnancy and birth to be provided by a midwife. My first child was born in the UK and I received community-based midwifery care. On arrival to Australia, I was surprised to find out that midwifery led care was not a mainstream option, furthermore, when I chose to receive care from a midwife and birth at

³³ Teale, Ruth. 1978. *Colonial Eve: Sources on Women in Australia 1788-1914*, Melbourne: Oxford University Press; McCalman, Janet. 1998a. *Sex and Suffering: Women's and a Women's Hospital: The Royal Women's Hospital Melbourne 1856-1996*, Carlton, Victoria: Melbourne University Press; Willis, Evan. 1989. *Medical Dominance*, North Sydney: Allen & Unwin; Barclay, "A Feminist History of Australian Midwifery from Colonisation until the 1980s."; Fahy, "An Australian History of the Subordination of Midwifery"; Reiger, Kerreen. 2001. *Our Bodies, Our Babies: The Forgotten Women's Movement*, Melbourne: Melbourne University Press; Reiger, Kerreen. 1985. *The Disenchantment of the Home: Modernizing the Australian Family 1880-1940*. Melbourne: Oxford University Press; Summers, Annette. 1995. "'For I Have Ever So Much More Faith in Her Ability as a Nurse': The Eclipse of the Community Midwife in South Australia 1836-1942'." Flinders University of South Australia; Potter, Lesley Evelyn. 2015. "Weaving the Threads: A Tapestry of Sydney's Colonial Midwives, 1788-1901" PhD, University of Sydney; Selby, Wendy. 1992. "Motherhood in Labour's Queensland 1915-1957" PhD, Griffiths University, Queensland; Grehan, "Heroes or Villains? Midwives, Nurses, and Maternity Care in Mid-Nineteenth Century Australia"; Kyle, Noeline. 2017. *Women's Business: Midwives on the Mid North Coast of New South Wales to 1950, a Study of Armidale, Kempsey and Port Macquaire / Dr Noeline Kyle*, Lake Cathie, New South Wales: Noeline Kyle; Davies, Rita Ann. 2003. "She Did What She Could: A History of the Regulation of Midwifery Practice in Queensland 1859-1912." Queensland University of Technology.

³⁴ McKenzie, "Place and Power: A History of Maternity Service Provision in Western Australia, 1829-1950"; Thorogood, Carol. 2001. "Politics and the Professions: Homebirth in Western Australia" PhD, Murdoch University, Perth; Hobbs, Victoria. 1980. *But Westward Look: Nursing in Western Australia 1829-1979*, Nedlands: University of Western Australia; Flanagan, May. 1997. "Lying-in (or Maternity) Homes in Western Australia from About 1860-1960." *Early Days*, 11 (3): 338-353; Carter, Jennie and Bevan Carter. 2016. *King Eddies: A History of Western Australia's Premier Women's Hospital 1916-2016*. Subiaco: King Edward Memorial Hospital Alumni.

home I realised that not only was it considered an alternative pathway it was also stigmatised.

I became a midwife following the births of my children, and although having previously worked as a nurse knew that one day, I would become a midwife. I have always had an inquisitive mind and want to 'know things'. Following my initial midwifery education, I completed a Master of Philosophy. My masters research explored the experiences of WA women who chose a PPM to provide midwifery care for them during pregnancy, birth and the postnatal period. My findings revealed that women chose this model of care predominantly because they wanted a relationship with their care provider that was based on a shared philosophy, and that this shared philosophy and positive relationship contributed to women experiencing an empowering birth.³⁵

I currently work as both a midwifery lecturer and a PPM. As a midwife I have worked in hospitals and the community. My experience of working as a midwife within the community sparked my interest in the topic of autonomous midwifery practice. I was curious as to why midwifery in Australia was based in hospital and women seemed to expect to receive medicalised care. I also learnt so much from the stories that my PPM colleagues told and wanted to be able to talk to more PPMs about their experiences. I was interested in the history and experiences of WA PPMs, as the opportunity to learn from history is important to me. I felt that the history and experiences of WA PPMs could offer insight to how we could improve conditions for current and future midwives who choose to work in this model.

As indicated, my interest in this topic came from my own experiences. This stance and passion had the potential to impact the research I selected. Therefore, to reduce the possibility of unconscious bias, I have made every effort not to allow my own beliefs, values and interests to influence this study. To achieve this, I had to identify my own biases and assumptions, prior to commencing the interviews and data analysis. However, I also acknowledged that my own experiences could enable me to have insights and empathy for the interviewees that another researcher may not have had. This reflective process is discussed further in the methodology chapter.

³⁵ Davison, "The Relationship is Everything: Women's Reasons for, and Experience of Maternity Care with a Privately Practising Midwife in Western Australia."

Aim and Objectives

The overall aim of this study was to generate new and useful knowledge by documenting and discussing the history and experiences of Privately Practising Midwives (PPMs) in Western Australia and fill a gap in the existing literature.

The objectives are defined as follows:

- Record and explore the history of the privately practising midwife in Western Australia from approximately 1830 to 2018.
- Describe the past and present privately practising midwife's experience of providing midwifery care in WA.
- Analyse the relationship between the privately practising midwife and other health professionals.

Research Methodology

A naturalistic, feminist paradigm was used to investigate, analyse and describe the history of Privately Practising Midwives in WA. One of the aims of any feminist research is to explore the unique experiences of women themselves and this thesis sits within that research tradition. Midwifery is predominantly a female profession focusing on the needs of women, as such, a feminist approach is particularly relevant to midwifery research. As Hunt argues "childbirth is a woman's issue and I have always wondered why anyone could possibly believe that childbirth and midwifery, in particular could be studied without some reference or even a mention of feminist framework".³⁶ Barnes believes that midwifery research should be based on feminist theory and suggests that there are two important main principles underlying feminist approaches to midwifery research. Firstly, research is conducted for the benefit of women. Secondly, research is seen as a means of social change, such as improvements within the practice of midwifery and the organisation and culture of maternity services.³⁷

In addition to the use of feminist theoretical and practical approaches, a historical narrative methodology was chosen, as the intent of the research was to interpret and

³⁶ Hunt, Sheila. 2004. "Foreword," in *Pregnancy, Birth and Maternity Care: Feminist Perspectives*, ed. Mary Stewart, London: Elsevier Science.

³⁷ Barnes Margaret. 1999. "Research in Midwifery: The Relevance of a Feminist Theoretical Framework," *Australian College of Midwives Incorporated Journal* 12 (2): 6-10.

narrate past events. The study of women's history provides an exciting challenge to the researcher because it is an opportunity to discover new knowledge of gendered social lives that we previously had little or no understanding of, knowledge that is grounded in the women's own experiences. As Anderson states:

women's experiences and realities have been systematically different from men's in crucial ways and therefore needed to be studied to fill large gaps in knowledge. This reconstitution of knowledge was essential because of a basic discontinuity: women's perspectives were not absent simply as a result of oversight but had been suppressed, trivialized, ignored, or reduced to the status of gossip and folk wisdom by dominant research traditions institutionalized in academic settings and in scientific disciplines. Critical analyses of this knowledge often showed that masculinist biases lurked beneath the claims of social science and history to objectivity, universal relevance, and truth.³⁸

Oral histories were obtained through in-depth interviews from the living midwives who practiced or were still practising as PPM's in WA. In using oral histories and a feminist perspective, a narrative 'storytelling' approach was adopted. Stories and storytelling are embedded in the culture of midwifery, and in the culture of women's knowledge sharing.³⁹ A narrative storytelling approach can also reduce the power imbalances between researcher and participants.⁴⁰

Archival information was gathered from both primary and secondary sources about midwives and midwifery in Western Australia from 1830-2018. The data included the recorded stories (such as diary excerpts or family histories), newspaper articles, government documents and maternity health policies and guidelines. The archival and contemporary documents combined with the oral history interviews were analysed using narrative analysis and the themes that emerged from the data form the findings of this study.

³⁸ Anderson, Kathryn, Susan Armitage, Dana Jack, and Judith Wittner. 1987. "Beginning Where We Are: Feminist Methodology in Oral History," *The Oral History Review* 15 (1).105.

³⁹ Wickham, S. 2004. "Feminism and Ways of Knowing," in *Pregnancy, Birth and Maternity Care: Feminist Perspectives*, ed. Mary Stewart, London: Elsevier Science; Coates T. 2007, "How Do They See Us? Portrayals of Childbirth and the Role of the Midwife in Literature," in *The Art and Soul of Midwifery: Creativity in Practice, Education and Research*, ed. L. Davies. London: Churchill Livingstone; Leamon, L. 2009. "Stories: Using Narrative Research Approach in Exploring Stories about Childbirth," *MIDIRS Midwifery Digest*, 19 (2): 169-174.

⁴⁰ Leamon, "Stories: Using Narrative Research Approach in Exploring Stories About Childbirth."

Significance of the Study

As previously stated, the overall aim of undertaking this research was to explore the history and experiences of Privately Practising Midwives (PPMs) in Western Australia. Previous studies have explored aspects of maternity care in WA (this work will be outlined in Chapter Two, the literature review)⁴¹; however, this study is unique because it fills a gap in existing knowledge by combining historical and contemporary data to examine the history of autonomous midwifery practice in Western Australia. Considering the importance of woman-centred midwifery care and the concerns regarding the over medicalisation of birth in Australia,⁴² there has been little research into the historical experiences of midwives providing this community based, midwifery-led model of care. The findings of this research add a valuable dimension to the understanding of autonomous midwifery practice in Western Australia.

The present is a product of the past, so to truly understand what is happening now we first need to look backwards. Historical research opens a window to the past and provides a way for us to know and understand the events of the past. The history of autonomous independent midwives in WA, similar to much of women's history, has not been recorded in detail.

Overview of the Thesis

This thesis will present a historical discussion of autonomous independent midwifery practice (now referred to as Privately Practising Midwives [PPM]) in Western Australia. The thesis, beginning with this introduction, is presented in eleven chapters. A glossary of terms and abbreviations used within this thesis is provided on page xix.

In Chapter Two, an in-depth review of the literature relating to the history of midwifery is provided. This chapter reviews literature from international and Australian authors has been used to contextualise the history of midwifery in Western Australia, informed the researcher on the current state of knowledge and identified the gaps in

⁴¹ McKenzie, "Place and Power: A History of Maternity Service Provision in Western Australia, 1829-1950"; Thorogood, "Politics and the Professions: Homebirth in Western Australia"; Hobbs, *But Westward Look: Nursing in Western Australia 1829-1979*; Flanagan, "Lying-in (or Maternity) Homes in Western Australia from About 1860-1960."; Carter and Carter, *King Eddies: A History of Western Australia's Premier Women's Hospital 1916-2016*.

⁴² Shaw et al., 2016. "Drivers of Maternity Care in High-Income Countries: Can Health Systems Support Woman-Centred Care?" *The Lancet*, 388 (10057): 2282-2295.

knowledge relating to the subject under investigation. Chapter Three provides details of how this study was conducted using historical narrative research within a naturalistic, feminist paradigm and outlines why this was the most appropriate method. Chapter Four, provides historical context relating to midwifery in the Western World. This chapter describes the progression and development of midwifery in the UK, as this has had the biggest influence on Australian midwifery; it also briefly describes American, Canadian and New Zealand midwifery as midwifery in these countries developed from similar beginnings. Chapter Five provides a brief history of midwifery in Australia, before focusing on Western Australia. This chapter provides the historical context of this study and explores midwifery in WA from 1829 to 2018. Chapters Six to Nine present the qualitative research findings of this current study on PPMs in WA. The qualitative analysis drew upon data predominantly from in-depth interviews with living PPMs who practiced in WA between 1978 and 2018. This data was also supplemented with interviews with medical practitioners, media reports, archival documents, and National and State maternity health policies and guidelines. Chapter Ten, provides an in-depth discussion, situating the findings of this current research within the existing literature and highlights the unique contribution of this study. Chapter Eleven concludes this thesis and provides a brief overview of the findings, including the study's limitations and strengths. Recommendations for midwifery practice and education and suggestions for future research is also provided.

Summary

In this introductory chapter, the aim and objectives of this feminist historical narrative study of PPMs in WA were presented. The significance and aim of the study were outlined, along with a description of the author's background and the chosen methodology. The context of the research and a description of the study's setting in Western Australia were provided. A brief history of maternity care and PPMs in Western Australia was offered. Finally, an overview of the thesis and a brief explanation of each chapter were included. In Chapter Two a comprehensive review of the literature will be presented.

Chapter Two – Literature Review

Chapter Overview

This chapter provides an in-depth review of the literature relating to the history of midwifery. The purpose of the literature review is to inform the researcher on the current state of knowledge, theories and unanswered questions or gaps in the subject under investigation. Several literature searches for this thesis were conducted beginning in late 2016 and continuing throughout 2017. Literature was searched using a systematic method to ensure that all relevant literature was included into the review. A number of databases were searched including JSTOR, SAGE, Science direct, Taylor and Francis Journals, CINAHL PLUS, Medline, ProQuest, Worldcat.org and Trove (The Database of the National Library of Australia). Depending on the database, the keywords were used in differing combinations such as 'history of midwives', 'autonomous midwives', 'history of midwifery' 'midwifery legislation', 'social history of birth', medicalisation of childbirth'. Truncations were applied to the key search words to expand search. This extensive search strategy enabled historical, sociological and midwifery resources, books and theses to be included in the search. The literature reviewed was then placed into core concepts such as the history of midwifery, birth attendants and the medicalisation of birth. If relevant, the references within the texts were obtained. Eventually no new concepts emerged, and no further literature was sought.

Thus, the following review contains literature from international and Australian authors which has been used to contextualise the history of midwifery in Western Australia (WA). The literature review is organised according to the core concepts explored by the authors. These core concepts are followed by the review of the literature relating to Western Australia (WA). The history of midwifery has been researched by a small number of Australian midwives and historians; however, a study of autonomous midwifery practice by independent midwives in Western Australia (WA) has not been comprehensively undertaken, which therefore justifies this study. A feminist post-revisionist stance underpins this study. Feminist theory will be discussed in the methodology chapter. This thesis focuses primarily on the history of the colonial European midwives and therefore the history and practices of Indigenous midwives are beyond the scope of this thesis.

The History of Midwifery; the Battle between Midwives and Doctors

Prior to the 1970s the history of childbirth rarely involved midwives. The rhetoric, argued by writers such as early twentieth century historian Charles Singer, describes the advance of medicine and the medicalisation of childbirth as both a positive and successful endeavour that benefitted women.⁴³ Feminist writer Anne Oakley makes the point that history is usually recorded by the victors.⁴⁴ When we look at the history of midwifery it could be argued that obstetricians were the victors. Since the 1970s, international and Australian writers have re-examined the history of childbirth and midwifery and their work has greatly influenced this study.⁴⁵ Most of this revisionist and post-revisionist writing focuses on the argument of who is the most appropriate and safest care provider during childbirth. The outcome can be viewed from two simplified perspectives: it is either a success story of the medicalisation of birth with the medical men increasing safety in birth

⁴³ Singer, Charles. 1928. *A Short History of Medicine*, London: Oxford University Press.

⁴⁴ Oakley, Ann. 1994. *Essays on Women, Medicine and Health* Edinburgh: Edinburgh University Press.

⁴⁵ Ibid.; Oakley, Ann. 2005. *The Ann Oakley Reader: Gender, Women and Social Science*, Portland: The Policy Press; Oakley, Ann. 1984. *The Captured Womb*, Oxford: Basil Blackwell; Donnison, *Midwives and Medical Men: A History of Inter-Professional Rivalries and Women's Rights*; Oakley, *The Captured Womb*; Donnison, *Midwives and Medical Men: A History of Inter-Professional Rivalries and Women's Rights*; Ehrenreich and English, *Witches, Midwives and Nurses: A History of Women Healers*; Ehrenreich and English. 2005. *For Her Own Good: Two Centuries of the Experts' Advice to Women*, 2nd ed. New York: Anchor Books; Katz Rothman, Barbara. 1984. *Giving Birth: Alternatives in Childbirth*, Middlesex: Penguin Books; Katz Rothman, *Recreating Motherhood: Ideology and Technology in a Patriarchal Society*; Katz Rothman, *In Labour: Women and Power in the Birth Place*; Wagner, Marsden. 1994. *Pursuing the Birth Machine: The Search for Appropriate Birth Technology / Marsden Wagner*. Camperdown, NSW: ACE Graphics; Wagner, Marsden. 2006. *Born in the USA: How a Broken Maternity System Must Be Fixed to Put Women and Children First*, Berkeley: University of California Press; Davis-Floyd Robbie. 1992. *Birth as an American Rite of Passage*, ed. Robbie E. Davis-Floyd. Berkeley: University of California Press; Davis-Floyd, Robbie. 2018. *Ways of Knowing About Birth: Mothers, Midwives, Medicine and Birth Activism*, Long Grove, Illinois: Waveland Press, Inc.; Davis-Floyd Robbie and Christine Barbara Johnson. 2006. *Mainstreaming Midwives: The Politics of Change*, ed. Robbie Davis-Floyd and Christine Barbara Johnson. New York: Routledge; Davis-Floyd Robbie and Carolyn F. Sargent. 1997. *Childbirth and Authoritative Knowledge: Cross-Cultural Perspectives*, ed. Robbie E. Davis-Floyd, Carolyn F. Sargent. Berkeley, California: University of California Press; Murphy-Lawless, Jo. 1998. *Reading Birth and Death: A History of Obstetric Thinking*, Cork: Cork University Press; Wertz, Richard and Dorothy Wertz. 1977. *Lying-In: A History of Childbirth in America*. New York: The Free Press; Kitlinger, Sheila. 2005. *The Politics of Birth*, Edinburgh: Elsevier; Kitlinger, Sheila. 2011. *Rediscovering Birth*. London: Printer & Martin Ltd; Leap, Nicky and Billie Hunter. 1993. *The Midwife's Tale*, London: Scarlet Press; McIntosh, Tania. 2012. *A Social History of Maternity and Childbirth*, London: Routledge; Thorogood, "Politics and the Professions: Homebirth in Western Australia"; McKenzie, "Place and Power: A History of Maternity Service Provision in Western Australia, 1829-1950"; Potter, "Weaving the Threads: A Tapestry of Sydney's Colonial Midwives, 1788-1901."

for both women and babies, or a story of the exploitation and control of midwives and women by the patriarchal men. Historian and British midwife, Tania McIntosh states:

The way in which the story of the history of maternity is told— with midwives forced into subjugation by doctors, or women forced to give birth in hospital rather than at home—is relevant not only to historians but to all that are involved in maternity today. The rhetoric of conflict and control continues to exert a powerful influence on the way in which maternity is viewed and experienced.⁴⁶

The late Jean Donnison (1925-2017) and Ehrenreich and English (1973) were some of the first revisionist feminist historians to question the established medical accounts of the history of childbirth, and the history of the providers of care during childbirth. Donnison's 1977 book *Midwives and Medical Men* retells the history of the struggle for the control of childbirth, focusing on midwifery in Europe and in particular England, from a revisionist stance.⁴⁷ Ehrenreich and English revisit the Western history of women healers in their 1973 book, *Witches, Midwives and Nurses*, which focuses upon American childbirth history.⁴⁸ One of the key points discussed in these revisionist accounts are the traditional medical historian's assumptions that midwives were unskilled, ignorant and dangerous. The early modern midwife in Europe from 1400-1800 is discussed in *The Art of Midwifery* edited by post-revisionist historian Hilary Marland.⁴⁹ Marland (1993) describes the early midwives of Europe in the Early Modern Age (fifteenth to eighteenth century) as active members of their communities, as missionary and political figures, and as defenders of their occupation against the invasion of male practice.⁵⁰ She urges caution in approaching the history of the midwife from the standpoint of a contest between female and male birth attendants where the midwife is the loser, asserting that it is more complex than that. Likewise, Hess (1993) studied the working practices of seventeenth century Quaker midwives in the south of England, again demonstrating the diversity of the midwives' working practices; some only attended occasional births whilst others built up a clientele and worked across several

⁴⁶ McIntosh, *A Social History of Maternity and Childbirth*.10.

⁴⁷ Donnison, *Midwives and Medical Men: A History of Inter-Professional Rivalries and Women's Rights*.

⁴⁸ Ehrenreich Barbara and Deirdre English. 1973. *Witches, Midwives and Nurses: A History of Women Healers*, New York: The Feminist Press.

⁴⁹ Marland, Hilary. 1993b. *The Art of Midwifery: Early Modern Midwives in Europe*, London: Routledge.

⁵⁰ Ibid.

counties.⁵¹ In a similar way, feminist sociologist Jo Murphy-Lawless' (1998) in-depth discussion of the history of childbirth, obstetrics and midwifery in Ireland from the eighteenth century, *Reading Birth and Death*, continues to explore the thinking around obstetric science and the "convincing thesis that the male medical model of childbirth has disempowered women".⁵²

Conversely, Edward Shorter's (1983) patriarchal and patronising interpretation *A History of Women's Bodies* challenges the revisionist history by stating:

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, they were captives of a folkloric view that the best midwife is the one who interferes most.⁵³

One of the key areas of debate in the opposing accounts, as demonstrated by Shorter, is the representation of midwives and their practice prior to the medicalisation of birth. Shorter, for example, relies heavily on the doctors' accounts of midwives' failings throughout his book. He uses these accounts as evidence to highlight the ignorant and dangerous practice of the midwives and the success of the 'much needed' medical dominance in saving women during birth. Shorter asks, regarding the doctors' written accounts:

how do we know we can trust them or that they are not viciously distorting the historical record in order to lie about their enemies, the midwives? We know that in the past midwives attended most births. And we know that from statistics that many mothers died in those deliveries. The statistics are the most stunning of any indictment of the traditional midwives.⁵⁴

Shorter invokes statistics to prove his point; however, these statistics are not necessarily accurate representations of reality. Statistics would have been compiled by the medical men themselves or other patriarchal authorities.⁵⁵ The assumptions that women were dying at the hands of midwives and being saved by medical men are contested by

⁵¹ Hess, Giardina Ann. 1993. "Midwifery Practice among the Quakers in Southern Rural England in the Late Seventeenth Century " in *The Art of Midwifery: Early Modern Midwives in Europe*, ed. Hilary Marland, London: Routledge.

⁵² Murphy-Lawless, *Reading Birth and Death: A History of Obstetric Thinking*.

⁵³ Shorter, Edward. 1983. *A History of Women's Bodies*, London: Allen Lane.59.

⁵⁴ Ibid.97-98.

⁵⁵ Tew, Marjorie. 1990. *Safer Childbirth?: A Critical History of Maternity Care*, London: Chapman Hall.

feminist revisionist writers and will be discussed later in this chapter. Donnison asserts that the man-midwife exaggerated the dangers of birth, frightened women into believing that attendance by a man midwife was the only safe option, and at the same time took every opportunity to “denigrate the understanding and competence of the midwives”⁵⁶ and blame them unjustly for anything that went wrong in birth. Medical historian Charles Singer (1928) reinforces the unsubstantiated belief that once medical men became involved, birth moved away from the ‘ignorant’ midwives and into the institutions, and thus became safer:

The midwives were for the most part ignorant, dirty, unskilful 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.⁵⁷

These assumptions are not based on historical fact. It is argued by revisionist historians that these are inherited myths that have been constantly repeated by historians, often medical men themselves, until they appear to be historical fact.⁵⁸ They were not based on actual evidence; however, they were used to give the medical men status and power. According to Oakley, this rhetoric was continually perpetuated to discredit midwives. Oakley (2004) highlights this way of thinking by referencing a book written by nineteenth century American obstetrician Henry Garrigues. Garrigues book’s chapter entitled “Midwives”, contains certain critical assumptions relating to the nineteenth century midwife. Oakley describes these assumptions as:

midwives are ignorant and dirty; therefore, their practice is dangerous; even trained midwives are dangerous; midwives are especially unscientific because they only care for women and children’s health generally; men know more about obstetrics than women; doctors know more about obstetrics than anyone else; and obstetrics is a science.⁵⁹

Oakley argues that these patriarchal beliefs— that obstetricians know more about birth than women themselves—have led to a deep cultural divide between obstetricians

⁵⁶ Donnison, *Midwives and Medical Men: A History of Inter-Professional Rivalries and Women's Rights*.40.

⁵⁷ Singer, *A Short History of Medicine*.163-164.

⁵⁸ Tew, *Safer Childbirth?: A Critical History of Maternity Care*; Donnison, *Midwives and Medical Men: A History of Inter-Professional Rivalries and Women's Rights*; Towler, Jean, and Joan Bramall.1986. *Midwives in History and Society*. London Croom Helm.

⁵⁹ Oakley, *Essays on Women, Medicine and Health*.66;"Oakley, Ann. 2004. Who Cares for Women? Science Versus Love in Midwifery Today," in *Midwifery and the Medicalization of Childbirth: Comparative Perspectives*, ed. Edwin Van Teijlingen, et al., New York: Nova Science Publishers Inc.

and birthing women that has continued until today.⁶⁰ Conversely, Adrian Wilson's (1995) book *The Making of Man-Midwifery: Childbirth in England 1660-1770* argues that the revolution in childbirth was started by birthing women not medical men. He believes that the introduction of men to midwifery was not an evil—a question of medical men denigrating midwives—but that it was led by women themselves choosing the medical men rather than the female midwives.⁶¹ This view is interesting and raises several challenges to the feminist revisionist writer. Although there is evidence to support the assertion that some women did encourage the move from female midwives to medical men, there is also evidence to suggest that this shift was not as simple as it seems. As Irvine Loudon has noted, there were multiple reasons why a social shift in birth attendants might take place including; the rise in the scientific understanding of pregnancy and childbirth; an increase in demand for male attendants because of a change in female culture; and the success of medical men at all levels persuading women to accept men midwives rather than the female midwife to attend them in childbirth.⁶² However, these factors also highlight the fact that midwives would have been excluded from these advances in scientific understanding due to their gender and class, also making the point that women would not have been able to 'choose' something that was not available.

Furthermore, McIntosh asserts that the history of midwifery has been seen by historians as a metaphor for the wider issues of health, control, class, gender and power.⁶³ These are significant issues as they not only affect midwives, but they also affect all women. In his book *Medical Dominance*, medical sociologist, Evan Willis agrees, as he concedes that the midwives, undoubtedly, were easy to subordinate and this subordination reflects patriarchal division of labour from the seventeenth to mid-twentieth century.⁶⁴ Yet, the subordination of midwives cannot be viewed only as a process of male medical imperialism. Alongside the gender transformation, a class transformation also took place; the working-class midwives had little power and were unable to develop a good defence, due to their gender, social standing and the social and gender-based division of labour. Ehrenreich and English (2010) state that the real answer to the success of the medical professions' monopoly in birth was not a "made up drama of science versus ignorance and superstition,

⁶⁰ Oakley. "Who Cares for Women? Science Versus Love in Midwifery Today."

⁶¹ Wilson, Adrian. 1995. *The Making of Man-Midwifery: Childbirth in England, 1660-1770*, London: UCL Press.

⁶² Loudon, Irvine. 1993. *Death in Childbirth: An International Study of Maternal Care and Maternal Mortality 1800-1950*. Clarendon Press: Oxford.

⁶³ McIntosh, *A Social History of Maternity and Childbirth*.

⁶⁴ Willis, *Medical Dominance*.

but part of the nineteenth century's long story of class and sex struggles for power in all aspects of life".⁶⁵ The rise of the medical profession to political and economic power was a result of this.

Looking again at the wider context, American authors Wertz and Wertz (1977)⁶⁶, in their book *Lying-in: A history of childbirth in America*, refer to and reflect on the history of childbirth in Europe and its comparison to the history of childbirth in America. They demonstrate that from the 1820s independent midwifery started to disappear in America. There were many reasons for the gradual disappearance of midwives from the practice of midwifery, the most obvious being the competition from the new medical men. The increase in doctor-attended births reinforced the medical men's belief that more intervention was needed. Wertz and Wertz describe this:

they came to adopt a view endorsing more extensive interventions in birth and less reliance upon the adequacy of nature. This view led to the conviction that a certain mastery was needed, which women were assumed to be unable to achieve.⁶⁷

In the American context, Wertz and Wertz assert that, due to the low status of women in American society, it was "unthinkable to confront women with the facts of medicine".⁶⁸ Wertz and Wertz state that the American doctors were much more aggressive and less regulated than their English counterparts in their treatment of the midwives. They dealt with the 'midwife problem' by actively opposing midwives, describing them as "relics of the barbaric past"⁶⁹; their campaign against the 'granny midwives'⁷⁰ included posters and advertisements in magazines complete with horror stories containing racial and ethnic slurs. According to Wertz and Wertz, the question in America during the nineteenth century was not whether midwives should disappear but how rapidly this could be achieved.⁷¹

As seen with other histories of women, until recently little research existed of the handywomen and untrained midwives' lives. UK Midwives, Nicky Leap and Billie Hunter (1993) used original interviews and secondary sources to weave together the vivid and moving stories of handywomen, midwives and women in the first half of the twentieth

⁶⁵ Ehrenreich and English, *Witches, Midwives and Nurses: A History of Women Healers*.63.

⁶⁶ Wertz and Wertz, *Lying-In: A History of Childbirth in America*.

⁶⁷ *Ibid.*47.

⁶⁸ *Ibid.*47.

⁶⁹ *Ibid.*216.

⁷⁰ Empirically-trained midwives (midwives trained through experience rather than formally educated) (Please see Glossary)

⁷¹ *Ibid.*216.

century in England. These women were familiar figures in the working-class community as they provided care both at the beginning of life and also at the end of life.⁷² Until the mid-twentieth century both birth and death tended to occur at home and the English handywoman would provide care in both circumstances. Leap and Hunter expected to uncover “a treasure chest of forgotten skills and experiences that would enhance and inspire today’s midwives”.⁷³ They were initially disappointed however, to find that handywomen often displayed authoritative behaviours. Leap and Hunter also described that in the handywoman’s limited knowledge of anatomy and physiology of birth, and the lack of training and education they had some “meddlesome, and even dangerous practice, that sometimes took place in the absence of education, where there was limited information about the basic anatomy and physiology of childbirth”.⁷⁴ However, as the study progressed, they gained more insight into the extraordinary achievement these women made in the face of the “severe restrictions imposed by the politics of gender, class and poverty”.⁷⁵ Leap and Hunter state that arguably the subordination of the midwifery profession was reinforced by legislation that ensured the services of a doctor had to be employed in all situations when there were complications; a ruling that ensured a regular income for the medical profession. They believe that the parallels between the subordination of an all women profession and the position of women in society is obvious. However, in spite of these social constraints most of the midwives interviewed saw themselves as equal to doctors, and many described positive working relationships with doctors.⁷⁶

In a disappointingly similar way to the medical men, middle and upper-class midwives poured scorn on these untrained independent midwives. Donnison and Leap and Hunter describe how these midwives also referred to the untrained midwives as ‘Gamps’.⁷⁷ Leap and Hunter’s interviews, however, paint a very different picture from the ‘Gamp’ image that was used to demonstrate these midwives’ dangerous practices. They describe one midwife “Granny Anderson’s” love of “carbolic soap and cleanliness,” and “her pure

⁷² Leap and Hunter, *The Midwife's Tale*.

⁷³ *Ibid.*xxiii.

⁷⁴ *Ibid.*xxiii.

⁷⁵ *Ibid.*xxiii.

⁷⁶ *Ibid.*57.

⁷⁷ Donnison, *Midwives and Medical Men: A History of Inter-Professional Rivalries and Women's Rights*; Leap and Hunter, *The Midwife's Tale*.

white apron.”⁷⁸ They also mentioned that she may have been “paid in kind”⁷⁹, paying her things instead of money, although definitely not alcohol, as portrayed in the depictions of the Sairey Gamps. Leap and Hunter found no evidence to suggest that the handywomen were in any significant way responsible for ‘death and destruction’ or the other accusation of ‘dealing out abortions’.⁸⁰ Written accounts and their research from the interviews suggested that the skills and behaviours of the individual handywomen and independent midwives was as varied as in any other profession.⁸¹

Colonial Australia’s culture was based on the culture of its sovereign country Britain, therefore, in the early years of colonisation (1788-1850) many aspects of midwifery in Australia paralleled midwifery in Britain. Ruth Teale’s (1978) work reinforces the conventional theme of medical historians in her depictions of the colonial woman in Australia from 1788-1914, stating that if the woman was poor and unable to afford a doctor to attend her in childbirth then she:

remained at the mercy of the local midwife, the proverbial ‘Mrs Gamp’, who was usually totally untrained. Such women had no conception of surgical cleanness; they sometimes transmitted puerperal fever; they could through ignorance, strangle the child, or cause its death by improper feeding; and their attempts to tie the umbilical cord or remove the placenta made maternal death from ‘rupture of the uterus’ a frequent autopsy finding.⁸²

Teale’s claims that midwives were dangerous was an unsubstantiated generalisation based on the concept that the midwives were untrained and ignorant, and the doctor was trained and educated. The sources discussed above indicate that many midwives were experienced and, although not formally trained, they were skilled and competent; conversely, many doctors, although educated, were unskilled and incompetent. In contrast, medical sociologist Evan Willis (1989)⁸³ also comments on the literary stereotype of ‘Gamps’– based on Charles Dickens’ fictional character Sarah Gamp: sloppy, drunkard and hired attendant of the poor– being widely used in the eighteenth and nineteenth centuries by opponents of midwifery in Australia to describe midwives in general, but particularly untrained independent ones.⁸⁴ He states using the term ‘Gamps’ must be seen as an

⁷⁸ Leap and Hunter, *The Midwife's Tale*.17.

⁷⁹ Ibid.20.

⁸⁰ Ibid.89-102.

⁸¹ Ibid.

⁸² Teale, *Colonial Eve: Sources on Women in Australia 1788-1914*.122.

⁸³ Willis, *Medical Dominance*.

⁸⁴ Ibid.100.

attempt to discredit midwives as a whole and as an element in the strategy of male medical takeover in Australia.⁸⁵ Willis provides early examples of conflicts between midwives and doctors in Australia. He includes cases where doctors refused to attend a birth where complications had arisen, although he indicates that this, as well as an anti-midwife element, may have also reflected the arrogance and neglect which was a feature of class relations at the time in Australia as well as in the wider context of the Western world.⁸⁶ In their opposition to the practice of midwifery by independent midwives and the attempt to control midwives, some doctors' motivations resulted from the perceived concern for maternal and infant welfare. However, according to Willis (1989), another important component of their motivation was the fear of competition from the cheap and popular local Independent midwife.⁸⁷ Furthermore, he believes the claim that midwives were ignorant and dangerous was used as an ideological weapon in the struggle for the control over childbirth.⁸⁸

The battle between the obstetricians and the midwives continues in Australia today according to Australian writer Mary-Rose MacColl, in her 2013 her book titled *The Birth Wars*, which reviewed maternity services in Queensland.⁸⁹ MacColl states that, prior to her research, she knew nothing about what she describes as "the birth wars", and she had a few preconceptions about maternity care.⁹⁰ However, she learnt when it came to childbirth everyone has beliefs and preconceptions, even though some are deeply hidden. In her analysis MacColl suggests that it seems that very little has changed since the early pioneer days, when conflicts occurred between midwives and doctors in Australia over who was the most appropriate care giver during birth, with both trying to discredit the other.⁹¹ MacColl describes how in Queensland, members of the two professions fire shots at each other in the media, at clinical care conferences and over the individual patients.⁹² She reports how an obstetrician called a midwifery-led birth centre 'the killing fields', resulting in the President of the Queensland branch of the College of Midwives firing back claims of unprofessional conduct against the obstetrician. When midwives are recreated as witches

⁸⁵ Willis, *Medical Dominance*.101.

⁸⁶ Ibid.103.

⁸⁷ Ibid.102.

⁸⁸ Ibid.102.

⁸⁹ MacColl, Mary-Rose. 2013. *The Birth Wars*, Queensland: University of Queensland Press.

⁹⁰ Ibid.

⁹¹ Ibid.

⁹² Ibid.

and demons and obstetricians are maligned for 'golf driven' caesareans, she emphasises that none of this helps birthing women who can get caught in the middle.⁹³

Philosophy of Childbirth, the Medicalisation of Birth and the Body as a Machine

From the 1700s, with the rise of science and what was considered the more 'modern' and rational approach to midwifery theory, the old midwifery 'ways of knowing' were dismissed as superstitions and old wives' tales. The medical men accused midwives of using ancient, dangerous and outdated practices. Eighteenth century medical men in the Western World, such as Fielding Ould in Ireland and William Smellie in Scotland, were gaining respect and developing new birthing theories that were based on the science, anatomy and technical knowledge.⁹⁴ Lorna Duffin examines one of the most significant aspects of the new medical 'science', namely the suggestion that the body operated like a machine. Within this discourse, childbirth was understood as a mechanical process. Duffin and Murphy-Lawless argues that, during Victorian times, it was believed that women were subordinate to men in all areas of life, men, with their superior knowledge, and being more practical and mechanically minded, were apparently more suited to preside over childbirth. Women's minds were seen as unscientific, they could not comprehend the mysteries of science, and therefore they could not be obstetricians in the modern world.⁹⁵ Similarly, Donnison states that doctors argued that danger in childbirth could arrive suddenly and, even if women were not precluded from attaining the necessary anatomical knowledge, they were "unfit by nature" for all scientific mechanical employment. They could never possibly use the obstetric instruments "with advantage or precision".⁹⁶

This mechanical view of childbirth supported the idea that midwives —because they were women—did not have the knowledge or ability to understand the mechanisms of birth or deal with any defective mechanisms. Therefore, it made sense that the whole of midwifery would be safer in the hands of men.⁹⁷ : Barbara Brandon Schnorrenberg asserts

⁹³ MacColl, *The Birth Wars*.

⁹⁴ Murphy-Lawless, *Reading Birth and Death: A History of Obstetric Thinking*.

⁹⁵ Duffin, Lorna. 2012. "The Conspicuous Consumptive: Woman as an Invalid," In *The Nineteenth-Century Woman: Her Cultural and Physical World*, ed. Sara Delamont and Lorna Duffin, Hoboken: Taylor and Francis; Murphy-Lawless, *Reading Birth and Death: A History of Obstetric Thinking*.

⁹⁶ Donnison, *Midwives and Medical Men: A History of Inter-Professional Rivalries and Women's Rights*.59.

⁹⁷ Ehrenreich and English, *Witches, Midwives and Nurses: A History of Women Healers*.

that these arguments were, in the end, the most critical in the decline of the midwife.⁹⁸ Until the twentieth century many women were excluded from universities, teaching hospitals and from the professional organisations. Medicine, like other professions, was a male preserve to be guarded jealously against incursion from the illogical, unscientific and weak women. Increasingly, over the next two hundred years, faith in the science and technology available in the birth environment has led women and their caregivers to trust machines rather than women's reported experience of their own observation.⁹⁹

The obstetric model (or medical model) views pregnancy and childbirth as pathological. According to Davis-Floyd, the obstetric model also reinforces the validity of the patriarchal structures, the superiority of science and technology, and the importance of machines and institutions.¹⁰⁰ The obstetric model is patriarchal: it does not place any emphasis on the positive relationship between the woman and her caregiver and does not place the woman at the centre of the care experience. Patriarchy supports the weak feminine ideal described by Duffin as the perfect symbol of status, with the perfect lady portrayed as the disabled, invalid female, this contributes to the idea that the working-class women are more able to have births with little or no help and that middle and upper-class women are more delicate and need more help.¹⁰¹ Duffin asserts that the Victorian image of the woman as "an invalid, weak, delicate and prone to illness could not have been maintained without the support of the medical profession".¹⁰² Other sources have argued that this assumption has been proposed because of the type of birth attendant, as the working-class women were more likely to be attended by midwives.¹⁰³

From the eighteenth century, the rise of obstetrics and its eventual dominance over midwifery in the Western world, was achieved by the argument that those who cared for the female body could only do so by viewing it as a machine to be supervised, controlled and interfered with by technical means. Science and reason were—and continue to be—

⁹⁸ Schnorrenberg, Barbara Brandon. 2004. "Is Childbirth Any Place for Women? The Decline of Midwifery in Eighteenth Century England." in *Midwifery and the Medicalization of Childbirth: Comparative Perspectives* ed. Edwin Van Teijlingen, et al., New York: Nova Science Publishers Inc.

⁹⁹ Lawrence-Beech B and B Phipps. 2008. "Normal Birth: Women's Stories," in *Normal Childbirth Evidence and Debate.*, ed. Soo Downe, Edinburgh: Churchill Livingstone.

¹⁰⁰ Davis-Floyd, *Birth as an American Rite of Passage*; Oakley, "Who Cares for Women? Science Versus Love in Midwifery Today."

¹⁰¹ Duffin, "The Conspicuous Consumptive: Woman as an Invalid."

¹⁰² *Ibid.*26.

¹⁰³ Kitzinger, *Rediscovering Birth*; Murphy-Lawless, *Reading Birth and Death: A History of Obstetric Thinking*; Oakley, *The Ann Oakley Reader: Gender, Women and Social Science*; Donnison, *Midwives and Medical Men: A History of Inter-Professional Rivalries and Women's Rights*.

dominant in support of this approach. Initially, the scientific basis of obstetrics was limited, however the eighteenth and nineteenth century doctors were committed to the 'mastery of birth'. In the absence of an understanding of the process of birth, the control and management of birth were critical; childbirth and women had to be 'mastered'. Oakley emphasises that the masculine gender of this term is highly significant. The male role in obstetrics paralleled the male role in a patriarchal society.¹⁰⁴ Similarly Katz Rothman asserts that:

The source of the pathological orientation of medicine towards women's health and reproduction is a body as a machine model (the ideology of technology) in which the male body is taken as the norm (the ideology of patriarchal). From that viewpoint, reproductive processes are stresses on the system, and thus disease like.¹⁰⁵

The change in attitudes and care givers also had an impact on the process of giving birth. Harley argues the shift to man midwifery, and the associated change to the lithotomy position for birth helped to instil the idea that women were naturally passive in the process of birth and encouraged the infantilisation of pregnant and birthing women that is seen in the twentieth century maternity hospitals.¹⁰⁶

The works of Marsden Wagner (1930-2014), a well-respected American epidemiologist and paediatrician, Barbara Katz Rothman, an American feminist sociologist, and Robbie Davis-Floyd, an American feminist anthropologist, discuss childbirth philosophies and the difference in the care provided by midwives and doctors in the twentieth and twenty-first centuries. Wagner describes fundamental differences between the obstetric or medical philosophy and the midwifery philosophy of care.¹⁰⁷ The medical philosophy focuses on the pathology of pregnancy and birth; in other words, potential adverse outcomes, the things that could and probably would go wrong. Within medical thought, birth is only ever normal retrospectively. In contrast, the midwifery philosophy proposes that pregnancy and birth are, for most women, a normal physiological process that will require minimal intervention and only needs a supportive role, rather than an

¹⁰⁴ Oakley, *The Ann Oakley Reader: Gender, Women and Social Science*.

¹⁰⁵ Katz Rothman, *In Labour: Women and Power in the Birth Place*.37.

¹⁰⁶ Harley, David. 1993. "Provincial Midwives in England: Lancashire and Cheshire, 1660-1760 " in *The Art of Midwifery: Early Modern Midwives in Europe*, ed. Hilary Marland, London: Routledge.

¹⁰⁷ Wagner, *Born in the USA: How a Broken Maternity System Must Be Fixed to Put Women and Children First*.

active role by the care provider.¹⁰⁸ These works are significant to this thesis as they underpin this current study of WA midwifery by providing some of the theoretical and ideological framework.

Robbie Davis-Floyd experienced a traumatic caesarean birth which prompted her to research why birth in the Western world was so focused on technology and intervention. Her subsequent book, *Birth as an American Rite of Passage*, published in 1992, describes the 'technocratic' model of care¹⁰⁹. Obstetrics is described as an assembly line production of goods; the woman's reproductive tract is treated like a birthing machine with the function of delivering the final product, the baby. As previously discussed, the patriarchal profession of medicine is considered the leader in scientific thinking and therefore the management of the 'machine' (the woman) requires control by skilled operators, usually male doctors. Although it is acknowledged that women now work as obstetricians, in this technocratic model of birth they are still working within the patriarchal and male dominated paradigm.¹¹⁰ Davis-Floyd asserts that this metaphor defines the baby and mother as separate entities; this model implies that the medical doctors (who are operating within a patriarchal discourse) become the producers of the product (the baby), therefore making the mother's role in the whole process passive and merely the vessel for the end product.¹¹¹ Feminist sociologist Oakley also writes extensively on the discourse of the body as a machine; this view produces well known metaphors, for example, the garage analogy where the doctor is a mechanic and the pregnant woman a broken-down car. The garage is the hospital providing the tools to fix the malfunctioning parts.¹¹² The mechanical model of childbirth is not a good description of reality. The pregnant woman is much more than an ambulant pelvis, she is an individual with mind, emotions and a complex social and personal life.¹¹³ Katz Rothman asserts that within the medical model problems in the body are "technical problems requiring technical solutions, whether it is a mechanical repair, a chemical rebalancing or a 'debugging' of the system".¹¹⁴ In this technocratic model, anything that goes 'wrong' is because the machine—the woman— is inherently faulty.

¹⁰⁸ Wagner, *Born in the USA: How a Broken Maternity System Must Be Fixed to Put Women and Children First*.

¹⁰⁹ Davis-Floyd, *Birth as an American Rite of Passage*.

¹¹⁰ Wagner, *Born in the USA: How a Broken Maternity System Must Be Fixed to Put Women and Children First*.

¹¹¹ Davis-Floyd, *Birth as an American Rite of Passage*.160.

¹¹² Oakley, "Who Cares for Women? Science Versus Love in Midwifery Today."

¹¹³ *Ibid*.

¹¹⁴ *Ibid*.

Davis-Floyd states “when something goes wrong during pregnancy or birth, it is the woman’s fault, due to either her refusal to follow doctor’s orders, to the inherent defectiveness of her body, or to her own inadequacy as a person.”¹¹⁵ In contrast to the medical model, the midwifery model presents an integrated holistic approach. To be able to fully understand the medical model of childbirth and obstetrical philosophy of pregnancy and childbirth Katz Rothman states:

a second major ideological basis of the medical model must be considered: medicine is based not only on the ideology of technological society, but also on the ideology of patriarchal society. Medicine is geocentric and patriarchal, and its values are those of men as the dominant social power.¹¹⁶

Extremely significant to this current study, Katz Rothman, Davis-Floyd and Donnison believe these ideologies that medicine employs, reinforce the validity of the patriarchal philosophy, the superiority of science and technology and the importance of machines and institution. This patriarchal way of thinking— in the context of the medical professions’ takeover of midwifery during the nineteenth and early twentieth — leads to the conclusion that men with their superior knowledge, and being more practical and mechanically minded than women, are more suited to preside over childbirth.¹¹⁷

Wagner asserts that the medical philosophy and the midwifery philosophy are two different ways of looking at birth and the practitioners who attend it. Doctors deliver babies, and some see having a baby as something that happens to a woman, whereas midwives believe that pregnancy and birth are normal processes; therefore, midwives should assist women in birth as they believe that giving birth is something a woman does.¹¹⁸ This view is reinforced by Katz Rothman in her 1982 book *In Labour; Woman and Power in the Birth Place*. She describes the perspective of doctors and compares it with the perspective of homebirth advocates and ‘lay’ midwives. She suggests that these two perspectives are “diametrically opposed”.¹¹⁹ The medical model portrays pregnancy and birth through the “perspective of a technological society, and from men’s eyes. Birthing

¹¹⁵ Davis-Floyd, *Birth as an American Rite of Passage*.194.

¹¹⁶ Katz Rothman, *In Labour: Women and Power in the Birth Place*.36.

¹¹⁷ Ibid.; Katz Rothman, *Recreating Motherhood: Ideology and Technology in a Patriarchal Society*; Davis-Floyd, *Birth as an American Rite of Passage*; Donnison, *Midwives and Medical Men: A History of Inter-Professional Rivalries and Women's Rights*.

¹¹⁸Wagner, *Born in the USA: How a Broken Maternity System Must Be Fixed to Put Women and Children First*.

¹¹⁹ Katz Rothman, *In Labour: Women and Power in the Birth Place*.33.

women are thus objects upon which certain procedures must be done".¹²⁰ In contrast, the midwifery model highlights as of equal importance the woman's perspective on birth, "in which women are the subjects, the doers and the givers of birth".¹²¹

The medicalisation of childbirth in the Western world continues into the twenty-first century, with interventions in birth increasing. Over the past decades the overuse of technologies such as induction of labour (IOL), electronic foetal monitoring (EFM), ultrasound, surgical births and other medicalised procedures have arisen.¹²² Research shows that often the high levels of intervention are not justified, and, in some cases, the high level of intervention is actually detrimental to birthing women.¹²³ The place of technology is a unique one as it highlights the difference between the techniques of watching and waiting as employed by midwives, and the intervention and pathological thinking inherent in obstetrics.

McIntosh asserts that as the rise of science continued, the development of the ultrasound, for example, meant that doctors did not have to rely on what women were telling them.¹²⁴ Everything from the date they conceived, the position of the foetus and the date it should be born are now the provision of the expert doctor due to access to this technology. This shift in thinking and reliance on technology rather than the intuitive and intimate knowledge of the woman as the expert in her own body has had profound effects on the relationship between women and their care givers. Risk and safety are discussed as paramount; technology is held above women's own experiences and doctors are the experts in all birth, with some midwives now also embracing the technological birth.

Birth in the Institution: with the Appropriate Care Giver

Integral to the displacement of midwives was the redefinition of birth as a medical event, fraught with danger and in need of intervention by obstetricians. This redefinition led to the

¹²⁰ Katz Rothman, *In Labour: Women and Power in the Birth Place*.35.

¹²¹ *Ibid.*.35.

¹²² Kessler, Daniel, Nicholas Summerton, and John Graham. 2006. "Effects of the Medical Liability System in Australia, the UK and the USA." *The Lancet* 368 (9531): 240-246; McDougall, Lori, Oona M. R. Campbell, and Wendy Graham. 2016. "Maternal Health: An Executive Summary for the Lancet's Series"; Wagner, *Born in the USA: How a Broken Maternity System Must Be Fixed to Put Women and Children First*.

¹²³ McDougall, Campbell, and Graham, "Maternal Health: An Executive Summary for the Lancet's Series."

¹²⁴ McIntosh, *A Social History of Maternity and Childbirth*.

increase in obstetrician attended births and the move from home to hospital, and from the early twentieth century, the reinvention of midwifery as subordinate to medicine. The discourse of risk and safety also started to come to the forefront with the unsubstantiated claim that birth would be safer in the hospital rather than at home.¹²⁵ Katz Rothman (1982) debunks the rhetoric of the 'safer birth' and the claims of a decline in maternal and infant mortality following the move to the institution and medically managed births in the twentieth century in America. She states that a midwife attended homebirth was the safest for both the woman and her baby. In Washington the percentage of births reported by midwives declined from 50% in 1903 to 15% in 1912; with the corresponding increase in medically managed and institutional births, came an increase in infant mortality in the first day, first week, first month of life.¹²⁶ In the same time period in New York the midwives did significantly better than the doctors in preventing both stillbirth and puerperal sepsis.¹²⁷ In Newark the maternal mortality rates were reported as 1.7 per thousand for midwife attended births. In comparison, in Boston where midwives were banned, the maternal mortality rate was 6.5 per thousand for doctor attended births. The infant mortality rate in Newark was reported as 8.5 per thousand, compared with 36.4 in Boston.¹²⁸

Revisionist writers such as Katz Rothman, Donnison and Murphy-Lawless¹²⁹ believe that as the physicians trained in the specialty of obstetrics and gynaecology they declared themselves to be the proper caregivers for childbearing women, and the lying-in house or hospital was deemed to be the proper setting for that care. Birth was evolving from a woman's physiological event attended by women, into a medical procedure where women were the patients treated by the male doctors. Furthermore, Margaret Versluysen (1981)¹³⁰ argues that lying-in hospitals were primarily patriarchal institutions that took the control away from birthing mothers and undermined the midwives. Similarly, Murphy-Lawless describes how the founding of these hospitals was the basis for the medical hierarchy, which led to the medicalisation of birth in Ireland, where the obstetricians spoke of increased safety to mothers and babies. In contrast to the views of writers such as Shorter

¹²⁵ Tew, *Safer Childbirth?: A Critical History of Maternity Care*.

¹²⁶ Katz Rothman, *In Labour: Women and Power in the Birth Place*.41.

¹²⁷ *Ibid.*41.

¹²⁸ Katz Rothman, *In Labour: Women and Power in the Birth Place*.41.

¹²⁹ Donnison, *Midwives and Medical Men: A History of Inter-Professional Rivalries and Women's Rights*; Murphy-Lawless, *Reading Birth and Death: A History of Obstetric Thinking*; Katz Rothman, *In Labour: Women and Power in the Birth Place*.

¹³⁰ Versluysen, Margaret. 1981. "Midwives, Medical Men and 'Poor Women Labouring of Child': Lying-in Hospitals in Eighteenth-Century London," in *Women, Health and Reproduction*, ed. Helen Roberts, London: Routledge and Kegan Paul.

¹³¹who emphasises this apparent increased safety, Murphy-Lawless agrees with Versluisen in cautioning that the claim that obstetrics has made childbirth safer for women and babies requires careful examination. Murphy-Lawless asserts, “the medicalisation of childbirth has not been an unqualified success and has not given women all the benefits it has claimed”.¹³²

Historian Lisa Forman Cody, (2004)¹³³ who re-examined documents and wrote an account of living and dying in Georgian (1714-to 1830s) London’s lying-in hospitals, acknowledged that the evidence appeared to offer clinical advantages to the men midwives stating:

that female midwives and their defenders have long viewed these institutions as contributing to a broader male medical campaign to destroy the autonomy and prestige that early modern midwives once enjoyed.¹³⁴

Despite the clinical advantages gained by men midwives, Cody’s research shows these lying-in hospitals were “communal spaces filled primarily with women who controlled the experience of birth as midwives, women and fellow sufferers.”¹³⁵ The early lying-in hospitals seemed like a rational choice for women as they promoted many early modern expectations for an ideal birth: “Christian succor, delivery by a female midwife while surrounded by other women, plentiful caudle and weeks of postpartum rest away from routine and family demands.”¹³⁶ Interestingly, Cody compares these institutions with the institutions of the mid-twentieth century and modern day Western World and concludes that the women in the eighteenth century actually had more control and autonomy. She states:

Perhaps most surprisingly, reconstructing daily life inside these institutions shows that an institutional birth in Georgian London was not like a modern American hospital birth, in which mothers in fact did lose both consciousness through anaesthesia and complete control and political agency over their reproductive bodies. Eighteenth-century lying-in hospitals, unlike American obstetric practices in the 1950s, were communal spaces filled primarily with women who largely controlled the experience of birth as midwives, mothers, and “fellow sufferers.”

¹³¹ Shorter, *A History of Women's Bodies*.

¹³² Murphy-Lawless, *Reading Birth and Death: A History of Obstetric Thinking*.13.

¹³³ Cody, Lisa Forman. 2004. "Living and Dying in Georgian London's Lying-Hospitals." *Bulletin of the History of Medicine* 78 (2): 309-348.

¹³⁴ *Ibid.*311.

¹³⁵ *Ibid.*347.

¹³⁶ *Ibid.*347.

These hospital births rarely involved either instruments or even the attendance of men midwives in most instances.¹³⁷

Nevertheless, Cody agrees with Murphy-Lawless and Versluysen that the institutions were far from perfect; however, she states they were not – as claimed by other historians – an environment that sought to marginalise and deskill midwives. Her study of archival documents found that the midwives attended most of the births and ran the hospitals with very little input from the medical men.¹³⁸ However, like modern hospitals, lying-in hospitals were not the same in what they offered and how they were managed. Some revisionist writers¹³⁹ argue that most of the lying-in houses were run by a board of governors headed by medical men; thus, although the running of the establishment was done by the matron – always a widowed woman who received an annual salary and board and lodging – the matron of the lying-in hospital was subordinate to the medical men and not an autonomous midwife.

Versluysen also finds fault with the lying-in houses. She highlights that the lying-in hospitals' facilities were only available for certain types of women and believes this again is a sign of the male control. The services of the lying-in hospitals were provided to married women of 'good character'; women with a letter of recommendation came to the hospital generally two weeks before the baby was due, "cleanly clad, free of vermin and contagious disease".¹⁴⁰ Women who did not meet these criteria and needed free assistance would have to rely on the poor law and seek assistance at the local parish church.¹⁴¹

The rise of the institution and the medicalisation of birth continued to impact women and midwives throughout the Western World during the nineteenth and early twentieth century. This rise was accompanied by the rhetoric that institutional birth was safer. Wendy Selby's (1992) study on motherhood following the introduction of Queensland's maternity act of 1922, challenges conventional history on maternal and infant welfare.¹⁴² She found that in Queensland the management of birth by untrained but skilled independent

¹³⁷ Cody, "Living and Dying in Georgian London's Lying-Hospitals."347.

¹³⁸ Ibid.

¹³⁹ Donnison, *Midwives and Medical Men: A History of Inter-Professional Rivalries and Women's Rights*; Towler and Bramall, *Midwives in History and Society*; McCalman, *Sex and Suffering: Women's and a Women's Hospital: The Royal Women's Hospital Melbourne 1856-1996*.

¹⁴⁰ Versluysen, "Midwives, Medical Men and 'Poor Women Labouring of Child': Lying-in Hospitals in Eighteenth-Century London."

¹⁴¹ Donnison, *Midwives and Medical Men: A History of Inter-Professional Rivalries and Women's Rights*; Towler and Bramall, *Midwives in History and Society*.

¹⁴² Selby, "Motherhood in Labour's Queensland 1915-1957."

midwives was common until the 1920s and even later in some parts of the state. The evidence she found suggested that women who used the government maternity hospitals in the 1920s and 1930s, for themselves and their babies, were at greater risk of injury or death than women who were birthing in a more traditional facility such as at home or in lying-in homes with independent midwives.¹⁴³ The risks were not assessed however, because there was widespread support from maternity hospitals and doctor-managed births. By the 1920s childbearing women in Queensland used maternity hospitals because they had few alternatives and because they were led to believe that childbirth would be safer and less painful there. Selby argues that although this was not an informed choice for many women, caution must be taken in presuming that women were merely victims of the patriarchal medical profession. The closure of Queensland's alternative facilities such as the independent midwives' lying-in homes and small maternity hospitals and increasing pressure to prevent untrained independent midwives from practising, limited women's choices. Selby states that something the statistics of the government records do not show is the important place the independent midwives had in the lives of women.¹⁴⁴

In keeping with the more traditional historical view, historian Janet McCalman's (1998) in-depth history of Australia's oldest maternity hospital, The Royal Women's Hospital in Melbourne, documents the development of institutionalised childbirth in Melbourne from early lying-in houses leading to the establishment of medical institutions for birth and the medicalisation of childbirth.¹⁴⁵ With the move from the private sphere of the woman's home to the new institutions designed for confinement of the birthing woman, she states:

the hospital is more than just a building, it was a pre-meditated medical system designed to regulate a natural and passionate event, childbirth; and to impose an order which would prevent or ameliorate the unexpected and the dangerous.¹⁴⁶

McCalman makes little positive reference to independent midwives, appearing to continue the rhetoric that the independent midwives were unsafe, and stating that some abortionists used midwifery as a screen for illegal abortions. She describes the substantial problem of venereal disease, particularly after World War I, and the frequent septic

¹⁴³ Selby, "Motherhood in Labour's Queensland 1915-1957."

¹⁴⁴ Ibid

¹⁴⁵ McCalman, *Sex and Suffering: Women's and a Women's Hospital: The Royal Women's Hospital Melbourne 1856-1996*.

¹⁴⁶ Ibid.15.

abortion cases seen, and details how independent midwives were accused of performing backstreet abortions.¹⁴⁷ Post-revisionist Australian historian Lesley Potter, however, points out that as most of midwifery care was undocumented and 'part and parcel' of ordinary life, the only cases that were recorded would have been the unusual, such as the midwives accused of being abortionists. In her study of colonial midwives in Sydney she constructed a microhistory to investigate the presence and significance of colonial midwives in the Sydney region of New South Wales in the nineteenth century. Despite a comprehensive search she was unable to find primary documents to clarify what midwives' work entailed or what constituted midwifery practice in the nineteenth century colony of New South Wales, and although some "were scoundrels and imposters, the majority appeared to be respectable hard-working women."¹⁴⁸ Furthermore, although they may have lacked education and training as a group they often "received bad press on account of the mistakes of a few, from literary stereotyping and a masculine perspective".¹⁴⁹

Similar findings are illustrated by Australian historian Madonna Grehan (2009) who revisits the traditional and revisionist views of the midwives of nineteenth century Australia to review what she describes as the "sweeping generalisations of a complex and nuanced history".¹⁵⁰ Her research into midwifery in Australia found "an unrecognised history replete with heroes, villains and uncomfortable truths. Among these truths are that midwives were involved in abortion and infanticide and, in some cases, very questionable practice."¹⁵¹ The belief that many midwives were abortionists is again challenged by UK midwifery researchers Leap and Hunter (1993) who report from their oral history interviews that independent midwives and handywomen in the early twentieth century in the UK felt the need to keep themselves ignorant of abortion practices to ensure they were not accused of being involved in the illegal practice. Handywomen were often accused of being abortionists by the ones who wanted to drive them out of practice, but Leap and Hunter's research indicates that there was little likelihood of handywomen risking their reputations and livelihoods by performing abortions. No women they interviewed made the connection

¹⁴⁷ McCalman, *Sex and Suffering: Women's and a Women's Hospital: The Royal Women's Hospital Melbourne 1856-1996*.

¹⁴⁸ Potter, "Weaving the Threads: A Tapestry of Sydney's Colonial Midwives, 1788-1901." 314.

¹⁴⁹ Ibid. 315.

¹⁵⁰ Grehan, "Heroes or Villains? Midwives, Nurses, and Maternity Care in Mid-Nineteenth Century Australia."

¹⁵¹ Ibid.

between handywoman and abortionist, although some midwives were very aware of “picking up the pieces” when abortions went wrong.¹⁵²

Definition of Normal and Abnormal, Risk and Safety

Katz Rothman (1982) defines two important events in the history of midwifery: firstly, midwives lost their autonomy and control of their work to doctors; and secondly, doctors and midwives allocated patients according to the notions of appropriate territory; ‘normal’ for midwives and ‘abnormal’ for doctors.¹⁵³ Both Murphy-Lawless and Katz Rothman highlight the work by American obstetrician Joseph De Lee.¹⁵⁴ In the 1920s De Lee wrote an article published in the *American Journal of Obstetrics and Gynaecology* titled “The Prophylactic Forceps Operation”.¹⁵⁵ In this article he defined a procedure for a routine normal birth. This routine birth required the mother to be sedated during labour and unconscious for the actual birth. The baby was removed by forceps following an episiotomy. The placenta was also manually removed and drugs given to make the uterus contract and prevent bleeding.¹⁵⁶ For De Lee, labour was a dangerous crushing threat comparable to a baby’s head being crushed in a door; therefore, the use of forceps was to spare the baby’s head from epilepsy, idiocracy, imbecility and cerebral palsy as well as death. The episiotomy was done to prevent tearing of the perineum, and once repaired would “restore virginal conditions to the woman”.¹⁵⁷ De Lee believed that there was no such notion of a normal birth, describing the tearing, rupture and displacement of the maternal tissues as highly abnormal and comparable to the woman falling on a pitchfork, driving the handle through her perineum.¹⁵⁸ Katz Rothman and Murphy-Lawless assert that in using these analogies, De Lee was able to conclude that labour itself was abnormal.¹⁵⁹ Consequently, all birth is defined as inherently pathological and abnormal, so there is no place for the midwife.

¹⁵² Leap and Hunter, *The Midwife's Tale*.103.

¹⁵³ Katz Rothman, *Giving Birth: Alternatives in Childbirth*.51.

¹⁵⁴ Katz Rothman, *In Labour: Women and Power in the Birth Place*.58-59.; Murphy-Lawless, *Reading Birth and Death: A History of Obstetric Thinking*.172.

¹⁵⁵ De Lee, Joseph. 1920. "The Prophylactic Forceps Operation," *The American Journal of Obstetrics and Gynecology* 1 (1): 34-44.

¹⁵⁶ Ibid.

¹⁵⁷ Katz Rothman, *In Labour: Women and Power in the Birth Place*.59.

¹⁵⁸ De Lee, "The Prophylactic Forceps Operation."

¹⁵⁹ Katz Rothman, *In Labour: Women and Power in the Birth Place*.59; Murphy-Lawless, *Reading Birth and Death: A History of Obstetric Thinking*.172.

The professionalisation of medicine and the medicalisation of childbirth demonstrates how the medical professions' claim to clinical autonomy, political, economic, and operational control, underpin the erosion of independent midwifery and the institution of birth as a normal physiological process. These issues of power and scientific knowledge, as they relate to the development of the technocratic and medical model of childbirth, are built on the discourses of risk and safety, normality and abnormality. Katz Rothman states that doctors continue to control midwives by controlling their support services. However, because the doctors' control these 'back up services' in complicated or 'abnormal' cases, midwives must therefore work within the restrictions and parameters defined by doctors even in births defined as 'low risk'. Katz Rothman asserts that unlike other specialist areas of medicine, a woman is never defined as healthy in childbirth. Even if a woman has all the "healthy characteristics medicine can ask for she still won't be called healthy or even normal. She will be classified low-risk".¹⁶⁰ Childbirth is defined as 'low-risk, medium risk and high-risk' with the emphasis always on risk; having defined childbirth as pathological and abnormal, the doctors then defined the entire pregnancy as pathological, therefore requiring medically managed care to monitor the risks.¹⁶¹ In Australia, the discourse around risk and the need for the experts to manage pregnancy and birth continued, and by the 1930s women themselves, according to Reiger, were campaigning for institutional maternity care that valued "scientific knowledge and modern technology".¹⁶²

Marjorie Tew's (1990) critical history of maternity care in the UK highlights how the concept of 'safer childbirth' was used to underpin the UK's government maternity policy.¹⁶³ She states that the statistics were misrepresented to show an increased risk in childbirth at home without highlighting any risks of birth in hospital, thereby supporting universal hospital birth.¹⁶⁴ In keeping with the philosophy of the body as a faulty machine, Wagner supports the view that the state and the medical profession used the discourse of risk and safety to define pregnancy and childbirth as inherently unsafe and hazardous:

¹⁶⁰ Katz Rothman, *In Labour: Women and Power in the Birth Place*.132.

¹⁶¹ *Ibid.*132.

¹⁶² Reiger, *The Disenchantment of the Home: Modernizing the Australian Family 1880-1940*.93.

¹⁶³ Tew, *Safer Childbirth?: A Critical History of Maternity Care*.27.

¹⁶⁴ *Ibid.*

The risk approach defines the birth as the most important issue in maternal health and perinatal care...the risk approach makes the pregnant woman a patient. As such, there is a tendency for her to become a passive thing on which screening tests are performed.¹⁶⁵

Wagner emphasises that doctors focus on the negatives and what could go wrong, and the risks involved in childbirth, thereby creating uneasiness about pregnancy and birth in general. He asserts that, as a result, it is argued that it is more appropriate to have all births take place in the hospital with easy access to the equipment and specialists.¹⁶⁶ This contributes to the claim, as explained by Oakley and Murphy-Lawless, that obstetrics deals with problems so complex and risky that the childbearing women cannot be expected to make choices in their own interests; thus as the experts, only medical practitioners should be allowed to choose what is best for the birthing woman.¹⁶⁷ Again, this reinforces the idea that women's bodies are faulty machines and highlights the inherent patriarchy in the system, as the woman herself is not seen as the authority over her body. Tew reasons that as obstetrics has a clear financial interest in retaining childbirth within its exclusive domain, it will continue to define pregnancy and birth as a state of illness always requiring medical treatment at some level.¹⁶⁸ The birth predicted to be at low risk of complications, will need medical supervision just in case a complication occurs; the birth predicted to be a high-risk, requires essential medical supervision so that immediate emergency intervention can be given once complications occur. Murphy-Lawless describes what she calls "shroud waving"¹⁶⁹, doctors' and obstetricians' language about the risks of death to the foetus, to reaffirm the obstetricians' position as the expert and demonstrate that it, the medical profession, possesses profound scientific knowledge about pregnancy and birth which other healthcare professionals, such as midwives and women, lack.

¹⁶⁵ Wagner, *Pursuing the Birth Machine: The Search for Appropriate Birth Technology / Marsden Wagner*.98.

¹⁶⁶ *Ibid.*98.

¹⁶⁷ Oakley, "Who Cares for Women? Science Versus Love in Midwifery Today"; Murphy-Lawless, *Reading Birth and Death: A History of Obstetric Thinking*.

¹⁶⁸ Tew, *Safer Childbirth?: A Critical History of Maternity Care*.

¹⁶⁹ Murphy-Lawless, *Reading Birth and Death: A History of Obstetric Thinking*.26.

Antenatal Care and the Identification of the Foetus as a Potential Person

Feminist historian Lisa Featherstone's (2004)¹⁷⁰ analysis of antenatal care in Australia in the early twentieth century diverges from previous historical studies in a number of key ways. Firstly, in contrast to McCalman¹⁷¹ who found that interest in the foetus as a potential person came to the forefront in the 1920s, Featherstone suggests this interest peaked earlier than the 1920s, particularly within the context of the declining birth rate in Australia at the end of the nineteenth century and beginning of the twentieth century.¹⁷² Secondly, Featherstone discusses the ways in which wider historical processes impacted on the bodies of women. In this case, the First World War and wartime rhetoric highlighted the need for antenatal care to save maternal, foetal and infant lives. The discourses of war articulated the perceived need for a replacement population and this was crucial to the spread of antenatal care.¹⁷³ Featherstone states that the rise of antenatal care is notable for being more than an extension of medical services to the mothers. Featherstone and Selby along with other writers such as Murphy-Lawless and Oakely agree that the interest in the wellbeing of the foetus marked a significant shift in thinking around pregnancy and childbirth.¹⁷⁴ This contributed to the foetus being regarded as less a part of the mother and more an independent potential person. Featherstone also argues that in recognising the foetus as a separate entity and at the same time, the development of an antenatal regime, this justified intervention into the lives of women and mothers. This belief around foetal identity extended medicalisation throughout the pregnancy and beyond. Thus, the medicalised pregnancy reinforces the role of the medical doctor and medical science need to monitor its progress; rather than the unscientific care of the midwife and the women's own knowledge and experience of her body. Therefore, doctors continue to view pregnancy and childbirth as a pathological condition and treat it accordingly. Katz Rothman believes applying the medical model to pregnancy and childbirth is inappropriate, since

¹⁷⁰ Featherstone, Lisa. 2004. "Surveying the Mother: The Rise of Antenatal Care in Early Twentieth-Century Australia." *Limina*, 10: 16-31.

¹⁷¹ McCalman, *Sex and Suffering: Women's and a Women's Hospital: The Royal Women's Hospital Melbourne 1856-1996*.

¹⁷² Featherstone, "Surveying the Mother: The Rise of Antenatal Care in Early Twentieth-Century Australia."

¹⁷³ Ibid.

¹⁷⁴ Featherstone, "Surveying the Mother: The Rise of Antenatal Care in Early Twentieth-Century Australia"; Selby, "Motherhood in Labour's Queensland 1915-1957"; Murphy-Lawless, *Reading Birth and Death: A History of Obstetric Thinking*; Oakley, "Who Cares for Women? Science Versus Love in Midwifery Today."

being pregnant is something “one is, not something one has. Childbirth on the other hand, may be better viewed as something one does.”¹⁷⁵

Katz Rothman suggests that an important factor in the way maternity care is provided is the way the mother-foetus relationship is viewed. In the medical model this relationship is seen as that of the parasite and a host.¹⁷⁶ The foetus in the medical model is a foreign intruder in the mother’s body; this is based in the patriarchal ideology “in which women are the carriers of men’s children”.¹⁷⁷ The implications of this idea can be seen throughout the organisation of maternity care medicine. The medical management of pregnancy can best be understood in terms of the separation of mother and foetus, as their needs are seen to be at odds with each other. Wagner asserts that as the risk approach focuses more on the foetus than the woman, then the woman can be considered as merely a container for the foetus.¹⁷⁸ This poses the risk that the obstetrician may feel that they, not the woman, are responsible for the health and wellbeing of the foetus, and this can cause considerable conflict, particularly if the woman is deemed to be choosing unsafe or risky options resulting in her being labelled selfish and irresponsible. In contrast the midwifery model is a woman centred rather than patriarchal ideology, where the foetus is a part of the mother’s body. The needs of the mother and the foetus are the same; in meeting the needs of one, the needs of the other are also met.¹⁷⁹ Selby states that these are issues that feminists must address, asserting women have earned the right to control their bodies and nurture their babies.¹⁸⁰

Revisionist Histories of Independent Midwifery in Australia

Few Australian authors of the twenty-first century are focused on the history of midwifery. Contemporary debates in Australian midwifery investigate the rising interventions in childbirth and the high caesarean rate in all Australian states. Relevant now as in the past, notions of choice, control, childbirth attendant and place of birth are still being researched along with women’s expectations and experiences of birth and the impact this has on their

¹⁷⁵ Katz Rothman, *In Labour: Women and Power in the Birth Place*.39.

¹⁷⁶ *Ibid.*.275.

¹⁷⁷ *Ibid.*.275.

¹⁷⁸ Wagner, *Pursuing the Birth Machine: The Search for Appropriate Birth Technology / Marsden Wagner*.98.

¹⁷⁹ Katz Rothman, *In Labour: Women and Power in the Birth Place*.122.

¹⁸⁰ Selby, "Motherhood in Labour's Queensland 1915-1957."

lives. Since the 1980s some Australian authors have focused on revisionist history and in some cases previously untold histories of women and midwives.

A key work in Australian revisionist history was undertaken by sociologist Evan Willis (1989) who examined the development of the social structure and healthcare delivery in Australia. His critical study analyses the causes and consequences of the occupational division of labour within the health sector, its relationship to the State and the distribution of power.¹⁸¹ He identifies two distinct characteristics of the division of labour in health care, its hierarchal nature and the dominance of the medical profession.¹⁸² One of the areas he explores in his work is subordination as a form of medical dominance, with midwifery as the chosen occupation.¹⁸³ Willis argues that class and gender are key social structures that are represented in the division of labour in healthcare and medical dominance.¹⁸⁴ This is of particular relevance to midwifery. He analysed four distinct periods in Australian midwifery history. The first describes the evolution of the British midwife; the next three periods describe the evolution of the Australian midwife. The Pioneer Era covers colonisation of Australia and the early white settlers; The Transitional Era covers the period 1880 until 1910; and the Era of Take-over covers the period from 1910-1930.¹⁸⁵ The three timelines of Australian midwifery, as defined by Willis, will be used in the subsequent chapters in the context of this study of Western Australian midwifery.

Willis documents how the overall process of transition in the attendance of childbirth from untrained working-class women to formally trained medical men had begun well before the settlements in Australia commenced. Although there are no midwives recorded amongst the 191 female convicts of the First Fleet in 1788, undoubtedly a number of convict women also became midwives out of necessity.¹⁸⁶ He describes how the changing division of labour of the childbirth attendant progressed:

In this change, both the gender and class basis of childbirth attendant was affected, as the change has basically been from attendance by working class women to attendance by middle class men. Associated with this change in attendant has been a transition from home to

¹⁸¹ Willis, *Medical Dominance*.

¹⁸² *Ibid.* 2.

¹⁸³ *Ibid.* 92-124.

¹⁸⁴ *Ibid.* 201.

¹⁸⁵ *Ibid.* 92-124.

¹⁸⁶ *Ibid.* 99.

hospital as the location of birth. Both the sexual division of labour and the occupational division of labour were thus transformed.¹⁸⁷

Willis also describes how initially it was the “rank and file general practitioner”¹⁸⁸ not the ‘elite’ obstetricians who were in direct competition with the independent midwives. A similar insight is provided by Kathleen Fahy (2007)¹⁸⁹ in her interpretation of secondary sources and her analyses of the history and the subordination of midwifery to nursing in Australia. She asserts that most historical reviews of Australian midwifery have taken a neutral approach to the “issues of power and control”.¹⁹⁰ Her study found that due to medical competition in Britain a large number of General Practitioners (GPs) emigrated to Australia where there was less medical rivalry.¹⁹¹ She states that in the absence of scientific evidence, GPs had no strong claim to expert knowledge. However, as the number of migrant GPs increased so did the competition leading the GPs to move away from the cities to rural areas. In doing this they came into direct competition with the midwives. Fahy draws parallels between the large number of GPs who emigrated to Australia and the reduction of independent midwives.¹⁹²

Making a similar point, midwife Lesley Barclay (2008) wrote a feminist history of Australian midwifery from colonisation in the 1800s until the 1980s. Barclay states:

Important assumptions influence today’s assessment of past situations. One is the assumption, explicit in most medical history and rarely questioned, that medicine is progressing along a continuum from darkness into light, with ever increasing specialisation.¹⁹³

As other revisionist writers before them, Barclay and Fahy suggest these important assumptions influence today's assessment of past situations and argue that the analysis is neither straightforward nor correct. Barclay states that much of what we think is coloured by this view.¹⁹⁴ Historically, midwives themselves rarely chronicle their own activities and we have to rely on others’ interpretation of their performance. Frequently, as previously noted, these writings contain scarcely veiled threats and blatant attempts to discredit midwives for the writer’s own ends. Barclay found that following the marked change in who

¹⁸⁷ Willis, *Medical Dominance*.93.

¹⁸⁸ *Ibid.*94.

¹⁸⁹ Fahy, "An Australian History of the Subordination of Midwifery."

¹⁹⁰ *Ibid.*25.

¹⁹¹ *Ibid.*27.

¹⁹² *Ibid.*27.

¹⁹³ Barclay, "A Feminist History of Australian Midwifery from Colonisation until the 1980s."

¹⁹⁴ *Ibid.*3.

became responsible for the conduct of normal labour and birth during Australian colonisation, there is substantiated evidence suggesting this parallels changes in society and the powerful place of medicine in Australian society.¹⁹⁵ Reiger (1984) agrees, stating that it would be simplistic and naïve to attribute the major changes that took place from the 1880s-1930s in the organisation of pregnancy, childbirth and the place of birth in Australia to be the “conscious intention of the medical profession, whether interpreted as benevolent or malevolent”.¹⁹⁶ In her historical and sociological account of the modern Australian family from the 1880s to the 1930s, Reiger¹⁹⁷ discusses the connection between broader economic, social and cultural forces and changes in personal and family life. These changes include the move from changing patterns of reproduction by placing childbirth under professional control, along with women demanding institutionalised birth with the accompanying analgesia.¹⁹⁸

In a similar way, Annette Summers (1995)¹⁹⁹ examined factors that led to the marginalisation of the community midwife in South Australia in the twentieth century. She found that this demise was a slow process and the result of three significant factors: the professionalisation of nursing and its subordinate relationship to medicine; the persuasive medical risk-adverse discourse on the dangers of childbirth; and the resulting gradual changes in responsibility for the childbearing woman from the private world of the home to the public sphere of the hospital.²⁰⁰ However, she asserts that the introduction of legislation for the registration of nurses and midwives in South Australia was the deciding factor in the eclipse of the independent community midwife. Summers found little evidence to support the premise that the community independent midwives were incompetent in South Australia. On the contrary Summers found evidence, such as letters and testimonials about the care provided by the independent community midwife, that demonstrated how childbirth under their care was a relatively safe event for women in South Australia.²⁰¹

In her research on Sydney colonial midwives, Australian historian, Lesley Potter’s (2015) definition of the term midwife is broad as it included any woman who took upon

¹⁹⁵ Barclay, "A Feminist History of Australian Midwifery from Colonisation until the 1980s."7.

¹⁹⁶ Reiger, *The Disenchantment of the Home: Modernizing the Australian Family 1880-1940*.84.

¹⁹⁷ Ibid.

¹⁹⁸ Ibid.; Reiger, *Our Bodies, Our Babies: The Forgotten Women's Movement*.

¹⁹⁹ Summers, ""For I Have Ever So Much More Faith in Her Ability as a Nurse": The Eclipse of The Community Midwife in South Australia 1836-1942".

²⁰⁰ Ibid.

²⁰¹ Ibid.

herself the role of midwife, who called herself a midwife, or was called a midwife by another; and was trained or untrained. She found that amongst the trained midwives there were women who possessed or claimed to possess a document of British or foreign certification to practice as a midwife, and in the later decades of the nineteenth century following the introduction of midwifery education into Australia, midwives also possessed colonial certificates as evidence of their training which they used to authenticate their practice.²⁰² By engaging with such a broad definition of the midwife in her thesis, Potter challenges concepts about colonial midwives in Sydney (1788-1901) that were generally accepted by contemporary observers of the period. The first of these concepts was that midwives and women in general were insignificant to the economy of the colony and made little or no contribution to maternity health care. The second assumption was that midwives were callous and uncaring towards women in childbirth. The third concept she questioned was that the midwives were ignorant and unschooled in their craft. In challenging the traditional view of the 'Sairey Gamps' described by the traditional historians, she states it was not her intention to "sentimentalise midwives or to whitewash their activities"²⁰³ as she found that some did engage in illegal activities. Her intention was to situate them in their time environment, one that is very different from modern twenty-first century midwifery practice.²⁰⁴

The mid-nineteenth century, the period immediately after the convict era, saw the beginning of rapid economic and population expansion in Australia. Potter describes this period as the "hey-day of the independent midwife"²⁰⁵, and at this time the independent midwife was still generally untrained. Towards the end of the nineteenth century in Australia increasing presence and value was placed upon the trained independent midwife as opposed to the untrained midwife. However, the training opportunities were limited, the trained midwife of the late nineteenth century in Australia may have received her training at one of the new hospitals or arrived from Britain with her certificate from one of the midwifery schools there. The trained midwife still maintained a certain independence by working in private practice. However, Selby, Summers and Potter²⁰⁶ individually report, and

²⁰² Potter, "Weaving the Threads: A Tapestry of Sydney's Colonial Midwives, 1788-1901."

²⁰³ Ibid.27.

²⁰⁴ Ibid.31.

²⁰⁵ Ibid.31.

²⁰⁶ Selby, "Motherhood in Labour's Queensland 1915-1957"; Summers, ""For I Have Ever So Much More Faith in Her Ability as a Nurse": The Eclipse of The. Community Midwife in South Australia 1836-1942"; Potter, "Weaving the Threads: A Tapestry of Sydney's Colonial Midwives, 1788-1901."

all agree, that management of birth by untrained but skilled midwives was common until the 1920s and even later in some parts of Australia. Selby found that the midwives would only call doctors if labour was complicated; indeed, as seen in Summer's history of South Australia, many doctors of this period were happy to leave normal midwifery to midwives as they were seen to be more experienced and more able to "take the time to birth the babies".²⁰⁷ Most women that Selby interviewed reported having no fear of dying in childbirth but were aware of the risk of childbirth for themselves and their babies.²⁰⁸

As seen in the other revisionist histories of other states and discussed in this literature review, Selby found that although the independent midwife still existed— increasingly through the later decades of the nineteenth century— more and more women sought the safety and expertise they thought was to be found within the developing maternity hospitals. Selby's findings demonstrate that safety and expertise was not found in Queensland hospitals; as although birth moved from home to the hospital, deaths of newborn infants did not significantly decrease.²⁰⁹ She suggests that medical incompetence was partly responsible for the delay in an improvement in the statistics. The evidence she found from the women's stories and archives suggest that forceps were applied to at least twenty percent of all births, resulting in a large number of damaged perineums with consequent septic infections and damaged babies.²¹⁰ In fact, Selby found that as De Lee had advocated for it in 1920s America, many doctors routinely used forceps for all births and justified the procedure by arguing that it shortened labour at the most painful stage: "Rather than practising 'watchful expectancy and masterful inactivity', doctors focused instead on expecting the worst and being more 'masterful' in their interventions".²¹¹ Selby states "the bottom line was that women were now seen to be less capable of unassisted childbirth".²¹²

As women were deemed less capable of unassisted birth, it was thought more appropriate for them to birth in the hospitals. Potter states that it was this move within Australia in the early twentieth century from the home to the hospital that increasingly shifted the practice of midwifery from private independent practice to employment within

²⁰⁷ Summers, ""For I Have Ever So Much More Faith in Her Ability as a Nurse": The Eclipse of The Community Midwife in South Australia 1836-1942'."

²⁰⁸ Selby, "Motherhood in Labour's Queensland 1915-1957."

²⁰⁹ Ibid.158.

²¹⁰ Ibid.149.

²¹¹ Ibid.166.

²¹² Ibid.166.

the institution.²¹³ As documented by other Australian revisionist historians, Potter also found that as independent midwives' work involves the private space of domestic homes or small lying-in homes, "midwifery was in the realm of sequestered domestic woman's work".²¹⁴

Potter clarifies the claim that the work of midwifery was regarded as being embedded within domestic duties, therefore not significant enough to record. She states:

association of midwifery work with domestic spaces reduces the visibility of midwives and their work to the public gaze, causing significance to be overlooked. In a similar fashion to the fate suffered by other colonial female workers, these midwives possessed the historiographical invisibility.²¹⁵

Grehan (2009) reiterates how important it is for the history of midwifery to be re-examined stating:

the history of midwifery also includes narratives, awaiting investigation, of the remarkable and invisible women who attended to others in the most difficult of circumstances in Australian settler society. Like the recent re-visioning of nursing by historians, the history of midwifery in Australia deserves further examination with a critical eye, to develop a sophisticated and palpable understanding of its complexities.²¹⁶

As evidenced by the findings of Selby, Summers and Potter while midwives were hidden in the historical records, they were not hidden from the daily lives of the Australian community. Potter states the objective of her historical study has been to place midwives into women's history as it has been necessary to insert women's history into history.²¹⁷ The historical records concealed midwives as they have concealed women in general. Her study demonstrated that midwives were active in their local communities. Many midwives conducted small enterprising midwifery businesses, whether from their own residences, in women's homes or by managing their own small lying-in hospitals. In her thesis she attempted to "view colonial midwives as real women, as individuals and not as a collective

²¹³ Potter, "Weaving the Threads: A Tapestry of Sydney's Colonial Midwives, 1788-1901."

²¹⁴ Ibid.305.

²¹⁵ Ibid.305.

²¹⁶ Grehan, "Heroes or Villains? Midwives, Nurses, and Maternity Care in Mid-Nineteenth Century Australia."

²¹⁷ Potter, "Weaving the Threads: A Tapestry of Sydney's Colonial Midwives, 1788-1901."

noun".²¹⁸ In a similar way, Rita Ann Davies' (2003)²¹⁹ study of midwifery in Queensland during the period 1859 to 1912 explores the reasons that underpinned the regulation of midwifery practice and the transition of the role of midwife from lay to qualified practitioner. Her work supports the previously explored concepts; that the medical profession and the State were the leading influences on the regulation of midwives, and the subsequent decline of the independently practising midwife within Australia. She also identifies the disparity in social and occupational classes, gender and education, between the lay midwife and the medical practitioner that contributed to the lack of resistance to the legislation and regulation that resulted in the decline of the lay midwife. Historian Noeline Kyle (2017) book titled *Women's business: midwives on the mid-north coast of New South Wales* compiles a history from archival sources and oral histories of the women that provided midwifery in New South Wales country towns from the late nineteenth century until 1950s.²²⁰ Like other Australian historians, Kyle established that increasing legislation and competition from the State and the medical profession eventually put the independent midwife and the independently run midwifery lying-in homes and small hospitals out of business by the early 1950s. She claims that when many individual midwives and nurses closed their hospitals, the leaving was viewed with alarm and sorrow by the communities because they held the independent midwives in high esteem and they were well-regarded.²²¹ Kyle also asserts the most striking aspect of the country midwife was the collegiality and support among the midwives. Many of the women documented by Kyle, not only established hospitals together and worked together, but as they aged they also took care of each other.²²²

In Australia in the twenty-first century, many people assume that midwifery is merely a branch of nursing. Australian Sociologist Evan Willis (1989) believes the subordination of midwifery was achieved by incorporating midwifery into nursing, an occupation which was already structurally located in the position of subordination to medicine. By becoming in effect a branch of nursing, midwifery changed from having an independent status to a

²¹⁸ Potter, "Weaving the Threads: A Tapestry of Sydney's Colonial Midwives, 1788-1901." 314.

²¹⁹ Davies, "She Did What She Could: A History of the Regulation of Midwifery Practice in Queensland 1859-1912."

²²⁰ Kyle, *Women's Business: Midwives on the Mid North Coast of New South Wales to 1950, a Study of Armidale, Kempsey and Port Macquaire / Dr Noeline Kyle.*

²²¹ Ibid.

²²² Ibid.

subordinate one.²²³ A similar insight is provided by Davies (2003)²²⁴ who supports this view, stating that the redefining of the midwife in Australia was strongly dependent on the social construct of the trained nurse, the perception that the midwifery-nurse was more professional and competent than the untrained midwife was promoted, and the nurse-midwife ultimately became a product of the hospital institution and subordinate to medicine. She highlights how in incorporating nursing and midwifery their opposing philosophies were overlooked:

Midwifery practice is different from nursing practice in that it is derived from a wellness perspective in which the focus of its attention, childbirth and the rearing of the neonate, are looked upon as normal life events that benefit from facilitation rather than as clinical conditions that require treatment.²²⁵

Summers' (1995) work in the South Australian context challenges the popular notion that the medical profession was united in the elimination of the community midwife. Summers found that in South Australia this resistance to and campaigning against the midwife came from only a small pocket of medical men who saw the midwife as competition. However, her argument does not contradict the claim that medicine wished to have control of nursing and midwifery, for she found clear evidence to demonstrate the medical men promoted the premise that nursing and midwifery should be subordinate to medicine.²²⁶

Independent Midwifery in Western Australia

Unlike some of the other Australian states, very little has been written about the history of midwifery in Western Australia. A review of the literature in Western Australia found that prior to the twenty-first century no comprehensive analysis of the history of maternity care in Western Australia had been undertaken.

Similar to other traditional histories, Victoria Hobbs's (1980) historical account of nursing in Western Australia from 1829 to 1979 makes little reference to midwives. She refers to nurses undertaking some midwifery work in the early days of the Swan River

²²³ Willis, *Medical Dominance*.

²²⁴ Davies, "She Did What She Could: A History of the Regulation of Midwifery Practice in Queensland 1859-1912."

²²⁵ *Ibid.* 409.

²²⁶ Summers, "'For I Have Ever So Much More Faith in Her Ability as a Nurse': The Eclipse of The. Community Midwife in South Australia 1836-1942'."

Colony (1829-1850s), thereby from the beginning incorporating midwifery into the field of nursing rather than acknowledging midwifery as an autonomous, independent practice. Hobbs embraces the Dickensian view of the midwife, stating “all nurses practised midwifery in the course of their nursing duties and like Mrs Gamp went with equal zest to a lying in and lying out”.²²⁷ She also accepts the subordinate relationship between nurses and doctors describing how “women who showed particular aptitude and willingness to undertake nursing management of a very ill patient were invaluable to the medical practitioner”.²²⁸ Hobbs also highlights the differences in the autonomy between nurses and midwives with what she sees as the concerning lack of control over midwives’ practice:

Generally speaking, the professional nurse carried out the treatment on the orders of the 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 the patient’s home. There was no legislation against such practice.²²⁹

Another West Australian writer May Flanagan (1997)²³⁰ focuses on the development of institutional birthing and provides a description of the lying-in homes in Western Australia from 1860-1960. She describes how lying-in homes became a feature of maternity services in Western Australia towards the end of the nineteenth century due to the increase in the population and establishments of permanent towns and settlements in Western Australia. Her writing describes the small lying-in homes provided by midwives in their own homes throughout WA, and benevolent institutions such as the House of Mercy, Salvation Army and Sisters of the People in the city of Perth.²³¹ She provides little analysis of these facilities or the midwives who provided them, although in her closing statement she does refer to the medicalisation of childbirth and the corresponding change in care provider, but she does not provide any critique of this statement:

The place of childbirth 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, with its concern and demands,

²²⁷ Hobbs, *But Westward Look: Nursing in Western Australia 1829-1979*.2.

²²⁸ *Ibid.*2.

²²⁹ *Ibid.*14.

²³⁰ Flanagan, "Lying-in (or Maternity) Homes in Western Australia from About 1860-1960."

²³¹ *Ibid.*

belonged now to the medical rather than the domestic arena within our society, and medical care was available to all women irrespective of their circumstances.²³²

In keeping with the traditional historical view, Jennie Carter and Bevan Carter's (2016) history of Western Australia's first women's hospital 'King Edward Memorial Hospital' from 1916-2016 makes little reference to the independent midwives in Western Australia.²³³ However, in its defence this history's aim is to document the development of the hospital rather than midwifery. It does reference that one of the increasing concerns and factors in lobbying for legislation and the formation of a midwives' registration board, was the number of unqualified midwives practising in the state at the end of the nineteenth and beginning of the twentieth century.²³⁴

A text of particular importance to this thesis, is post-revisionist writer Carol Thorogood's (2001) historical and socio-political study of Australian homebirth.²³⁵ Thorogood's work has implications for both practitioners and the policymakers of the twenty-first century, because it provides a detailed account of the processes whereby, in Australia, homebirth and independent midwifery are enabled or restricted by the state. Thorogood's analysis indicates that the same kind of institutional forces and dynamics which led to the demise of autonomous independent midwifery and homebirth in parts of the Western World and other states of Australia are still relevant today.²³⁶ She uses the Commonwealth Government funded Alternative Birthing Services Program (ABSP) as a case study to illustrate that today, as it has done in the past, obstetrics uses its power and privilege as well as the authoritative discourse of risk and safety, to reinforce its belief that birth is inherently pathological.²³⁷ As previously highlighted, Thorogood's analysis demonstrates how the medical professions' close links with the State supports it to eliminate competition from non-medical practitioners such as midwives.²³⁸

Thorogood's detailed case studies of homebirth, community projects, and independent midwifery included interviews with midwives, bureaucrats and obstetricians. Her investigation shows how medicine uses the strategies of subordination and exclusion to

²³² Flanagan, "Lying-in (or Maternity) Homes in Western Australia from About 1860-1960."

²³³ Carter and Carter, *King Eddies: A History of Western Australia's Premier Women's Hospital 1916-2016*.

²³⁴ *Ibid.*

²³⁵ Thorogood, "Politics and the Professions: Homebirth in Western Australia."

²³⁶ *Ibid.*

²³⁷ *Ibid.*

²³⁸ *Ibid.*

prevent the implementation of alternative models of care that might facilitate birthing women to seek the care of practitioners, such as midwives rather than medical doctors.²³⁹ As seen throughout the history of midwifery, Thorogood's thesis demonstrates how the Australian medical profession used its professional networks to inhibit competition from midwives and to reassert its dominance over a largely female workforce.

In particular relevance to this current historical study, Thorogood provides examples of how the WA medical profession used its power and privilege to protect its professional and economic interests. She details how during the latter part of the twentieth century, negotiations with hospitals and medical boards over midwives visiting rights and the development of guidelines, provided the medical profession with ample opportunity to oppose and delay, and in some cases prevent, the ABSP's projects.²⁴⁰ Obstetricians that Thorogood interviewed used language that supports the rhetoric previously highlighted in this chapter. The belief that the doctor knows best about what is good for women and babies, and that women who do not follow what medicine dictates are selfish. As seen in the work of other revisionist writers such as Murphy-Lawless (1989)²⁴¹, Thorogood (2001)²⁴² reports that obstetrics reinforces its control of childbirth and women by telling horror stories of independent midwives' practices and 'shroud waving'.

Another post revisionist history, *Place and Power: A history of Maternity Service Provision in Western Australia, 1829-1950* by Bri McKenzie (2015)²⁴³ is of particular importance and relevance to this study and the first comprehensive Western Australian study of maternity care to date. McKenzie's work is a history of maternity service provision beginning in 1829 and finishing in 1950, and although there is some discussion of independent midwives' they are not the focus of her study.²⁴⁴ McKenzie's analysis and critique of the archives includes previously recorded oral histories. 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".²⁴⁵ McKenzie's (2015) analysis, includes recorded interviews with Australian women —

²³⁹ Thorogood, "Politics and the Professions: Homebirth in Western Australia."

²⁴⁰ Ibid.

²⁴¹ Murphy-Lawless, *Reading Birth and Death: A History of Obstetric Thinking*.

²⁴² Thorogood, "Politics and the Professions: Homebirth in Western Australia."

²⁴³ McKenzie, "Place and Power: A History of Maternity Service Provision in Western Australia, 1829-1950."

²⁴⁴ Ibid.

²⁴⁵ Ibid.196.

although these women were not from WA— who birthed in the 1920 -1950s.²⁴⁶ Forming one of the central themes to her work, McKenzie demonstrates how women interacted with and understood different childbirth locations in the past and the different things they offered, such as birth attendant and use of anaesthesia.²⁴⁷ She found that in the period of her study WA women gave birth in one of three places: their own homes, lying-in homes or maternity hospitals. She attempts to demonstrate that in the past women's reactions to different birthing spaces are more complex and multifaceted than first assumed; some women appeared to enthusiastically accept the move to medicalised birth in the institution with the access to analgesia and a rest from daily life. Of great importance and relevant to contemporary midwifery debates and my current study is the concept of choice of birth place. McKenzie (2015) states:

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.²⁴⁸

McKenzie also states that choice as a concept is not something that easily transfers into retrospective analysis.²⁴⁹ As identified in other parts of the Western World and supported by the literature, in the Australian context the increasing medicalisation of childbirth has led to continued restriction of choices through the normalisation of institutionalised and medicalised birthing. Therefore, McKenzie emphasises that "there is no real freedom of choice within this context, women can only choose what they are allowed to choose".²⁵⁰ However, it would also seem that women's expectations changed, with some women not only accepting but demanding analgesia and institutional birth. Intervention and analgesia gradually become accepted as the norm.

McKenzie's investigations are comparable to the findings of the previous studies identified in this literature review of midwifery in other states in Australia, such as Selby

²⁴⁶ McKenzie, "Place and Power: A History of Maternity Service Provision in Western Australia, 1829-1950."

²⁴⁷ Ibid.

²⁴⁸ Ibid.199.

²⁴⁹ Ibid.

²⁵⁰ Ibid.206.

(1992)²⁵¹, Summers (1995)²⁵² and Potter (2015).²⁵³ Not all medical men were aiming to remove midwifery from the hands of women. However, cases presented from the WA early history support the rhetoric also demonstrated by other Australian revisionist historians; that medical men used their “professional ties with one another to undermine midwives as individuals and midwifery as a female occupation”.²⁵⁴ As described by Flanagan (1997)²⁵⁵, WA had a number of lying-in homes and these also are investigated in McKenzie’s thesis, providing evidence to support the argument that the development of these lying-in homes had some impact on woman’s choice in location of birth. However, as previously discussed these choices were limited by socio-economic factors and some women may have found the cost prohibitive.²⁵⁶ In particular, McKenzie draws attention to the many country lying in-homes and hospitals run by independent midwives that existed in the late nineteenth and early twentieth century, as they provided the only out of home care to women at this time.²⁵⁷ The perceived need to control and regulate independent midwifery was apparent in WA as in the other states; legislation and regulation was gradually increased during the early twentieth century, including the requirement of formal training and education. McKenzie states that “through their hospital-based training and their assimilation into the ranks of nurses, midwives in WA gradually ceased to operate as independent professionals”.²⁵⁸ In hospitals the midwife’s role gradually reduced to the work of an obstetric nurse, carrying out doctor’s orders and rarely managing the births independently. According to McKenzie, the future for the midwives working outside the hospitals as independent autonomous practitioners in women’s homes or in the lying-in hospitals was limited.²⁵⁹ By the 1930s fewer women were having their babies at home and the financial pressures and increasing legislative requirements of running the lying-in homes led to their gradual decline during the 1940s. McKenzie makes an interesting point in relation to the medical profession’s arguments in relation to the dangerous and ignorant care of independent midwives:

²⁵¹ Selby, "Motherhood in Labour's Queensland 1915-1957."

²⁵² Summers, ""For I Have Ever So Much More Faith in Her Ability as a Nurse": The Eclipse of The. Community Midwife in South Australia 1836-1942'."

²⁵³ Potter, "Weaving the Threads: A Tapestry of Sydney’s Colonial Midwives, 1788-1901."

²⁵⁴ McKenzie, "Place and Power: A History of Maternity Service Provision in Western Australia, 1829-1950."86.

²⁵⁵ Flanagan, "Lying-in (or Maternity) Homes in Western Australia from About 1860-1960."

²⁵⁶ McKenzie, "Place and Power: A History of Maternity Service Provision in Western Australia, 1829-1950."

²⁵⁷ Ibid.

²⁵⁸ Ibid.130.

²⁵⁹ Ibid.

The suggestion put forward by traditional medical historians, that all births 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.²⁶⁰

Summary

This literature review of the history of midwifery in Western Australia has identified that although some work has been undertaken in WA, there is still a gap in knowledge that warrants investigation. Post-revisionist writers such as Thorogood and McKenzie have begun to rectify this by providing some insight into the history of WA maternity care, and the previously untold experiences of women and midwives. However, to date there is no study specifically looking at the history of autonomous independent midwives in WA. This post-revisionist history and discussion of autonomous independent midwives in Western Australia is therefore justified. This study aims to continue to address the existing gaps in the post-revisionist analysis of independent midwives in WA. Demonstrating and analysing how independent midwifery in Western Australia (WA) has evolved from 1830 to 2014 can assist the midwives of today. The following chapter will provide details of how this study was conducted using historical narrative research within a naturalistic, feminist paradigm and outlines why this was the most appropriate method.

²⁶⁰ McKenzie, "Place and Power: A History of Maternity Service Provision in Western Australia, 1829-1950."209.

Chapter Three – Methodology and Methods

Chapter Overview

This chapter provides details of how a study of the history of privately practising midwifery in Western Australia (WA) was conducted using historical narrative research within an inductive naturalistic, feminist paradigm.

Firstly, guiding philosophies in research will be discussed; two opposing research paradigms and their relation to the two research methods, 'quantitative' and 'qualitative', are outlined. Secondly, feminism and feminist research will then be presented. Thirdly, historical and narrative research methods used in this study will be described including a discussion of the archival and oral history research approach.

The second part of the chapter will highlight the research process followed in the study. The research study's question, aim and objectives are outlined. The participant sample, sample recruitment process and ethical considerations are described. The process of data collection and analysis are explained within the context of feminist historical narrative research.

Guiding Philosophy in Research

Cresswell and Poth state that "philosophy means the use of abstract ideas and beliefs that inform our research", therefore, before undertaking a study, it is important to have an understanding of the philosophical assumptions that underpin different approaches to research.²⁶¹ Research, regardless of the approach used, is governed by the concepts of ontology, epistemology, axiology and methodology.²⁶² Lincoln and Guba suggest that researchers throughout history have asked four fundamental questions: the ontological question, "What is there that can be known or what is the nature of reality?"; the epistemological question, "What is the nature of the relationship between the knower and the knowable?"; the methodological question, "How does one acquire this knowledge?", and finally the axiological question, "Of all the knowledge that is available to me, which is

²⁶¹ Cresswell John W. and Cheryl N. Poth. 2017. *Qualitative Inquiry and Research: Design Choosing Among Five Approaches.*, 4th ed. Los Angeles: Sage.16.

²⁶² Ibid.

the most valuable, truthful and life-enhancing?"²⁶³ Prior to commencing their study, the researcher must be aware of the impact of paradigms and theoretical frameworks, as these impact how we formulate the research question and how we seek the information to answer the question.²⁶⁴

Sarantakos describes a paradigm as a worldview, a set of propositions that explain how the world is perceived,²⁶⁵ and Cresswell and Poth describe paradigms as the philosophical belief system that underpins and guides the research.²⁶⁶ The paradigm's worldview shapes a researcher's approach to the data collection, data analysis and interpretation of the research they are conducting.²⁶⁷ Two main scientific paradigms exist, commonly these are referred to as 'positivist/post positivist' (quantitative) and 'naturalistic/constructivist' (qualitative).²⁶⁸

The fundamental assumption in the positivist paradigm is that there is one single reality that can be studied based upon the belief that an objective reality exists independent of human observation, awaiting discovery.²⁶⁹ The world is not assumed to be a creation of the human mind. In the positivist paradigm, the object of the study is believed to be independent of researchers. Researchers guided by this paradigm practice in an orderly, disciplined, procedural way; tight controls are maintained over the research process. Knowledge is discovered and verified through direct observations or measurements. Post positivist researchers still believe in an objective reality; however, they recognise the impossibility of total objectivity. They see objectivity as a goal and they strive to achieve it however they acknowledge that their own value systems play an important role in how they conduct and interpret their research.²⁷⁰ Generally, research conducted

²⁶³ Lincoln Yvonna G. and Egon G. Guba. 2016. *The Constructivist Credo*, Walnut Creek, USA: Routledge.

²⁶⁴ Cresswell and Poth, *Qualitative Inquiry and Research: Design Choosing Among Five Approaches*.18.

²⁶⁵ Sarantakos, S. 2013. *Social Research*. 4th ed., Basingstoke: Palgrave Macmillan.29-52.

²⁶⁶ Cresswell and Poth, *Qualitative Inquiry and Research: Design Choosing Among Five Approaches*.

²⁶⁷ Schneider et al., 2016. *Nursing and Midwifery Research Methods and Appraisal for Evidence-Based Practice*, 5th ed., Australian and New Zealand edition: Elsevier.

²⁶⁸ Polit, Denise F. and C.T. Beck. 2014. *Essentials of Nursing Research: Appraising Evidence for Nursing Practice.*, 8th ed., Philadelphia, PA: Lippincott, Williams & Wilkins; Schneider et al., *Nursing and Midwifery Research Methods and Appraisal for Evidence-Based Practice*.

²⁶⁹ Sarantakos, *Social Research*.

²⁷⁰ Ibid.; Streubert, Helen J. and Dona R. Carpenter. 2011. *Qualitative Research in Nursing: Advancing the Humanistic Imperative*, 5th ed., Philadelphia Lippincott, Williams and Wilkins; Krauss, Steven Eric. 2005. "Research Paradigms and Meaning Making: A Primer," *The Qualitative Report*, 10 (4): 758-70; Polit and Beck, *Essentials of Nursing Research: Appraising Evidence for Nursing Practice*.

using a belief system grounded in positivist /post positivist understandings, will have a scientific approach and represent quantitative research.²⁷¹

In the late 19th century the naturalistic/constructivist paradigm began as a countermovement to positivism. According to the naturalistic paradigm, reality exists within a context and therefore many constructions of reality are possible. Max Weber (1864-1920) asserted that reality is not fixed but is a construction of the individual who is participating in the research. The world that people experience in everyday life is an active process, where people construct their own reality based upon personal interpretation.²⁷² Knowledge (that is, what people 'know', or believe to be true, about a situation) is established through the meanings they attach to phenomena. For researchers working within the naturalistic paradigm, people's interpretations of specific phenomena are the key to understanding those phenomena.²⁷³

Researchers who adopt a naturalistic / constructivist paradigm usually conduct research using qualitative methods. Qualitative methods yield rich, in-depth information from the real-life experiences of the research participants who have lived experience of the phenomenon under study. Qualitative research methods are ideally suited to explore topics where little is known and greater insight is desired from the perspective of those undergoing the experience.²⁷⁴ Krauss suggests one major advantage of the qualitative approach is that we are able to see the point of view of the research participant.²⁷⁵

Qualitative data can provide rich insight into human behaviour. Lincoln and Guba endorse the use of the researcher's 'self' in the research process and their term 'the human instrument' describes the way in which qualitative researchers use their experience, background and knowledge to clarify and summarise information.²⁷⁶ This enables a final

²⁷¹ Cresswell and Poth, *Qualitative Inquiry and Research: Design Choosing Among Five Approaches*; Schneider et al., *Nursing and Midwifery Research Methods and Appraisal for Evidence-Based Practice*.

²⁷² Sarantakos, *Social Research*.

²⁷³ Streubert and Carpenter, *Qualitative Research in Nursing: Advancing the Humanistic Imperative*; Sarantakos, *Social Research*; Krauss, "Research Paradigms and Meaning Making: A Primer"; Polit and Beck, *Essentials of Nursing Research: Appraising Evidence for Nursing Practice*.

²⁷⁴ Grove, Susan, Jennifer Gray, and Nancy Burns. 2012. *Understanding Nursing Research*, 6th ed. Philadelphia Saunders; Maxwell, Joseph A. 2013. *Qualitative Research Design an Interactive Approach*, 3rd ed., London: Sage; Schneider et al., *Nursing and Midwifery Research Methods and Appraisal for Evidence-Based Practice*.

²⁷⁵ Krauss, "Research Paradigms and Meaning Making: A Primer."

²⁷⁶ Lincoln, Yvonna G. and Egon G. Guba. 1985. *Naturalistic Inquiry*, Beverly Hills, California: Sage.

product that reflects the researcher's and participants' interaction with the findings, rather than the application of mathematical formulae as used in quantitative methods.²⁷⁷

Therefore, research originates from and is underpinned by the researcher's philosophical, theoretical and world views.

Social Research

Social research has a variety of goals. The purpose of social research is the generation of knowledge and the identification of regularities in social processes to enable the researcher to understand the presence, the extent of problems and the ways they can be resolved²⁷⁸. Sarantakos states the purpose of social research has three parts²⁷⁹. The first is to explore social reality for its own sake or in order to make further research possible; to explain social life by providing reliable, valid and well-document information; evaluate the status of social issues and their effects on society; facilitate predictions; and to develop and/or test theories. The second is to understand human behavior and action and the third is to offer a basis for a critique of social reality; emancipate people; suggest possible solutions to social problems and to empower and liberate people²⁸⁰. Social research can take many forms and the way social research is conducted will depend on the paradigm that guides the research and the phenomenon to be studied.

The phenomenon under study was the history of privately practicing midwives. Midwives are predominantly women, caring for women, therefore, this study was conducted within a naturalistic, feminist paradigm using a historical narrative research methodology. The research data was obtained from oral history interviews and archival research. This approach was chosen as it was the most appropriate methodology to answer the research question. The methodology will now be discussed in more detail.

Feminist Research

The online Oxford Dictionary defines Feminism as "the advocacy of women's rights on the ground of the equality of the sexes".²⁸¹ This dictionary definition is social constructed and

²⁷⁷ Lincoln, Yvonna G., and Egon G. Guba. 1994. "Competing Paradigms in Qualitative Research" in *Handbook of Qualitative Research*, ed. Norman K. Denzin and Yvonna G. Lincoln (Thousand Oaks, California: Sage.

²⁷⁸ Sarantakos, *Social Research*.10.

²⁷⁹ *Ibid.*.11.

²⁸⁰ *Ibid.*

²⁸¹ Oxford Online Living Dictionary, "Feminism."

basic. It is argued that feminism has many definitions; it can be described as a social movement, a philosophy, a world view, a theory, a practice and a research method.²⁸² The history of feminism has been described in three main waves; the first wave of feminism is described as the struggle for gender equality, the fight for the end of slavery and the women's suffrage movement during the nineteenth and early twentieth century.²⁸³ The second wave of feminism began in the 1960s and 1970s, and participants believed that the rights of women in order to gain true equality, needed to include not only the public and political position of women, but take into account private worlds such as family, sexuality and health.²⁸⁴ The third wave of feminism (mid 1990s) describes efforts by younger women and men to apply feminist principles and values to women of all classes, cultures, races and sexual preferences and was considered a backlash towards a system that prioritised the perceived needs of privileged white women who rode the first and second waves of feminism. As we move onto the fourth wave of feminism it is suggested by some feminist scholars that we need to deconstruct the feminist wave metaphor as the feminist movement and women's histories do not happen in waves but are a constant flow; a long, continuous, and contentious struggle for equality.²⁸⁵

Radical feminism is a specific feminist theory that emphasises the role of patriarchal systems and claims that women are oppressed by patriarchy and that this patriarchal system is so prevalent that it has become the natural order of the world.²⁸⁶ As previous stated, second wave feminism began in the 1960s and 1970s and was the time when women began to question the prevailing paradigm of childbirth, which focused on birth as a medical event, and feminist writers such as Ann Oakley began to make the connections between childbirth, birth attendants and the position of women in society.²⁸⁷ Feminist

²⁸² Hesse-Biber, Sharlene. 2012. *Handbook of Feminist Research: Theory and Praxis*, 2nd ed, London: Sage; McCool, William F. and Sandi J. McCool, 1989. "Feminism and Nurse Midwifery: Historical Overview and Current Issues." *Journal of Nurse-Midwifery* 34 (6): 323-24; Davison, Clare, Sadie Geraghty, and Kirsten Dobbs. 2018. "The F Word: Midwifery Students' Understanding of Feminism." *British Journal of Midwifery* 26 (11): 731-37.

²⁸³ Walters, Margaret. 2015. *Feminism: A Very Short Introduction*, Oxford: Oxford University Press.

²⁸⁴ McCool and McCool, "Feminism and Nurse Midwifery: Historical Overview and Current Issues"; Cott, Nancy. 1987. *The Grounding of Modern Feminism*. New Haven: Yale University Press.

²⁸⁵ Laughlin et al., 2010. "Is It Time to Jump Ship? Historians Rethink the Waves Metaphor," *Feminist Formations*, 22 (1): 76-135.

²⁸⁶ Kaufmann, Tara. 2004. "Introducing Feminism," in *Pregnancy, Birth and Maternity Care: Feminist Perspectives* ed. Mary Stewart, Edinburgh: Books for Midwives.

²⁸⁷ Oakley, *The Captured Womb*; Oakley, Ann. 1980. *Woman Confined: Towards a Sociology of Childbirth*, Oxford: Martin Robertson; Oakley, Ann. 1972. *Sex, Gender and Society*, San Francisco: Harper and Row.

theory identifies reproduction as both the site of the woman's worst exploitation and greatest power;²⁸⁸ therefore, it can be argued that any research relating to women and midwives must consider the impact of feminism, in particular Radical Feminism.

The feminist researcher's aim is to produce useful knowledge that will make a positive difference to women's lives through social and individual change and empowerment.²⁸⁹ Historically women have played only a small part in methods of gaining the scientific, objective, empirical knowledge that was accepted during the 20th century as the 'best' knowledge.²⁹⁰ Anderson states that this dominant knowledge – knowledge gained through empirical approaches to science which exist within the positivist quantitative framework—disadvantages women by:

- (1) excluding them from inquiry,
- (2) denying them epistemic authority
- (3) denigrating their "feminine" cognitive styles and modes of knowledge,
- (4) producing theories of women that represent them as inferior, deviant, or significant only in the ways they serve male interests,
- (5) producing theories of social phenomena that render women's activities and interests, or gendered power relations, invisible, and
- (6) producing knowledge (science and technology) that is not useful for people in subordinate positions, or that reinforces gender and other social hierarchies.²⁹¹

Ramazanoglu and Holland argue that feminist knowledge is grounded in experiences of gendered social life and is also dependent on judgments about social relationships and balances of power.²⁹² Feminist research can be defined as a quest for better knowledge of women's social realities and contemporary feminist research strives to give a voice to women's lives that have been silenced and ignored, uncover hidden knowledge contained within women's experiences, and bring about women-centred solidarity and social

²⁸⁸ Kaufmann, "Introducing Feminism"; Oakley, *Woman Confined: Towards a Sociology of Childbirth*.

²⁸⁹ Letherby, Gayle. 2003. *Feminist Research in Theory and Practice*, Philadelphia Open University Press.

²⁹⁰ Anderson, Elizabeth. 2017. "Feminist Epistemology and Philosophy of Science." In *The Stanford Encyclopedia of Philosophy*. ed. Edward N Zalta.

²⁹¹ Ibid.1.

²⁹² Ramazanoglu, Caroline and Janet Holland.2004. *Feminist Methodology, Challenges and Choices*, London: Sage.

change.²⁹³ The importance of feminist research is particularly relevant when looking at the history of midwives, a profession predominantly represented by women.

According to Morse and Field, regardless of research tradition, the aim of historical research is always the interpretation and narration of past events.²⁹⁴ The present is a product of the past, to truly understand what is happening now we first need to look backwards. Historical research opens a window to the past and provides a way for us to know and understand the events of the past. Due to the male dominance of the society in which we live and the rise of obstetrics, the history of midwives in Australia, similar to much women's history, has not been recorded in detail.

Beddoe suggests that a group without history is like a person without a memory. We need that memory to draw on the strengths of earlier successes and learn from the previous experiences.²⁹⁵ The study of women's history provides an exciting challenge to the researcher because it is an opportunity to discover new knowledge of gendered social lives that we previously had little or no understanding of, knowledge that is grounded in the women's own experiences. In uncovering this new knowledge of the past, we can consider how this will help women in the future.

To obtain the oral histories in this current study, a 'narrative' or 'storytelling' approach was used. Narrative comes from the Latin 'gnarus' meaning knowing and is defined as a "spoken or written account of connected events; a story".²⁹⁶ Historical narratives are the story of an account of events and the 'knowing' of this story is the narrative enquiry, the interpretation of these events.²⁹⁷ Holloway and Freshwater state that narratives in their simplest form are continuous stories with connected elements that include a plot, a stated problem and a cast of characters.²⁹⁸ This story is generally a verbal or written representation of events or experiences, expressed in a way that can be

²⁹³ Ramazanglu and Holland, *Feminist Methodology, Challenges and Choices*; Brooks, Abigail. 2007. "Feminist Standpoint Epistemology: Building Knowledge and Empowerment through Women's Lived Experience," In *Feminist Research Practice: A Primer*, ed. Sharlene Hesse-Biber and Patricia Lina Leavy. London: Sage; Hesse-Biber, *Handbook of Feminist Research; Theory and Praxis*.

²⁹⁴ Morse, Janice M and Peggy Anne Field. 1995. *Qualitative Research Methods for Health Professionals*, Thousand Oaks California: Sage.

²⁹⁵ Beddoe, Dierdre. 1998. *Discovering Women's History: A Practical Guide to Researching the Lives of Women since 1800*, 3rd ed. London: Longman.

²⁹⁶ Cresswell and Poth, *Qualitative Inquiry and Research: Design Choosing Among Five Approaches*; Oxford Online Living Dictionary, "Narrative Definition."

²⁹⁷ Holloway, Immy and Dawn Freshwater. 2007. *Narrative in Nursing*, London: Wiley Blackwater.

²⁹⁸ Ibid.

understood by others. Telling stories is part of human nature. People narrate past events and experience throughout their lives for many reasons. Storytelling can be used to give information, share thoughts and feelings. People may also use narrative story telling in justifying their actions or beliefs or by way of giving meaning to their experience.²⁹⁹ Clandinin and Connelly assert that people's experiences are the starting point and the core of narrative research.³⁰⁰ Oral history methodology will now be discussed.

Oral History

Oral history is a means of collecting and preserving memories and personal commentaries of historical significance through recorded interviews.³⁰¹ Oral histories have been recorded since history itself was first documented. Three thousand years ago the Zhou dynasty in China collected the words of people for the court historians, and centuries later Thucydides, the Greek historian, recorded the oral testimonies from participants in the Peloponnesian wars.³⁰² Oral histories continued into the modern day, becoming much easier to study following the invention of voice recording systems such as the tape recorder. In the 1940s American Historian, Allan Nevins began to use oral history to record the memoirs of 'significant Americans', generally the 'white male élite' whose memoirs, he believed, were important.³⁰³ Gradual acceptance of the usefulness and validity of recorded evidence as a research tool continued, particularly when the tape recorders became small enough to be portable. During the 1960s and 1970s, Historian Paul Thomson, played a leading part in the international oral history movement. Thomson believed that oral history transformed history by shifting the focus and opening areas of enquiry by bringing recognition to groups of people who had previously been ignored.³⁰⁴ Portelli asserts that Oral history is different to other historical accounts, as it doesn't just tell us about events, it tells us about their meanings. It tells us, not just what people did but why they did it –the reasoning behind their actions and their beliefs.³⁰⁵ As research methods evolved, the scientific more 'objective' research methods claimed the oral history method was

²⁹⁹ Holloway, Immy and Dawn Freshwater. 2007. "Vulnerable Story Telling: Narrative Research in Nursing," *Journal of Research in Nursing*, 12 (6): 703-711.

³⁰⁰ Clandinin D. Jean and F. Michael Connelly. 2000. *Narrative Inquiry: Experience and Story in Qualitative Research*. San Francisco Jossey Bass.

³⁰¹ Ritchie, Donald A. 1995. *Doing Oral History*, London, Twayne Publishers.

³⁰² Perks, Robert and Alistair Thomson. 1998. *The Oral History Reader*, London: Routledge.

³⁰³ Perks and Thomson, *The Oral History Reader*.

³⁰⁴ Ibid.

³⁰⁵ Portelli, Alessandro. 2003. "What Makes Oral History Different," in *The Oral History Reader*, ed. Robert Perks and Alistair Thomson, London: Routledge.

'subjective and biased'.³⁰⁶ However, Portelli argues that subjectivity is the business of history, as what people believe is a historical fact.³⁰⁷ Oral histories have their place and should not be dismissed as merely a biased representation of history.

Sangster discusses how the feminist embrace of oral history emerged from the recognition that traditional sources often neglected the lives of women.³⁰⁸ Feminist oral history puts women's voices back into history and in doing this can challenge the accepted definitions of social, economic and political history. Anderson, Armitage, Jack and Wittner agree, noting that when women speak for themselves, they can reveal hidden realities, new experiences and new perspectives that challenge the official accounts and cast doubt on established theories.³⁰⁹ In other words, in order to contextualise oral histories, we need to survey the dominant ideologies shaping the women's worlds; by actually listening to the women's words we can see how women understood, negotiated and sometimes challenged these dominant ideologies.³¹⁰

It has been suggested by some feminist historians that perhaps, women's feminist history is no longer 'special' and may not have a future.³¹¹ However, there is still a need today as there was in the beginning, as described by Gluck "to bring women's voice forth", and "give voice to those who had been rendered historically invisible and voiceless".³¹² Moreover, the role of the feminist historian is to also historicise the present to enable feminist history to be relevant, dynamic and vital to contemporary discussions.³¹³ This is particularly relevant when we look at the history of midwives working in the patriarchal medical system. Therefore, it can be argued that feminist oral history is a powerful tool for discovering, exploring and evaluating how women make sense of their past; how they connect individual experiences to the society they live in; how they use these experiences

³⁰⁶ Charlton Thomas L, Lois E Myers, and Rebecca Sharpless. 2008. *Handbook of Oral History*. Lanham: Altamira Press.

³⁰⁷ Portelli, "What Makes Oral History Different."

³⁰⁸ Sangster, Joan. 2003. "Telling Our Stories; Feminist Debates and Use of Oral Histories" in *Oral History Reader*, ed. Robert Perks and Alistair Thomson, London: Routledge.

³⁰⁹ Anderson et al., "Beginning Where We Are: Feminist Methodology in Oral History."127.

³¹⁰ Sangster, "Telling Our Stories; Feminist Debates and Use of Oral Histories".

³¹¹ Gluck, Sherna Berger. 2008. "Women's Oral History: Is It So Special?" in *Handbook of Oral History*, ed. Thomas S. Charlton, Lois E. Myers, and Rebecca Sharpless, Lanham: Altamira Press.

³¹² Ibid.359.

³¹³ Damousi, Joy. 2014. "Does Feminist History Have a Future?" *Australian Feminist Studies* 29, (80): 189-203.

to interpret their lives and the worlds around them and how the past affects and becomes part of the present.³¹⁴

Oral historical research has been used to study health care practices; it is described by nursing historians Boschma, Scaia, Bonifacio and Roberts as a historical methodology that allows the narrator the freedom to express ideas and thoughts in a way that that may not be otherwise preserved in a written form.³¹⁵ Oral history can provide evidence of people's work and life experience of which little written evidence exists and about subjects that have not traditionally been topics of historical investigation.³¹⁶ Bornat, Perks, Thompson and Walmsley argue that oral history can help create a more rounded picture of past health care practice,³¹⁷ and Boschma et al believe that oral history accounts of nursing and midwifery assist us in gaining an intimate understanding of practice dilemmas from the perspective of the people who experienced them.³¹⁸ As previously stated, oral history is particularly powerful in feminist research as it gives voice to the previously unheard women's voices, revealing new experiences and perspectives that may cast doubt on established theories.

Oral history, therefore, is an important methodological tool in studying the history of Privately Practising Midwives in Western Australia. Using oral history to reconstruct the history of midwifery in WA, the previously unheard voices of the midwives themselves are heard, therefore situating each individual woman's life story in specific social and historical settings. In telling this history I will show how women's actions and consciousness contributed to the structuring of social institutions and midwifery today. Archival research will now be discussed.

³¹⁴ Perks and Thomson, *The Oral History Reader*; Sangster, "Telling Our Stories; Feminist Debates and Use of Oral Histories"; Charlton, Myers, and Sharpless, *Handbook of Oral History*.

³¹⁵ Boschma et al., 2008. "Oral History Research," In *Capturing Nursing History: A Guide to Historical Methods in Research*, ed. Sandra B Lewenson and Eleanor Krohn Herrmann. New York: Springer Publishing Company.

³¹⁶ Biedermann, Narelle. 2001 "The Voices of Days Gone By: Advocating the Use of Oral History in Nursing." *Nursing Inquiry* 8 (1): 61-62.; Boschma Geertje. 2015. "Conducting Oral History Research in Community Mental Health Nursing," In *Nursing Research Using Historical Methods, Qualitative Designs and Methods in Nursing*, ed. Mary De Chesnay. New York: Springer Publishing Company.; Boschma et al., "Oral History Research."; D'Antonio, Patricia. 2008. "Conceptual and Methodical Issues in Historical Research." In *Capturing Nursing History: A Guide to Historical Methods in Research*, ed. Sandra B Lewenson and Eleanor Krohn Herrmann, 11-24; Ibid.

³¹⁷ Bornat et al., 2000. *Oral History, Health and Welfare*. London: Routledge.

³¹⁸ Boschma et al., "Oral History Research."

Archival Research

Archival research is the other main methodology in this study. In its simplest terms, archival research is the methodology of gathering information,³¹⁹ the word archives comes from the Greek *arkheion*, where the official documents were kept in the home of the magistrates in Ancient Greece.³²⁰ The archival research methodology was considered to be the more 'scientific' method of historical writing during the late eighteenth and early nineteenth centuries.³²¹ At this time the modern historian was concerned with writing about political history. However, the 'scientific' historical writing could never be fully objective. King suggests that archival research, and the historical writing developed from it, is intrinsically bound to state power, as the making, maintaining and the destruction of records allow different groups to choose what to record, what to keep and what to destroy, thereby enabling them to "lay claim to their own version of the past and control over the present".³²² This can be particularly relevant when studying women's history, as the 'official' record keepers were generally men.

Primary resources are described as the firsthand account of an event or subject of interest or documents by people who participated in or witnessed an event.³²³ The work of the historical researcher involves sourcing these primary resources, analysing them within the context they reside and considering the genuineness and authenticity of the material.³²⁴ To be genuine and authentic the document must provide a truthful report of the subject and be what it says it is; however, it is worth remembering when analysing these documents that the 'truthful report' is still the author's interpretation of the truth. Secondary sources use primary sources to tell a story, they are sources based on the

³¹⁹ Howell, Martha C and Walter Prevenier. 2001. *From Reliable Sources: An Introduction to Historical Methods*, New York: Cornell University Press.

³²⁰ King, Michelle T. 2011. "Working With/In the Archives," in *Research Methods for History*, ed. Simon Faire and Lucy Gunn, Edinburgh: Edinburgh University Press.101-117.

³²¹ Ibid.

³²² Ibid.15.

³²³ Lewenson, Sandra B and Annemarie McAllister. 2015 "Learning the Historical Method: Step by Step," in *Nursing Research Using Historical Methods, Qualitative Designs and Methods in Nursing*, ed. Mary De Chesney, New York: Springer Publishing Company; Lusk, Brigid. 1997. "Historical Methodology for Nursing." *Journal of Nursing Scholarship*, 29 (4): 355-59.355-359.

³²⁴ McAllister Annemarie and Sandra B Lewenson. 2015. "Inside Track of Doing Historical Research: My Dissertation Story," in *Nursing Research Using Historical Methods, Qualitative Designs and Methods in Nursing*, ed. Mary De Chesnay, New York: Springer Publishing Company; Lewenson and McAllister, "Learning the Historical Method: Step by Step"; Lewenson, Sandra B. 2008. "Doing Historical Research." in *Capturing Nursing History: A Guide to Historical Methods in Research*, ed. by Sandra B Lewenson and Eleanor Krohn Herrmann, 25-44. Los Angeles: Sage.

primary sources, materials that cite opinions and interpretations of the primary sources.³²⁵ Secondary sources can provide a contextual background to the subject under study or a specific period.³²⁶

Historians must consider the genuineness and authenticity of the sources they study, during careful reading of the documents, the researcher poses questions. Lewenson suggests that the researcher asks, "are the sources what they purport to be, and do they make sense given the time period in which the materials were found?"³²⁷ Validity relies on external and internal criticism of the data collected. External criticism questions the genuineness of the source and internal criticism questions the authenticity or truthfulness of the data. Information was gathered from both primary and secondary sources about midwives and midwifery in Western Australia. The material included the recorded stories (such as diary excerpts or family histories), newspaper articles, government documents and maternity health policies and guidelines.

Reflexive Bracketing, and Explicating the Researcher's Beliefs Prior to Data Collection

Speziale states that prior to commencing a qualitative research study the researcher should clear her thoughts, ideas, suppositions or presuppositions about the topic as well as personal biases.³²⁸ The idea behind this exercise is to bring to the consciousness any preconceived ideas the researcher may have about the topic. This will enable the researcher to be aware of any potential judgements that may occur during data collection and analysis that are based on the researcher's beliefs rather than the actual data. Fischer describes a process called bracketing which refers to the researcher's identification of personal experiences, prior assumptions, culture, and vested interest that could influence the way they view the research data.³²⁹

³²⁵ Lewenson, "Doing Historical Research."

³²⁶ Lewenson and McAllister, "Learning the Historical Method: Step by Step."

³²⁷ Lewenson, "Doing Historical Research."34.

³²⁸ Speziale, Helen Streubert. 2011. *Qualitative Research in Nursing: Advancing the Humanistic Imperative* / Helen J. Streubert, Dona R. Carpenter, ed. by Dona R. Carpenter. 5th ed. Philadelphia: Wolters Kluwer Health/Lippincott Williams and Wilkins.

³²⁹ Fischer, Constance. 2009. T, "Bracketing in Qualitative Research: Conceptual and Practical Matter," *Journal of Psychotherapy Research: Quantitative and Qualitative Methods for psychotherapy Research* 19 (4-5): 583-90.

Boschma et al state that the interviewer is an active participant in the research process and brings with her to interviews and its interpretations her own questions, biases and assumptions as well as the influences of her upbringing, education, family and professional life.³³⁰ I am also a PPM, therefore I had to identify my own biases and assumptions, prior to commencing the interviews and data analysis. However, I also acknowledged that my own experiences could enable me to have insights and empathy for the interviewees that another researcher may not have had.

Ahern describes reflexive bracketing as a process to make the researcher's personal values, background and cultural suppositions transparent. The researcher identifies his or her personal suppositions and ideas about the phenomena prior to the data collection and reflects on these to try and understand the thoughts behind them.³³¹ Sokolowski describes bracketing as a way of clearing one's view by recognising one's beliefs, perceptions and assumptions about a phenomenon, and putting them aside.³³² This strategy involves the researcher acknowledging and recording her own preconceptions and experiences about the phenomenon of interest to significantly reduce the likelihood of her 'forcing' the research to meet expected findings and this will also increase the credibility of the proposed research. Patton supports this assertion and suggests that the researcher should report any personal or professional information that may affect the data collection or analysis.³³³

Prior to data collection reflexive bracketing was used to facilitate the process of personal reflection. In doing this exercise I was able to acknowledge my views and beliefs and to 'bracket them and put them to one side'. I identified my views as a private midwife and my own experiences of working within this model; I also answered and explored my own research questions. As I had worked as a PPM, it was essential that I perform this exercise prior to the data collection to reduce bias as I had my own lived experiences of providing private maternity care that could have influenced my research. Following this reflective bracketing exercise I was able commence the research without imposing my

³³⁰ Boschma et al., "Oral History Research."

³³¹ Ahern, Kathryn J. 1999. "Pearls, Pith and Provocation: Ten Tips for Reflexive Bracketing." *Qualitative Health Research* 9 (3): 407-411.

³³² Sokolowski, R. 2000. *Introduction to Phenomenology*, Cambridge: Cambridge University Press.

³³³ Patten, M. 2002. *Qualitative Research and Evaluation Methods*, Thousand Oaks, California Sage.

views on the data analysis and felt I would be able to explore the data objectively.³³⁴ Being constantly aware of my own thoughts and beliefs enabled me to keep it separate from the data collected.

I was also sensitive to the impact that my background might have on my ability to analyse and interpret data objectively.³³⁵ Streubert and Carpenter believe it is in the researcher's best interest to make clear his or her thoughts, ideas, suppositions, or presuppositions about the topic as well as personal bias.³³⁶ This enables the researcher to be aware of the potential bias that could occur during data collection and analysis, preventing the researcher's judgements being based on her belief system rather than the actual data.³³⁷ Throughout the research journey, as suggested by Boschma et al., I continually reflected and used a journal to record my thoughts, ideas and questions.³³⁸

Methods Used in the Study

A naturalistic, feminist paradigm was used to investigate, analyse and describe the history of Privately Practising Midwives in WA from colonisation to the present day (approximately 1830-2018). This approach was chosen as the intent of the research was an interpretation and narration of past events.³³⁹

Research Question, Aim and Objectives

Lewenson offers steps to aid us in 'doing' historical research. These steps are:

- Identify areas of interest
- Raise questions
- Formulate title
- Review literature
- Interpret data
- Write the narrative³⁴⁰

³³⁴ Ahern, "Pearls, Pith and Provocation: Ten Tips for Reflexive Bracketing."

³³⁵ Boschma et al., "Oral History Research."

³³⁶ Streubert and Carpenter, *Qualitative Research in Nursing: Advancing the Humanistic Imperative*.

³³⁷ Ibid.

³³⁸ Boschma et al., "Oral History Research."

³³⁹ Schneider et al., *Nursing and Midwifery Research Methods and Appraisal for Evidence-Based Practice*.

³⁴⁰ Lewenson, "Doing Historical Research."

The area of interest was identified as the history of autonomous midwifery in Western Australia (WA). Following an extensive review of the existing historical literature around midwives practicing in Australia and Western Australia, the research question was formulated. The research question asks:

“How has private midwifery in WA evolved from 1830 to 2014, and what can midwives providing private midwifery care today, learn from the experiences of WA midwives who provided this type of midwifery care in the past?”

The overall aim of this historical qualitative study was to generate new and useful knowledge by investigating, analysing and describing the history of privately practicing midwives in Western Australian from colonisation to the present day (approximately 1830 – 2018). The qualitative analysis drew upon data from oral history interviews with currently practising or retired PPMs, women who had experienced maternity care from PPMs and doctors. This data was supplemented by data from media reports, archival documents, maternity health policies and guidelines and field notes.

The Specific Objectives were Identified as:

- Record and explore the history of the privately practising midwife in Western Australia from approximately 1830 to 2014.
- Describe the past and present privately practising midwife’s experience of providing midwifery care in WA.
- Analyse the relationship between the privately practising midwife and other health professionals.

To achieve these objectives the following questions were considered during the interviews and data analysis:

1. What reasons were cited for choosing to work as a privately practising midwife?
2. How did the privately practising midwife work? Did she provide care to women at home or in a hospital setting?
3. What was the privately practising midwife’s experience of providing private midwifery care?
4. Were there any barriers or benefits to providing private midwifery care? Did this change over time?

5. What were the views, and experiences of hospital-based midwives and doctors towards Privately Practising Midwives and women who used their services?
6. What can midwives today learn from the experiences of privately practising midwives?

As described above, the study was conducted using two concurrent methods of qualitative historical research: archival and oral history.

Sample for Oral History Interviews

The aim of qualitative research is not to generalise about the population, but to obtain individual insights into a phenomenon under investigation. Therefore, sampling in qualitative studies begins by selecting a sample that will provide information richness.³⁴¹

The primary aim of this research was to obtain information about the history of PPMs in WA and the experiences of PPMs; therefore, it was not appropriate to use random sampling.³⁴² To obtain the sample for the oral histories a purposive sample was obtained using a snowballing technique. Candidates were selected if they were currently practising as a PPM or had done in the past. Boschma suggests networking and building relationships within the field under study are important aspects of purposive sampling to find participants.³⁴³ The researcher was a PPM therefore had access to potential participants who were PPMs or knew of people who were able to facilitate an introduction. An email was sent to these contacts asking for names of midwives who had practiced or were still practicing as PPMs in WA and who may be interested in being interviewed. Purposive sampling was then undertaken, as the study was asking questions specific to a particular group and sample cases were needed to provide rich information specific to these questions.³⁴⁴ The snowball effect of sampling continued once the study commenced, as during the interview PPMs suggested other midwives that they had worked with or knew. Interviews with women who had received care under a PPM and doctors who had worked with PPMs were also sought.

³⁴¹ Schneider et al., *Nursing and Midwifery Research Methods and Appraisal for Evidence-Based Practice*; Polit and Beck, *Essentials of Nursing Research: Appraising Evidence for Nursing Practice*; Cresswell and Poth, *Qualitative Inquiry and Research: Design Choosing Among Five Approaches*.

³⁴² Boschma, "Conducting Oral History Research in Community Mental Health Nursing."

³⁴³ Ibid.

³⁴⁴ Cresswell and Poth, *Qualitative Inquiry and Research: Design Choosing Among Five Approaches*.

Boschma, Scaia, Bonifacio and Roberts suggest that a unique aspect of oral history research is that participants are usually selected because of their identity or experiences, consequently participants are not usually anonymous.³⁴⁵ The potential participants were sent an introductory letter written in plain English, containing information about the study, research aims and benefits, an explanation of selection, confidentiality issues, an indication of what the results would be used for and requesting consent to participate (Appendix One and Two). The letter also indicated that any questions that participants wished to ask would be welcome and that they could withdraw from the study at any time. The researcher and her supervisor's contact details were included in the information so that participants were able to contact the research team if they had any questions or concerns. A consent form to participate in the research was given to all participants, which included an option to remain anonymous (Appendix Three). All participants except one consented for their real name to be used in the study. The one participant who declined was allocated a pseudonym. Prior to the commencement of the interview informed consent was sought, and the consent form was signed by both the participant and the researcher. A copy of the signed consent form was given to the participant and the original was retained by the researcher.

All potential participants who were contacted agreed to take part in the study. Fifteen midwives and three doctors were interviewed, all interviews took place in the participant's own homes apart from one where the distance was too great, in this case, the interview was conducted via video calling.

Data Collection in the Study

The use of multiple methods can enhance the quality and credibility of data, this study involved data from oral history interviews and archival documents. The documentation and analysis of oral histories from interviews with living midwives who have and may still provide private midwifery care were collected as data. The qualitative research data was obtained from oral histories describing the experiences of PPMs providing private midwifery care in Western Australia. The original plan was to support the data with interviews from women who had received care from a PPM and other health professionals, such as doctors who had worked with the PPMs. During the interviews, however, it was

³⁴⁵ Boschma et al., "Oral History Research."

discovered that nine of the midwives and one of the doctors had also received midwifery care from a PPM therefore further interviews with women were not sought.

These oral histories were obtained through in-depth interviews from the living midwives who practised or were still practising as PPMs in WA and the doctors who consented to participate in this study. This allowed insight into the experiences of the people who have directly participated in the phenomenon under study.

The oral history interview is an in-depth, detailed and reflective account of the past. According to Shopes, oral history interviewing is historical in intent; it seeks new knowledge about and insights into the past. It represents an interplay between past and present, the individual and the social, and is grounded in historical questions, therefore, it requires that the interviewer has knowledge of the subject being researched and the interview participant's relationship to the subject. Minichello, Aroni, Timewell and Alexander describe interviews as a "conversation with a purpose" and suggest that in-depth interviews can be used "to gain access to, and an understanding of, activities and events that cannot be observed by the researcher".³⁴⁶ In-depth interviewing is an appropriate method to gain access to the individual's words and interpretations. Interview participants can tell researchers how they felt about particular events or experiences.³⁴⁷ The in-depth interview is a powerful data collection strategy as it allows one to one interaction between researcher and participant. Interviews also allow ample opportunity for researchers to ask for explanations of vague answers or provide clarification of questions.³⁴⁸ Anderson et al. suggest oral historians should take advantage of the fact that the interview is the only historical research that can ask people questions to clarify what they mean.³⁴⁹

In traditional interviewing the researcher becomes dominant and directs the interview with questions, which can make the relationship between the researcher and participant unbalanced.³⁵⁰ In using oral histories and a feminist perspective, a storytelling approach was used. Storytelling aims to rebalance the power relationship between

³⁴⁶ Minichiello, Victor, Rosalie Aroni, and Terrence Hays. 2008. *In-Depth Interviewing: Principles, Techniques, Analysis*, 3rd ed., Pearson Education Australia.70.

³⁴⁷ Ibid.

³⁴⁸ Ibid.; Teddie, Charles, and Abbas Taqshakkan. 2009. "Foundations of Mixed Methods Research." London: Sage; Serry, Tanya and Pranee Liamputtong. 2017. "The In-Depth Interviewing Method in Health," in *Research Methods in Health: Foundations for Evidence-Based Practice*, ed. Pranee Liamputtong, Australia: Oxford University Press.

³⁴⁹ Anderson et al., "Beginning Where We Are: Feminist Methodology in Oral History."

³⁵⁰ Sandelowski, Margarete. 1991. "Telling Stories: Narrative Approaches in Qualitative Research," *Journal of Nursing Scholarship*, 23 (2): 161-166.

researcher and participant. In allowing the participant to tell her story, the researcher hands control of the content of her story to the interviewee, rather than her just answering the researcher's questions. Participants can tell their stories in their own way and reflect on their experience in their own time, without constant disruption. It is imperative that the researcher allows the participant to tell their story and also that the researcher 'accepts' the information that is given and gives priority to what the participant wants to tell, rather than what the researcher wants to hear.³⁵¹ Another advantage of the narrative approach to interviewing is that it is a familiar concept for participants.

All the interviews were recorded with a digital voice recorder, conducted by the researcher and took place at the place and time chosen by the participants. As described above, all interviews, except one, took place in the participants own homes. One participant lived in the North West of Australia, a distance too far to travel for a face to face interview, therefore the interview was conducted using video calling. Prior to the interview, participants were asked to complete a short questionnaire to obtain demographic details such as the participant's date and place of birth, the place and year of nursing, midwifery or medical training and whether the midwife or doctor had personally received maternity care from a privately practising midwife.

The interviews lasted between one and three hours and began with the opening question "tell me about you?" Using a broad opening question to begin the interviews allowed the participants to talk freely during the interviews, rather than having the researcher interrupt their stories with questions.³⁵² A list of questions (based on the research objectives described above) had been prepared prior to the interviews, (see Appendix Four4); however, the questions were not needed during the interviews as the participants answered all the questions during the interview without interruption. Qualitative researchers suggest that the ability to use probes (follow up questions) effectively during an interview is an essential skill.³⁵³ Non-verbal prompts such as smiling, nodding, smiling, and verbal probes using language such as "mm" or "yes were used during the interviews to indicate that the researcher was engaged and listening. Elaboration

³⁵¹ Portelli, "What Makes Oral History Different."70.

³⁵² Serry and Liamputtong, "The In-Depth Interviewing Method in Health."

³⁵³ Sarantakos, *Social Research*; Denzin, Norman K. and Yvonna S. Lincoln. 2013. *Strategies of Qualitative Inquiry*, Fourth Edition. ed. Thousand Oaks: Sage Publications; Minichiello, Aroni, and Hays, *In-Depth Interviewing: Principles, Techniques, Analysis*.

probes were also used to encourage the interview participant to extend or amplify their answer to a question without affecting the direction of their thinking or causing bias.³⁵⁴

McAllister and Lewenson state that the exploration of archives and assessing the availability of primary and secondary sources are the key to developing the historian's research;³⁵⁵ furthermore, archives provide contemporary documents to verify the recollections of the interviewees. Lummis states that the validation of oral histories can be divided into two areas; the degree to which any interview yields reliable information on the historical experience and the degree that this experience is typical of the place and time.³⁵⁶ Thomson states that background research enables the historian to check for internal and external consistencies, and enables oral accounts to be put into historical context.³⁵⁷ Therefore using archival research and oral histories together provides triangulation of the research and aids in validating the experiences of the participants.

The search for primary and secondary sources was done using the internet, Google searches, and accessing references from scholarly articles. The archival research was comprehensive and drew upon data from multiple sources. Archival research was undertaken in archives at the Batty Library in Perth, the State Records Office of Western Australia, the museum at the King Edward Memorial Hospital in Perth, the Fremantle museum and State Museum Library.

Data Analysis

Data analysis in qualitative research is an ongoing process that starts early in the data collection phase and continues throughout the study as the researcher becomes immersed in the data. A feminist narrative analysis approach was undertaken in this study, with the intent of identifying similarities or differences between the participant's interviews and archival material. Cresswell and Poth suggest that narrative research is best for capturing the detailed stories or life experiences of a small number of individuals.³⁵⁸

³⁵⁴ Sarantakos, *Social Research*; Serry and Liamputtong, "The In-Depth Interviewing Method in Health."

³⁵⁵ McAllister and Lewenson, "Inside Track of Doing Historical Research: My Dissertation Story."41.

³⁵⁶ Lummis, Trevor. 2003. "Structure and Validity in Oral Evidence," in *The Oral History Reader*, ed. Robert Perks and Alistair Thomson, London: Routledge.273-283.

³⁵⁷ Thomson, Alistair. 2011. "Life Stories and Historical Analysis," in *Research Methods for History*, ed. Simon Faire and Lucy Gunn, Edinburgh: Edinburgh University Press.

³⁵⁸ Cresswell and Poth, *Qualitative Inquiry and Research: Design Choosing Among Five Approaches*.

Descriptive narrative research was used for both qualitative and archival data. D'Antonio describes a well written historical narrative as an engaging and well-constructed story, that deepens the understanding of issues, or a story that raises issues the reader had not thought of before.³⁵⁹ Creswell and Poth state the data collected in a narrative study needs to be assessed for the story it has to tell.³⁶⁰ Data obtained from both the oral histories and the archival research were critically examined for themes such as power dynamics, ethics, diversity, technology, political activism, bias and other topics that may continue to affect midwifery today. An inductive approach was used throughout the research process. An inductive approach involves the researcher working back and forth between the themes and the data until they establish a comprehensive set of themes that reflect the data.

Thomson asserts that it is important to understand that episodes in a person's life that have personal significance and impact are more likely to become long term memories, and that the act of creating the story about an experience, enables this experience to become a durable memory.³⁶¹ Thus, the event becomes meaningful and remembered through the narrative. McCalman agrees stating that we all construct an autobiography inside our head, and that as we progress through life, that autobiography record significant events and experiences, and tries to make sense of the past thereby defining our ever-evolving sense of identity.³⁶² Data analysis includes initial dialogue, transcription of recordings, critical examination of the interview transcripts and archival data, coding of the data, interpretation of the codes and ideas gathered from the data into themes and the reconstruction of what the data says about, and how it relates to the research question.³⁶³

There are multiple ways to 'do' narrative research, Fraser likens narrative researchers to chefs who see "cooking as an art form and who do not try to stay true to traditional recipes".³⁶⁴ A seven-phase narrative analysis described by Fraser was the method used to

³⁵⁹ D'Antonio, "Conceptual and Methodical Issues in Historical Research."

³⁶⁰ Creswell and Poth, *Qualitative Inquiry and Research: Design Choosing Among Five Approaches*.

³⁶¹ Thomson, "Life Stories and Historical Analysis."

³⁶² McCalman, Janet. 1998b. *Struggletown: Public and Private Life in Richmond 1900-1965*, Flemington: Hyland House Publishing.

³⁶³ Morse and Field, *Qualitative Research Methods for Health Professionals*; Denzin and Lincoln, *Strategies of Qualitative Inquiry*.

³⁶⁴ Fraser, Heather. 2004. "Doing Narrative Research: Analysing Personal Stories Line by Line," *Qualitative Social Work* 3 (2): 179-201.182.

analyse the oral history interviews.³⁶⁵ However, the research journey was not linear and the phases were often performed concurrently.

Phase One: Hearing the Stories, Experiencing Each Other's Emotions

The first phase commenced at interview. By conducting the interview, the researcher is already involved in the analysis process as she is hearing the stories narrated and experiencing the emotions of the participant and herself. Fraser describes how during this phase the researcher registers emotions stimulated during the discussions and reflects on body language used and feelings depicted or described, as they may provide clues to the meanings made during the interview.³⁶⁶ Reviewing data prior to coding helps identify emergent themes without losing the connections between concepts and their context.³⁶⁷ Fraser also suggests considering how each interview starts, unfold and ends can provide further clues.³⁶⁸

Following each oral history interview the researcher listened to the audio recording multiple times. Oral history interviews were assessed for meaning, with attention to language structure, effects of time on past and present meaning, chronological structuring of the narrative and social and historical context.

Not everything observed during an interview is captured on the audio recording, as suggested by Fraser, a research journal was used during the study.³⁶⁹ No notes were taken during the interview as the researcher preferred to focus all her attention on the participant. Following each interview, the researcher recorded the thoughts and feelings that emerged during the interview. Other information such as the demeanour of, and the type of communication used by the participant or other observations or thoughts were recorded if relevant. At each phase of the research journey notes and thoughts were written in the research journal and discussed with academic supervisors.

³⁶⁵ Fraser, "Doing Narrative Research: Analysing Personal Stories Line by Line."

³⁶⁶ Ibid.

³⁶⁷ Bradley, Elizabeth H, Leslie A Curry, and Kelly J Devers. 2008. "Qualitative Data Analysis for Health Services Research: Developing Taxonomy, Themes, and Theory." *Qualitative Data Analysis for Health Services Research* 42 (4): 1758–1772.

³⁶⁸ Fraser, "Doing Narrative Research: Analysing Personal Stories Line by Line."

³⁶⁹ Ibid.

Phase Two: Transcribing the Material

In the second phase the interviews are transcribed. The oral history interviews were transcribed verbatim within twenty-four hours of being conducted. The researcher transcribed all the interviews herself using a laptop and headphones, entering all the data into a Microsoft Word document. During the process of transcribing the data, the researcher is able to get closer to the data and the process of interpretation and analysis continues. All transcripts were checked for inaccuracies by listening back to the audio recording, then the interview transcripts were sent to each research participant for review.³⁷⁰ All participants were satisfied that the interview transcripts were an accurate reflection of the interview and no changes were made to the transcript following their review.

Phase Three: Interpreting Individual Transcripts

In the third phase of the research analysis, the researcher identifies the “specifics of each transcript”.³⁷¹ This phase involved identifying the types and directions of the stories contained in the interview transcript and beginning to identify themes within the stories. Fraser suggests asking questions of the transcript such as:

- What are the common themes in each transcript?
- Are there ‘main points’ that you can decipher from particular stories?
- What words are chosen and how are they emphasised?
- What kind of meaning might be applied to these words?
- What contradictions emerge?³⁷²

Each transcript was printed and read multiple times to enable the text to become familiar. The research question, aim and objectives were also considered during analysis. Transcript were read line by line and areas of interest were highlighted. Keeping the research question, aim and objectives in mind enabled attention to be drawn to words, phrases or stories. Concurrent notes were written in the research journal and notes were made in the margins of the transcripts.

³⁷⁰Lincoln and Guba, *Naturalistic Inquiry*; Fraser, "Doing Narrative Research: Analysing Personal Stories Line by Line."

³⁷¹ Fraser, "Doing Narrative Research: Analysing Personal Stories Line by Line."189.

³⁷² Ibid.190.

Phase Four: Scanning Across Different Domains of Experience

The fourth phase of analysis involved scanning the transcripts for different domains of experience by examining the narrative for intrapersonal, interpersonal, cultural and structural aspects. Fraser describes intrapersonal aspects of stories as those that involved intra body-mind experiences, for example, narrator self-talk such as rehearsing a possible course of action or 'confessing' to thoughts and feelings that are concealed.³⁷³

Interpersonal aspects of stories are those that involve other people; cultural aspects of stories refer to larger groups of people and sets of cultural conventions. These can include news items, social conventions, folklore, old wives' tales or research findings. These ideas are often broadcast through popular culture and dominant discourses may surface; structural aspects of stories overlap with other aspects of the narrative but are distinct by the claims made about the influence of public policies and social systems. References may include social systems, laws, class, gender, ethnicity and other modes of social organisation.³⁷⁴

Phase Five: Linking the Personal with the Political

Fraser states that "over many decades feminists have underlined the importance of linking the personal with the political".³⁷⁵ Overlapping phase four, the narrative was analysed to see how "dominant discourses and their attendant social convections constitute an interpretive framework for understanding the stories".³⁷⁶ Phase three to five occurred concurrently.

Phase Six: Looking for Commonalities and Differences among Participants

During this phase the transcripts were examined for commonalities and differences between research participants by comparing and contrasting the content. Following this phase, the connecting themes and subthemes became apparent.

³⁷³ Fraser, "Doing Narrative Research: Analysing Personal Stories Line by Line."

³⁷⁴ Ibid.

³⁷⁵ Ibid.193.

³⁷⁶ Ibid.193.

Phase Seven: Writing Academic Narratives about Personal Stories

The final phase of the narrative analysis, described by Fraser, is writing the academic narrative. Fraser states “for the research to be coherent and credible, narrative analysts may want to keep checking that the written analyses they are producing correspond to the stories told, as well as the objectives of the research”.³⁷⁷ Fraser suggests questions to consider such as: Are your analysis relevant to your research questions? Are the interpretations you made fair?³⁷⁸

A number of strategies were employed to facilitate reflexivity and ensure the themes and subthemes were grounded in the data and not forced by the researcher. As described earlier in this chapter, reflexivity of the researchers own assumptions, experiences and biases was undertaken and this continued throughout the research process. The research journal was used to reflect on the research process and data analysis was undertaken with the support of the research team. All phases of the research process and interpretations of the data was undertaken with support from the researcher’s supervisors. Concepts from the narrative, including participant’s quotes were discussed with supervisors to demonstrate the themes and subthemes that were emerging from the data and to ensure that the themes adequately described the narrative. The goal of narrative feminist research is not to find universally generalisable themes and understanding of experiences, but to offer insights and glimpses into the participant’s worlds and ways of seeing the world. These narratives are the medium through which individual participants provide insight and understanding about their experiences.³⁷⁹

Trustworthiness of the Data

According to Harding and Whitehead, currently, there are six broad positions that can be adopted in relation to trustworthiness of qualitative data, with the researcher adopting one or more of these positions. Position two, parallel methodological criteria, argues that qualitative research requires a different set of criteria for evaluating trustworthiness and is the position most relevant to this study. Guba and Lincoln developed four criteria which are

³⁷⁷ Fraser, "Doing Narrative Research: Analysing Personal Stories Line by Line."196.

³⁷⁸ Ibid.

³⁷⁹ Fraser, Heather and Christiana MacDougall. 2017. "Doing Narrative Feminist Research: Intersections and Challenges," 16 (2): 240-252.249.

parallel to those used in quantitative research. These criteria are credibility with internal validity (truth of findings are judged by participants and others within the discipline); auditability (accountability as judged by the adequacy of information leading the reader from the research question and raw data through various steps of analysis to the interpretation of the findings); fittingness (faithful to the everyday reality of the research participants, described in enough detail so that others can evaluate the importance for their own practice, research and theory development); and confirmability (findings that reflect implementation of credibility, auditability and fittingness standards).³⁸⁰ Credibility and dependability of the data can also be increased with prolonged engagement, triangulation, and external checks.³⁸¹ Data from both archival sources and interviews was collected over three years, commencing in October 2015 and was completed in October 2018. As described above, triangulation was achieved by frequent regular meetings held between the researcher and her supervisors to discuss and monitor the progress of the data analysis.

Ethical Consideration

It is expected that participant's rights are respected and protected during research studies.³⁸² This study was conducted within the National Health and Medical Research Council (NHMRC) guidelines for the ethical conduct of research with humans. (NHMRC, 2007).³⁸³ All participants provided informed written consent to participate in this study. Permission to conduct the proposed research was sought and granted from the Human Research Ethics Committee at Curtin University, and assigned the ethics code number RDHS-193-15. No-one other than the research team had access to the data.

As previously stated, oral history research has the potential for identification of participants, therefore it is essential that participants are aware of this prior to the interviews. All participants except one consented for their real name to be used in the study. The one participant who declined was allocated a pseudonym. It was also identified by the research team that some recollections could potentially be distressing for the

³⁸⁰ Harding, Thomas and Dean Whitehead. 2016. "Analysing Data in Qualitative Research," in *Nursing and Midwifery Research: Methods and Appraisal for Evidence-Based Practice*, ed. Zevia Schneider, et al., Elsevier.137.

³⁸¹ Polit and Beck, *Essentials of Nursing Research: Appraising Evidence for Nursing Practice*.

³⁸² Ibid.

³⁸³ Australian Government. 2007. "National Statement on Ethical Conduct in Human Research 2007 (Updated 2018)."

participants; contact details for a free government counselling service were given to all interviewees.

Data Storage

All interviews, both digital recordings and transcripts are stored on the master computer file which is password protected. The researcher is the only person to have access to these files. All data will be managed in accordance with the National Health and Medical Research Council (NHMRC) guidelines.³⁸⁴ Data will remain securely stored in a locked filing cabinet at the researcher's home office for the minimum period for retention of research data which is 5 years from the date of publication.³⁸⁵

Summary

This chapter presented how a study of PPMs in WA was conducted using qualitative historical methods. Research paradigms were outlined. The research methods used in this current study were described and the rationale for choosing the research approach was provided. A brief outline of the study's context along with the researcher's thought process prior to embarking on the study was described. The participant sample and sample recruitment process were given, and the process of data collection, analysis and interpretation was provided. In the following chapter the historical context of midwifery in the Western World will be presented, to situate the findings of midwifery in Western Australia.

³⁸⁴ Australian Government. 2007. "National Statement on Ethical Conduct in Human Research 2007 (Updated 2018)."

³⁸⁵ Ibid.

Chapter Four – Historical Context of Midwifery

Chapter Overview

This chapter provides a historical context on the history of midwifery in the Western World. This study examines the history of autonomous independent midwifery practice (now referred to as Privately Practising Midwives [PPM]) in Western Australia. However, to understand more about the history of midwifery in Australia we first need to explore the history of midwifery in Europe, in particular the United Kingdom (UK), as the early Australian pioneer women and midwives came from this region. As previously discussed, the history of Indigenous midwifery in Australia is beyond the scope of this thesis. This chapter, therefore, describes the progression and development of midwifery in the UK, as this has had the biggest influence on Australian midwifery; it also briefly describes American, Canadian and New Zealand midwifery as midwifery in these countries developed from similar beginnings.

Early History of Childbirth and the Midwife

Since the beginning of recorded history midwives have featured in the records of childbirth. The title '*midwife*', which was also referred to in ancient times as '*office of the midwife*' is very old, older than recorded time.³⁸⁶ In ancient times (prior to 400 A.D), midwifery was an honoured and respected profession. Midwives are featured in The Bible, on Egyptian hieroglyphics, in ancient Roman and Greek temples, and traditional art and sculptures throughout the world.³⁸⁷ Most of these depictions show the labouring or birthing women aided by women helpers. One of the first written references to midwives appears in The Bible in the book of the Old Testament, in the story of Benjamin, dating back to approximately 1800BC. In biblical stories midwives were recognised as skilful and valued professionals. In the story of the birth of Tamar's twins, the midwife was active and present during the labour, which shows that she was aware of the twins and possessed the ability to deal with the compound presentation (when one infant presents an arm first).³⁸⁸

³⁸⁶ Donnison, *Midwives and Medical Men: A History of Inter-Professional Rivalries and Women's Rights*.

³⁸⁷ Kitzinger, *Rediscovering Birth*.

³⁸⁸ Towler and Bramall, *Midwives in History and Society*.

Hippocrates wrote that male physicians were called upon to assist with difficult births, but that the management of normal labour was within the realm of midwives. Socrates' mother was a midwife, and Aristotle spoke of the wisdom and intelligence of the midwives of Greece.³⁸⁹ Soranus wrote that the demands of midwifery require: "a competent person who is literate, with her wits about her, possessed of a good memory, loving work, respectable and generally not unduly handicapped as regard to her senses, sound of limb and robust".³⁹⁰

Historically, childbirth was the domain of women only, for it was regarded as a female mystery, of which women alone had special knowledge and understanding. Prior to the 17th century there was no word to signify a male birth attendant. The modern word for the doctor of childbirth, the 'obstetrician', is derived from the Latin word for midwife, *obstetrix*, which literally means *one who stands before*. The English 'midwife' comes from *with woman*; the old Italian term, 'comare', from *with mother*. Other terms used such as the French, 'sage femme', *wise woman* implies that she may have had a wider function and knowledge than just an attendant in childbirth.³⁹¹

In Europe, childbirth was considered a social, women only event, in which the birthing woman's female relatives, friends and neighbours would gather.³⁹² In England these women were called *godsibbs* as they were the 'siblings of God' or 'godparents' to the unborn child. As with any social gathering there was chattering, and this is where the term 'gossips' came from; gossips also became a term for women friends, generally with no derogatory connotations.³⁹³ Modern day translation considers gossip to be a negative concept, 'idle chatter', although feminist writer, Deborah Jones (1990) defines gossip as:

³⁸⁹ Towler and Bramall, *Midwives in History and Society*; Donnison, *Midwives and Medical Men: A History of Inter-Professional Rivalries and Women's Rights*; Kitzinger, *Rediscovering Birth*; Wertz and Wertz, *Lying-In: A History of Childbirth in America*.

³⁹⁰ French, Valerie. 2004. "Midwives and Maternity Care in the Roman World," in *Midwifery and the Medicalization of Childbirth: Comparative Perspectives* ed. Edwin Van Teijlingen, et al., New York: Nova Science Publishers Inc.55.

³⁹¹ Kitzinger, *Rediscovering Birth*; Kitzinger, *The Politics of Birth*; Donnison, *Midwives and Medical Men: A History of Inter-Professional Rivalries and Women's Rights*; Wertz and Wertz, *Lying-In: A History of Childbirth in America*.

³⁹² Gelis, Jacques. 1991. *Fertility, Pregnancy and Birth in Early Modern Europe*, London Polity Press.

³⁹³ Roger, Pierson and Ed Hughes. 2013. "The Birth of Gossip." *Journal of Obstetrics and Gynecology Canada* 35 (6): 584.

a way of talking between women, intimate in style, personal and domestic in scope and setting, a female cultural event which springs from and perpetuates the restrictions of the female role, but also gives the comfort of validation.³⁹⁴

Other terms used to describe these early midwives were 'old wife' or 'handywoman' (although not all handywomen and old wives were midwives), and this is where the term 'old wives' tales' comes from. It is another example of how women's knowledge and experiences have been subjugated to the negative status of 'old wives' tales', as at the present time 'old wives' tales' is often used to suggest a silly idea not based on science.³⁹⁵ The handywomen tended to be elderly, and their traditional skills were not limited to midwifery. These women also cared for the sick and laid out the dead.

Although there were some instances of male influence and attendance at births in ancient times (prior to 400 A.D), 'women's matters' were generally 'women's business'. Conversely, the practice of medicine was generally forbidden to women and women generally could not become medical doctors in the Western world until the 19th century, although there were some isolated instances of educated women practising medicine. For example, the second century practitioner Aspasia, practised general medicine; in the 11th century; Trotula was the author of the work on gynaecology *De Mulierum passionibus*; the Italian Jacobina Felice had a successful medical practice in France in the 13th century; and Cecilia of Oxford was surgeon to Phillipa, wife of Edward III of England. The practice of medicine and surgery throughout Europe was also undertaken by the nuns, and at the most basic level the wise woman of the village whose remedies may have included: herbs, common sense, experience and superstition.³⁹⁶

The rise of the tradesmen's guilds in Britain commenced in the 13th century and among these guilds was that of the barber surgeons. Surgery, literally interpreted as 'hand work', was not recognised as a type of medical practice and was regarded as having a lower status than medicine. The guilds laid down conditions for apprenticeships and admission of members, and those practising without membership were persecuted.³⁹⁷ The formalisation

³⁹⁴ Jones, Deborah. 1990. "Gossip: Notes on Women's Oral Culture," in *The Feminist Critique of Language: A Reader*, ed. Deborah Cameron, London: Routledge.

³⁹⁵ Chamberlain, Mary. 1981. *Old Wives' Tales: Their History, Remedies and Spells*. London: Virago Press.

³⁹⁶ Towler and Bramall, *Midwives in History and Society*; Donnison, *Midwives and Medical Men: A History of Inter-Professional Rivalries and Women's Rights*.

³⁹⁷ Towler and Bramall, *Midwives and Medical Men: A History of Inter-Professional Rivalries and Women's Rights*.

of medicine as a 'learned' subject was taught in university—distinct from the Church— in Europe during the late Middle Ages (11th century). This formalisation actually prevented women from the practice of domestic medicine although it had previously been theirs through custom and tradition. Ironically, until the 16th century, men did not appear to have any interest in midwifery. Some historians argue that this stemmed from the churches' misogynistic beliefs that the pain of childbirth was God's punishment to women for the sins of Eve and therefore there was no need for intervention.³⁹⁸ The Church opposed the practice of medicine as it believed that illness and sickness was the work of God; a punishment for sins.³⁹⁹ However, once the universities started to teach medicine, the Church had no alternative but to condone attempts to heal the sick. In an attempt by the Church to keep control of communities, it conceded that "in every community there be appointed at least one widow to assist women who are stricken with illness"; however, the widow must only provide midwifery and care related to women's health and was accountable to the priest.⁴⁰⁰ Initially, the midwife performed a great service to the Christian church; she had a role in law enforcement and on occasions was called to examine women who were condemned to death to determine if they were pregnant. She could be called to examine unmarried women alleging rape, or accused of concealing pregnancy and killing their infants or procuring abortions. Historically the doctrine of some denominations of The Christian Church promoted the concept of 'Original Sin', meaning that all children are born with the sins of Adam and Eve until baptised. If a priest was unable to attend and it appeared that a child would die soon after birth, the midwife had a Christian duty to baptise a new-born baby and save its soul.⁴⁰¹ The midwife also had an important role to play in post-birth rituals, including carrying the infant to be christened. The midwife was present with the gossips (female family and friends), at the 'churching', the rite of purification and thanksgiving of women after childbirth. Women were deemed unclean after childbirth and therefore unable to re-enter the sanctity of the church until this ritual of purification.⁴⁰²

³⁹⁸ Towler and Bramall, *Midwives and Medical Men: A History of Inter-Professional Rivalries and Women's Rights*; Towler and Bramall, *Midwives in History and Society*; Kirkham, Mavis. 2007. *Exploring the Dirty Side of Women's Health*, Oxon, UK: Routledge.

³⁹⁹ Towler and Bramall, *Midwives in History and Society*.

⁴⁰⁰ Donnison, *Midwives and Medical Men: A History of Inter-Professional Rivalries and Women's Rights*.

⁴⁰¹ Ibid.; Towler and Bramall, *Midwives in History and Society*.

⁴⁰² Newell, Rachel C. 2007. "The Thanksgiving of Women after Childbirth: A Blessing in Disguise?," in *Exploring the Dirty Side of Women's Health*, ed. Mavis Kirkham, London: Routledge.

The work of midwives in Europe from the Early Modern Period (15th-18th century) varied greatly between what midwives were allowed to do by law, and what they actually did. Some midwives attended births on an occasional basis, going to their neighbours for support and family bonding, and to be a good friend and community member. Others worked regularly as a midwife for the main family income.⁴⁰³ Some scholars have shown that there were contrasts in the work of midwives, in their licensing, working practices and incomes.⁴⁰⁴ Many midwives in the UK and Europe practised midwifery sporadically, as they found obtaining licences too difficult and expensive; others who worked regularly gained esteem, and came to work and cooperate with local medical doctors. In England the episcopal licensing commenced in the 1500s and was not officially replaced until the 20th century, this set England apart from Europe where municipal licensing was involved in licensing and regulation of midwives.⁴⁰⁵ In the UK there was substantial variety in the education and training of the midwife. For example, midwifery in the north of England in the 17th century was a skill to be learned by experience and passed on from one midwife to another without any formal instruction.⁴⁰⁶ In 17th century London, however, apprenticeships were often lengthy and considered important and although no formal qualification was gained the midwife was awarded prestige and status on completion of the apprenticeship.⁴⁰⁷ At the same time in many places in Europe —such as France and Holland— extensive formal training was required.⁴⁰⁸ For example, in the late 16th century in France, legislation was introduced to regulate the midwives; these midwives were subject to the authority of the Church, State and local government. Dutch and German midwives were also regulated by municipal authorities.⁴⁰⁹ Diversity was shown in the practice of the midwives, with some only attending occasional births whilst others built up a clientele and

⁴⁰³ Marland, *The Art of Midwifery: Early Modern Midwives in Europe*.4.

⁴⁰⁴ Ibid.; Evenden, Doreen. 1993. "Mothers and Their Midwives in 17th Century London," In *The Art of Midwifery: Early Modern Midwives in Europe*, ed. Hilary Marland, London: Routledge; Harley, "Provincial Midwives in England: Lancashire and Cheshire, 1660-1760" *ibid*.

⁴⁰⁵ Towler and Bramall, *Midwives in History and Society*.55.

⁴⁰⁶ Harley, "Provincial Midwives in England: Lancashire and Cheshire, 1660-1760".

⁴⁰⁷ Donnison, *Midwives and Medical Men: A History of Inter-Professional Rivalries and Women's Rights*.

⁴⁰⁸ Vann Sprecher, Tiffany D. and Ruth Mazo Karras. 2011. "The Midwife and the Church: Ecclesiastical Regulation of Midwives in Brie, 1499-1504," *Bulletin of the History of Medicine* 85 (2): 171-192; Van Lieburg, M. J. and Hilary Marland. 2004. "Midwifery Regulations, Education and Practice in the Netherlands," in *Midwifery and the Medicalization of Childbirth: Comparative Perspectives* ed. Edwin Van Teijlingen, et al., New York: Nova Science Publishers Inc.

⁴⁰⁹ Evenden, Doreen. 2000. *The Midwives of Seventeenth-Century London*, Cambridge: Cambridge University Press; Marland, Hilary. 1993a. "The Burgerlijke Midwife: The Stradsvroedvrouw of 18th Century Holland," in *The Art of Midwifery: Early Modern Midwives in Europe*, ed. Hilary Marland, London: Routledge.

worked across several different areas. In some European countries there was also a different type of midwife from the independent midwife; countries such as France and Holland, provided midwifery education and training and these midwives were employed directly by the State.⁴¹⁰

Town authorities and medical hierarchies recognised the need for trained and licensed midwives to provide competent care to the women so that a healthy population could be maintained. For example, in France, The Hotel Dieu was probably the first school for midwives in modern Europe. Louise Bourgeois, midwife to the Queen of France, studied and worked at the Hotel Dieu and became famous throughout Europe.⁴¹¹ In 17th Century Holland, midwives were granted a license to practice midwifery following completion of a 4-year apprenticeship with an experienced midwife, and theoretical lessons run by medical authorities. Fees were high for training and licenses; therefore, there were still unlicensed midwives in rural areas, although in the towns and cities midwives were paid by local councils to provide care to women during childbirth.⁴¹²

Until the 17th century a personal experience of birth, both as a mother and as a birth attendant, was considered essential for a midwife. The midwife would probably have given birth many times herself, as would the other birth attendants.⁴¹³ This custom of having experienced women present at the birth addressed a number of needs. Firstly, the more experienced women would provide comfort to the labouring woman. Childbirth was considered dangerous at the time, and women may have been fearful of the unknown aspects of childbirth, so having women who had 'lived through' the experience may have been very comforting. Secondly, the attending women would have gained knowledge and

⁴¹⁰ Harley, "Provincial Midwives in England: Lancashire and Cheshire, 1660-1760" *ibid.*; Hess, "Midwifery Practice among the Quakers in Southern Rural England in the Late Seventeenth Century" *ibid.*

⁴¹¹ Towler and Bramall, *Midwives in History and Society*; Kalisch, Philip A. Margaret Scobey, and Beatrice J. Kalisch. 2004. "Louyse Bourgeois and the Emergence of Modern Midwifery," in *Midwifery and the Medicalization of Childbirth: Comparative Perspectives*, ed. Edwin van Teijlingen, et al., New York: Nova Science Publishers Inc.

⁴¹² Marland, "The Burgerlijke Midwife: The Stradsvroedvrouw of 18th Century Holland"; Marland, *The Art of Midwifery: Early Modern Midwives in Europe*; Schrader, Catharina. 1987. *"Mother and Child Were Saved" the Memoirs (1693-1740) of the Frisian Midwife Catharina Schrader*, trans. Hilary Marland, Amsterdam: Rodopi.

⁴¹³ Allotey, Janette C. 2011. "English Midwives' Responses to the Medicalisation of Childbirth (1671-1795)," *Midwifery* 27 (4): 532-538.

experience of the process of childbirth, and thirdly, these gatherings of women ensured that there were witnesses to the birth.⁴¹⁴

Control of Women and Midwives

The persecution of midwives accused as witches began in the late Middle Ages (14th-15th century) under Catholicism, and it continued under Protestantism and Catholicism alike until the 17th century. Childbirth was still a focus for many pagan beliefs and superstitions. The Inquisition (which literally translates as 'to question') lasted over 300 years and was set up by the Catholic Church in 1231. Its purpose was to investigate heresy and raise money for the Church.⁴¹⁵ During the Inquisition priests travelled around Europe preaching and investigating heretics. Those found guilty of heresy were handed over to the civil authorities —thereby absolving the Church of any moral consequences— for punishment which included fines, imprisonment and loss of land. Accused heretics who refused to recant were tortured and killed. In 1484 the Pope issued an order that allowed the Inquisition to investigate those who were accused of witchcraft.⁴¹⁶ Following the implementation of this order two German members of the Inquisition, Kraemer and Springer, wrote *Malleus Maleficarum* (meaning 'the hammer of the evil doing women' or 'the hammer of witches').⁴¹⁷ First printed in 1486, it makes extensive reference to 'witch midwives' and their practices. Chapter Thirteen of the book is entitled 'How witch midwives commit most horrid crimes when they either kill children or offer them to devils in most accursed wise' and it claims that "witch midwives surpass all other witches in their crimes".⁴¹⁸ This text can be read as representing misogynistic ideas of the time

⁴¹⁴ Donnison, *Midwives and Medical Men: A History of Inter-Professional Rivalries and Women's Rights*; Towler and Bramall, *Midwives in History and Society*.

⁴¹⁵ Perry et al., 1991. *Cultural Encounters: The Impact of the Inquisition in Spain and the New World* / Edited by Mary Elizabeth Perry and Anne J. Cruz, Cultural Encounters, Berkeley: Berkeley: University of California Press; O'Gorman, Bob and Mary Faulkner. 2001. "Glad You Asked: Q&A on Church Teaching: What Was the Inquisition?" *U.S. Catholic* 66 (10): 28.

⁴¹⁶ O'Gorman and Faulkner, "Glad You Asked: Q&A on Church Teaching: What Was the Inquisition?"

⁴¹⁷ Institoris, Heinrich. 1971. *The Malleus Maleficarum of Heinrich Kramer and James Sprenger* / Translated with Introductions, Bibliography, and Notes by Montague Summers, ed. Jakob or Sprenger, New York: Dover.

⁴¹⁸ Towler and Bramall, *Midwives in History and Society*; Institoris, *The Malleus Maleficarum of Heinrich Kramer and James Sprenger* / Translated with Introductions, Bibliography, and Notes by Montague Summers; O'Gorman and Faulkner, "Glad You Asked: Q&A on Church Teaching: What Was the Inquisition?"

because it argues that women are by virtue closer to the earth, and therefore are easier to lure away to the 'devil's ways'.

The claim that the midwife was a bad witch was an important part of the attempt by the Church and State to control both the role and power of women, and to restrict the practice of midwifery. In most communities the midwife and women healers were credited with arcane knowledge and power over sexuality and fertility.⁴¹⁹ Such knowledge was denounced by the Church; therefore, this encouraged accusations that midwives used their knowledge and powers for satanic purposes. The flesh of unbaptised infants was a common motif in stories of devil worship, and the midwife, by the nature of her work had extensive access to the babies. According to the *Mallues Maleficarum*, the midwife was the most dangerous of all witches, who, it alleged, commonly killed the new born infant in the womb or at birth and dedicated it to the devil.⁴²⁰ During the Early Modern Period (15th-18th century) the midwife was also at risk of accusations of witchcraft if the child was born with any abnormalities or deformities, as would be the mother. Furthermore, any midwife who used herbs for birth control or abortion was denounced as a witch. Thousands of midwives accused of witchcraft were discredited, disgraced and arrested. Many were tortured or put to death by burning at the stake, hanging or drowning.⁴²¹ The wise women midwives were valued by their communities because they were known and trusted, and therein lay their challenge to the church which distrusted women generally and particularly objected to those who professed to have healing powers.⁴²²

The first attempt at the control of midwives in the UK was in 1512 when Henry VIII made an Act to regulate physicians and surgeons. This Act aimed to reduce the number of 'ignorant' practitioners who practiced the art of medicine and surgery, commonly 'smyths, weavers and women'.⁴²³ It was in the interests of the elite physicians to limit competition from men and women without 'qualifications', a recurring theme throughout history focusing on who is regarded as the most appropriate childbirth attendant. Under this Act both women and men could be licensed. The Act did not mention midwifery specifically;

⁴¹⁹ Oakley, *Essays on Women, Medicine and Health*.

⁴²⁰ Donnison, *Midwives and Medical Men: A History of Inter-Professional Rivalries and Women's Rights*.

⁴²¹ Ibid.; Gelis, *Fertility, Pregnancy and Birth in Early Modern Europe*; Marland, *The Art of Midwifery: Early Modern Midwives in Europe*.

⁴²² Towler and Bramall, *Midwives in History and Society*.38.

⁴²³ Donnison, *Midwives and Medical Men: A History of Inter-Professional Rivalries and Women's Rights*.

however, midwifery was considered a manual art and a part of surgery. The responsibility for granting the license was given to the Church, thereby granting the Church power to control midwives' actions and activities.⁴²⁴ To gain licensing from the Church, the midwife had to swear a solemn oath to obey the rules and regulations laid down by the Church, and only practice in the way they deemed appropriate. Throughout the Early Modern Period (15th-18th centuries) the majority of midwives remained unlicensed. Unlicensed midwives carried the risk of being prohibited from practice if reported. Although, rather than being prevented from practicing, the midwives were more likely to be encouraged to obtain a proper licence as they were also providing a useful service of midwifery care to the poor.

The Rise of the Medical Men and the Decline of the Midwife

There are numerous social and educational reasons for the decline of midwifery in the Western World. The male midwives (medical men) were seen as having superior skills and education, whereas there was a lack of competent female midwives. The social climate of the times also compounded the denigration of female midwives. Published books about midwifery did not appear until the 16th century.⁴²⁵ One of the first books was the *Brythe of Mankind or the Womensbooke* by Rosslin, a German physician who held little respect for the midwives who, he said, were responsible for many babies' deaths and who would not share their knowledge with the medical men.⁴²⁶

The rise of the man-midwife had begun in France and was gradually moving throughout Europe. In England the man-midwife had been recognised by the early 1600s. If an obstetric disaster occurred, the midwife would have to call for help from a male practitioner who was permitted to use tools such as hooks, knives and crochets.⁴²⁷ These surgeons, it is suggested, were the group of surgeons who became man midwives. Like the female midwives, not all man midwives were from the educated classes. There was no guarantee that the man-midwife understood his business any more than did the women midwives.⁴²⁸

⁴²⁴ Donnison, *Midwives and Medical Men: A History of Inter-Professional Rivalries and Women's Rights*.

⁴²⁵ Harley, "Provincial Midwives in England: Lancashire and Cheshire, 1660-1760".

⁴²⁶ Towler and Bramall, *Midwives in History and Society*.

⁴²⁷ Evenden, "Mothers and Their Midwives in 17th Century London."

⁴²⁸ Donnison, *Midwives and Medical Men: A History of Inter-Professional Rivalries and Women's Rights*.

The 18th century was a time of great change. Industrialisation and the growth of cities had far reaching effects, particularly on women. From the 1720s onwards, men- midwives were gaining greater influence on childbirth in Europe and Britain, and rather than being called only to complicated births, they were starting to also attend the uncomplicated births. Traditionally, uncomplicated normal births were the realm of the midwives, thus if the man-midwives attended these births, they were putting themselves in direct competition with the midwives. As the man-midwives were considered 'men of learning' and afforded a higher status than the midwife, they were the more expensive option. The rising classes of wealthy trades-people and the middle classes could demonstrate their prosperity and status by employing a man-midwife.⁴²⁹

Another important change during the 18th century was the increasing use of the obstetric forceps. The new forceps were invented by the affluent English medical men of the Chamberlen family in the early 17th century. Some historians argue that the forceps used to deliver a dead foetus were an old instrument; however, the act of using forceps to deliver a living child without the death of the mother was considered a new advanced technique.⁴³⁰ The delay in the widespread use of the Chamberlen forceps was a result of the Chamberlen family keeping the tool a secret. The new forceps stopped the association of the man-midwife with death or disability for either mother or child during an obstructed labour; previously the tools they used were hooks, crochets and tongs and were used only to deliver a still birth.⁴³¹ The man-midwife could use forceps to deliver live infants who may otherwise have been born dead, and to shorten long labours. However, forceps could also do considerable damage to both mother and infant if used in inexperienced hands. It was not only midwives who had concerns about the rise of the man-midwife and the use of instruments during birth, physicians also questioned the practice. A pamphlet titled *A petition of the unborn babes* by Dr Frank Nicholls, physician to the British King George II, accuses the man-midwives of "wickedly building their fortunes by preying on the ignorance

⁴²⁹ Donnison, *Midwives and Medical Men: A History of Inter-Professional Rivalries and Women's Rights*; Wertz and Wertz, *Lying-In: A History of Childbirth in America*.

⁴³⁰ Donnison, *Midwives and Medical Men: A History of Inter-Professional Rivalries and Women's Rights*.

⁴³¹ Harley, "Provincial Midwives in England: Lancashire and Cheshire, 1660-1760"; King, Helen. 2012. "Midwifery, 1700-1800: The Man-Midwife as Competitor," in *Nursing and Midwifery in Britain since 1700*, ed. Anne Borsay and Billie Hunter, UK: Palgrave Macmillan.

of women” and frightening them into engaging a male practitioner when one is not needed.⁴³²

In a demonstration of the social climate, novelists also became involved in the discussion around who was the most appropriate birth attendant. For example, in the novel *Tristram Shandy* by Laurence Sterne, the well-known English man-midwife Dr Burton is caricatured as Dr Slop. Dr Slop’s belief in the use of forceps for all births, makes him wonder how the “world could have continued without them”. He rejects the term man-midwife and uses the more ‘exotic’ sounding French term accoucheur. Much to the annoyance of Dr Slop, the family’s midwife is also in attendance at Tristram’s birth. When at last the midwife asks for his assistance he belittles her in front of the family and in using his favourite instruments he crushes Tristram’s nose. In contrast to Sterne who mocked the doctor in his writings, Charles Dickens stereotyped the midwife in his. The fictitious handywoman ‘Sarah or Sairey Gamp’, was created by Dickens in the novel *Martin Chuzzlewit*. The term ‘Sairey Gamp’ was widely used as a derogatory term to describe the working-class midwives. Dickens portrayed Sarah Gamp as an alcoholic, incompetent, dirty and sloppy old woman:

The face of Mrs Gamp — the nose in particular — was somewhat red and swollen, and it was difficult to enjoy her society without becoming conscious of a smell of spirits. Like most persons who have attained to great eminence in their profession, she took to hers very kindly; in so much that, setting aside her natural predilections as a woman, she went to a lying-in or a laying-out with equal zest and relish.⁴³³

Once man-midwives began to attend more births, the birth position started to change.⁴³⁴ Many man-midwives were discouraging the traditional upright birthing position. Dr Burton (of Dr Slop fame in the novel *Tristram Shandy*), wrote in his 1751 *Complete New System of Midwifery*, that delivery on the back or side was “easiest for the patient and more convenient for the operator”.⁴³⁵ This was because it would be difficult for the man-midwife to use his forceps with the woman in the traditional upright position, and because when the woman was labouring in bed, the use of gravity may have made the progress slower. By the nineteenth century the recumbent position was becoming the norm for

⁴³² Nicholls, Frank. 1751. "The Petition of the Unborn Babes."

⁴³³ Charles Dickens. 1844. *Life and Adventures of Martin Chuzzlewit*.

⁴³⁴ Towler and Bramall, *Midwives in History and Society*.8.; Tew, *Safer Childbirth?: A Critical History of Maternity Care*.

⁴³⁵ Donnison, *Midwives and Medical Men: A History of Inter-Professional Rivalries and Women's Rights*.44.

middle and upper-class women and only the 'lower class' women would consider giving birth out of bed.⁴³⁶

As described above, midwives from the lower classes were thought of as drunk 'Gamps'. The more educated midwives denounced any partaking of alcohol and advised other midwives not to accept the 'cordals' and 'cordials' at births. Cordal or cordial — a mixture of oatmeal, alcohol, honey and various herbs— was a drink or food that was given to the woman during the labour and birth to sustain her. Margaret Stephens wrote that women and midwives should not partake of cordials, and Martha Mears, another educated midwife, in her book *Pupil of Nature* (1797) similarly stated that the taking of cordial was still very prevalent in the lower classes.⁴³⁷ Many midwives were working class women and would be expected to take part in all the drinking habits that were usual during this time. Alcohol was a big part of life in all the ranks of society. The midwife may have been expected to drink the cordial with the gossips and the woman at the birth.

Before 1750 man-midwifery was not distinguished from general surgical practice. From the mid-1730s onwards, the wider knowledge of the use of birthing instruments (especially the midwifery forceps), the potentially lucrative nature of man-midwifery, and the fashionable and status-defining trend of engaging a male midwife contributed to an increase in men specialising in midwifery. The fashion of employing a male midwife began in the European and English courts, followed by the upper classes and the aspiring middle classes.⁴³⁸ Even though birth was highly profitable, the man-midwife could not maintain himself comfortably on midwifery alone. Midwifery practice was considered very time consuming and exhausting to the man-midwife. However, in an over-crowded medical profession, man-midwifery was a route to more lucrative kinds of family practice such as general practice.⁴³⁹ The transition for women to use a man-midwife rather than a midwife was not straightforward.⁴⁴⁰ Prior to the 18th century the woman's relatives, particularly in lower class communities, were reluctant to call the male practitioner into a complicated

⁴³⁶ Donnison, *Midwives and Medical Men: A History of Inter-Professional Rivalries and Women's Rights*; Dundes, Lauren. 1987. "The Evolution of Maternal Birthing Position," *American Journal of Public Health* 77 (5): 636-41.

⁴³⁷ Bosanqueti, Anna 2010. "Inspiration from the Past (5) Martha Mears, Nature Worshipper," *The Practising Midwife* 13 (1): 34-36.

⁴³⁸ Donnison, *Midwives and Medical Men: A History of Inter-Professional Rivalries and Women's Rights*; Wertz and Wertz, *Lying-In: A History of Childbirth in America*; Wilson, *The Making of Man-Midwifery: Childbirth in England, 1660-1770*.

⁴³⁹ Harley, "Provincial Midwives in England: Lancashire and Cheshire, 1660-1760".39.

⁴⁴⁰ Marland, *The Art of Midwifery: Early Modern Midwives in Europe*.4.

birth due to their high association with death. This was probably compounded by the association of immorality and immodest behaviour with man-midwives. Although the man-midwife was becoming increasingly fashionable in the more affluent middle and upper classes, the lower classes disapproved of men being involved in the women's business of birth; some believing that having a man-midwife attend a woman 'polluted' the woman and made her more likely to become 'familiar with other men'. The man-midwife was also said to seduce the women he attended.⁴⁴¹ Despite the reservations of the lower classes, man-midwives continued to gain credibility in the following decades. Unlike in Europe and Scotland where formalised education for medical men and midwives had existed since the 17th century, England had no standardised education for either male or female midwives. For example, the Chamberlen man-midwives held no medical degree and the man-midwives who did —such as the famous Scottish man-midwife William Smellie—obtained their medical degrees from Europe or Scotland.⁴⁴² From the mid-1800s the more socially accepted term 'obstetrician' began to be used to identify medical men who practised midwifery in the Western World. As their credibility increased, obstetricians sought to separate themselves from midwives and promote their place in the birthing process. Some obstetricians (such as the Chamberlens described above) initially called for the regulation of midwives. However, many obstetricians felt that rather than regulating them, midwives should be excluded from practice. They also stated that allowing midwives to attend women in childbirth was 'degrading' to the obstetric branch of medicine.⁴⁴³

The midwives who were educated and respectable enough to try and improve the midwives' status were too few and too weak to join together to defend or further their interests.⁴⁴⁴ They were so poorly paid that they had to work long hours to make an adequate living and few had the education or leisure time to organise themselves. Furthermore, during the 19th century and the Victorian era, it was regarded as socially inappropriate for women to seek self-advancement.⁴⁴⁵ As a result of the patriarchal society

⁴⁴¹ Donnison, *Midwives and Medical Men: A History of Inter-Professional Rivalries and Women's Rights*.

⁴⁴² Schnorrenberg, "Is Childbirth Any Place for Women? The Decline of Midwifery in Eighteenth Century England"; Murphy-Lawless, *Reading Birth and Death: A History of Obstetric Thinking*.

⁴⁴³ Donnison, *Midwives and Medical Men: A History of Inter-Professional Rivalries and Women's Rights*.68.

⁴⁴⁴ Ibid.

⁴⁴⁵ Duffin, "The Conspicuous Consumptive: Woman as an Invalid."

and lack of organised opposition, the decline of midwifery and the rise of the obstetrician continued.

Education and Training of Midwives

Historically, until the 1800s the majority of midwives in the Britain would have had no formal training or education for their midwifery work. Some may have followed in their mothers' footsteps and some may have done this out of necessity following widowhood. Some midwives gained more formal education as apprentices, working for a period of years with a more experienced midwife. Sometimes this midwife would be her mother, as often midwifery was in the family and the knowledge and skills were handed down from one generation to the next.⁴⁴⁶ As previously discussed, in other European countries governments were becoming involved in the education and training of midwives. In France in 1531, the public hospital in Paris—the Hotel Dieu— had begun to take a few midwifery pupils. These pupils had to be Catholic, and either married women or widows. The training lasted 3 months and consisted of instruction in anatomy and dissections, following completion of examinations the midwives were recognised as certified and able to obtain licenses.⁴⁴⁷ One of main criticisms of the English midwife was the lack of formal training or qualifications to obtain licensing. In the first half on the 17th century the prominent Chamberlen family of man midwives proposed an organisation that would regulate and force requirements for training of midwives.⁴⁴⁸ This attempt of regulation was opposed by midwives and physicians alike.

Elizabeth Cellier, who was an English Catholic midwife, had initially come to the public's attention in 1680 when she was tried, convicted and then acquitted of treason. Subsequently, Cellier wrote a pamphlet which told her story as a Catholic woman who had been wrongly imprisoned.⁴⁴⁹ Following the publication of the pamphlet another trial ensued, where Cellier was named the 'Popish midwife' and the "cunning power of

⁴⁴⁶ Towler and Bramall, *Midwives in History and Society*; Donnison, *Midwives and Medical Men: A History of Inter-Professional Rivalries and Women's Rights*; Wertz and Wertz, *Lying-In: A History of Childbirth in America*.

⁴⁴⁷ Donnison, *Midwives and Medical Men: A History of Inter-Professional Rivalries and Women's Rights*; Evenden, *The Midwives of Seventeenth-Century London*.

⁴⁴⁸ Schnorrenberg, "Is Childbirth Any Place for Women? The Decline of Midwifery in Eighteenth Century England."

⁴⁴⁹ Beal, Jane. 2014. "Elizabeth Cellier: A Midwife of Seventeenth-Century London," *Midwifery Today*. 111: 20-22.

midwives” was vilified in the hands of pamphleteers and Protestant propagandists.⁴⁵⁰ Cellier was convicted of libel and imprisoned for three years. Cellier gained fame again in 1687, when in response to the encroachment of medical men on the practice and education of midwifery, she proposed plan to regulate the female midwives — that subsequently became a widely respected. Similar to the French system of Catholic charity hospitals for abandoned babies, her proposal included an administrative plan to incorporate and regulate midwives and provide a maternity hospital, and an orphanage.⁴⁵¹ Cellier also proposed to form a ‘college of midwives’. The aim of the college would be to provide instruction and supervision of its members. Cellier’s proposal was initially accepted by King James II; however, a highly publicised scandal relating to the birth of the Prince, and the subsequent ‘Bloodless Revolution’ of 1688 led to the exile of the King to France.⁴⁵² This scandal also exacerbated the fascination with women’s’ secret activities during birth; the rhetoric of midwives harbouring Catholics, undermining society and “permitting spurious princes to inherit the crown”⁴⁵³, helped to undermine the English midwife’s claim to being the most appropriate birth attendant and Cellier’s proposal failed to gain support.

Until the 17th Century, it was generally accepted that women’s lore was more commonly spoken than written. Midwives learned midwifery through practice; therefore, it was generally believed that documenting everyday practice was unnecessary.⁴⁵⁴ Midwives were often from the lower classes, where reading and writing was not taught; therefore, they had no access to the emerging knowledge about anatomy and obstetrics.⁴⁵⁵ However, some exceptions did exist, *The Midwives Book or The Whole Art of Midwifery Discovered* was the first book to be published by an English midwife, Jane Sharp, in 1671. The book instructed women how to manage their births and gave practical direction to each party involved in the birthing process which included the pregnant woman, the father of the baby, and the midwife. In her introduction, Sharp acknowledged midwifery as 'doubtless one of the most useful and necessary of all Arts for the being and well-being of Mankind.'⁴⁵⁶ The book consists of six parts. The first deals with female and male reproductive anatomy.

⁴⁵⁰ Cody, Lisa Forman. 2005. *Birthing the Nation: Sex, Science and the Conception of Eighteenth Century Britons*. Oxford: University Press.67.

⁴⁵¹ Ibid.70.; Beal, "Elizabeth Cellier: A Midwife of Seventeenth-Century London."

⁴⁵² Beal, "Elizabeth Cellier: A Midwife of Seventeenth-Century London."

⁴⁵³ Cody, *Birthing the Nation: Sex, Science and the Conception of Eighteenth Century Britons*.83.

⁴⁵⁴ Allotey, "English Midwives' Responses to the Medicalisation of Childbirth (1671-1795)."

⁴⁵⁵ Marland, *The Art of Midwifery: Early Modern Midwives in Europe*; McIntosh, *A Social History of Maternity and Childbirth*.

⁴⁵⁶ Sharp, Jane. 1671. *The Midwives Book: Or the Whole Art of Midwifery Discovered*.

The second covers the process of conception and the growth of the fetus. The third chapter describes the possible difficulties for both conception and birth. In the fourth and fifth chapters, Sharp discusses childbirth and the period immediately after, what to do and what problems might arise. Difficult births were described in the book and it also included anatomical illustrations. The sixth and last chapter regards life after childbirth. There was also a discussion about the problems of the venereal disease, syphilis, an ever-present threat in the 1600s.⁴⁵⁷

Perhaps Jane Sharp was one of the first feminists, as in addition to a practical guide to midwifery, she used her book as a platform to express her views on women's education, male midwives, and female sexuality. She was especially critical of the use of male midwives, arguing that they were expensive and unnecessary. Midwifery, she argued, was based on experience, not words. Very little is known about Jane Sharp, but she was obviously educated as she was able to read and write.

In 1737 another English midwife, Sarah Stone, published *A Complete Practice of Midwifery*. A midwife with 35 years of experience, she felt her book was needed for “all female practitioners in an art so important to the lives and wellbeing of the sex”.⁴⁵⁸ As previously mentioned, midwifery skills were often passed on through generations. Sarah’s mother was a midwife and she had been apprentice to her mother for a full six years. She emphasised that all women midwives should also spend at least three years “with some ingenious women” to learn the art of midwifery “for if seven years must be served to learn a trade, I think 3 years as little as possible to be instructed in an art where life depends”.⁴⁵⁹ Sarah hoped that the knowledge gained from her book would enable a woman of even the lowest capacity to safely deliver a child without the need for the intervention of the man-midwife. She warned that unless the women midwives showed themselves capable, the public would call the man in first, as was happening in parts of Europe and America.⁴⁶⁰ Elizabeth Nihell trained and worked in the Hotel Dieu in France before returning to her native England. In 1761 her *Treatise on the Art of Midwifery: Setting Forth Various Abuses Therein, Especially as to the Practice with Instruments* was published.⁴⁶¹ Nihell too is critical

⁴⁵⁷ Sharp, Jane. 1671. *The Midwives Book: Or the Whole Art of Midwifery Discovered*.

⁴⁵⁸ Stone, Sarah. 1737. *A Complete Practice of Midwifery*, T. Cooper.

⁴⁵⁹ Ibid.

⁴⁶⁰ Donnison, *Midwives and Medical Men: A History of Inter-Professional Rivalries and Women's Rights*.36; Stone, *A Complete Practice of Midwifery*.

⁴⁶¹ Nihell, Elizabeth. 1760. *Treatise on the Art of Midwifery: Setting Forth Various Abuses Therein, Especially as to the Practice with Instruments*, London: A Morley.

of the man-midwife and his use of instruments. Her experiences of working as an autonomous midwife in France led her to conclude that instruments were seldom, if ever, necessary for birth. Her writing makes some interesting points, stating that childbirth is generally natural, easy and safe and that it is the intervention in the process that is dangerous and detrimental to women. She advocates for empathy and patience in the process of childbirth and for the woman and the father of the child making their own judgments and decisions regarding their birth attendant, although fathers would have had little involvement with the actual birth.⁴⁶²

English midwife Margaret Stephens was more forgiving in *Domestic Midwife: or the Best Means of Preventing Danger in Child-birth* written in 1795. Like man-midwives, she refers to women as 'patients', implying that they were sick rather than pregnant – a new way of looking at pregnancy and birth – and includes details of medical procedures such as a forceps childbirth, while cautioning midwives not to attempt these themselves. She also advises midwives to refer women to man-midwives at the first sign of trouble.⁴⁶³ However, Stephens also accused male midwives of being jealous of the midwives and stated that the men tried to manipulate themselves into an advantageous position by controlling the quality, quantity and the cost of training available to women midwives. Margaret Stephens believed that midwifery was a respectable and worthy occupation and that midwives were a blessing to society.⁴⁶⁴

Throughout the 18th century midwives continued to question male midwifery practice.⁴⁶⁵ Sarah Stone (1737) claimed that such 'male pretenders' were causing great harm to mother and infant with their instruments and referred to instances where infants "have been born alive, with their Brains working out of their Heads".⁴⁶⁶ She also noted that "these young gentlemen put a finish'd assurance with pretense that their knowledge exceeds any woman's, because they have seen or gone thro, a course of anatomy".⁴⁶⁷ Stone was sure that more died at their hands than any of the "the greatest imbecility and

⁴⁶² Nihell, Elizabeth. 1760. *Treatise on the Art of Midwifery: Setting Forth Various Abuses Therein, Especially as to the Practice with Instruments*, London: A Morley; Beal, Jane. 2015. "Elizabeth Nihell: A Feisty English Midwife (1723-1776)," *Midwifery Today* 114: 56-57.

⁴⁶³ Stephens, Margaret. 1795. *Domestic Midwife: Or the Best Means of Preventing Danger in Child-Birth*, London: S. W. Fores.

⁴⁶⁴ *Ibid.*; Towler and Bramall, *Midwives in History and Society*; Leap and Hunter, *The Midwife's Tale*.

⁴⁶⁵ Allotey, "English Midwives' Responses to the Medicalisation of Childbirth (1671-1795)."

⁴⁶⁶ Stone, *A Complete Practice of Midwifery*.

⁴⁶⁷ *Ibid.*

ignorance of some women midwives".⁴⁶⁸ Elizabeth Nihell (1761) responded to the rise of the male midwife and medical men by saying that "ladies who want assistance in their lyings-in, are not very curious of having one that can dissect instead of delivering them".⁴⁶⁹ The fact that some of the British midwives during the 17th and 18th centuries wrote books attests to their intelligence, education, skill and determination to write for their fellow midwifery practitioners. The midwives may have had families of their own to care for, and many barriers to overcome such as a lack of access to formal education, lower class status and their gender.⁴⁷⁰

The story of Dutch midwives in the 19th century is similar to that of the English midwives', one of "pluses and minuses" legislation, the establishment of training facilities and codes of practices and division of labour that led the midwives in one direction. Although this direction gave them security, it also defined their roles more rigidly. Legislation introduced in the 1800s stated that the midwife was only to attend normal labour and birth and any abnormal labour or birth be handed over to or supervised by a medical doctor. This encroachment by medical practitioners on the midwives' traditional role and the legislation that supported it, although restrictive, enabled the midwife to ensure her survival, unlike other countries in Europe and the USA.⁴⁷¹ However, with the rise of literate middle-class midwives and the increased interest from male midwives throughout Europe, there came a backlash from both the male midwives and the middle-class midwives against the old wives and handywomen who served as midwives.⁴⁷²

Lying-in Hospitals

The lying-in house (also referred to as lying-in homes and lying-in hospitals) had become popular in 18th century Britain. The aim of the lying-in houses was to provide poor women with somewhere to go to birth and then stay for a period of time following the birth to regain their strength. The first permanent lying-in hospital was established in 1745 in Dublin, Ireland; this was later to become the Rotunda Hospital.⁴⁷³ This was followed by the

⁴⁶⁸ Stone, *A Complete Practice of Midwifery*.

⁴⁶⁹ Nihell, *Treatise on the Art of Midwifery: Setting Forth Various Abuses Therein, Especially as to the Practice with Instruments*.

⁴⁷⁰ Donnison, *Midwives and Medical Men: A History of Inter-Professional Rivalries and Women's Rights*.

⁴⁷¹ Van Lieburg and Marland, "Midwifery Regulations, Education and Practice in the Netherlands."

⁴⁷² Nihell, *Treatise on the Art of Midwifery: Setting Forth Various Abuses Therein, Especially as to the Practice with Instruments*.32.

⁴⁷³ Murphy-Lawless, *Reading Birth and Death: A History of Obstetric Thinking*.

establishment of permanent lying-in hospitals in Middlesex, London and Edinburgh in the UK in the mid to late 18th century.⁴⁷⁴ Rather than only being a charity for the poor, the lying-in hospital was also a way for the medical men to gain experience in birth, as they provided a 'ready source of clinical material' for their own and their pupils' study.⁴⁷⁵ Women who did not meet the lying-in hospital's strict criteria and needed free assistance had to rely on the Poor Law and seek assistance at the local parish church.⁴⁷⁶

Most UK lying-in houses were run by a board of governors headed by medical men with an employed widow, the matron, running the establishment. The matron received an annual salary and her board and lodging at the lying-in home. Unlike France where the head midwife of the Hotel Dieu was an autonomous midwife and independent of the medical men, the matron in the lying-in hospitals was subordinate to the medical men. However, not all lying-in homes were run by medical men and their employed midwives; in some areas of Britain and in other parts of the Western World, lying-in houses were also run as independent midwifery establishments.⁴⁷⁷

The establishment of the lying-in houses brought a different type of training and education for the midwives. It also brought a different type of midwife as the cost of training would have been unachievable for older married or widowed women. At the British lying-in hospital, the cost was 20 guineas for the 'gentlemen of the faculty' to give theoretical instruction in "all that is necessary for women to know".⁴⁷⁸ This idea is ambiguous and patronising as what was necessary for the midwifery students to know would be at the medical doctor's discretion and would also depend on his own knowledge. The pupils would have to pay a further ten shillings a week for board and lodgings and fees for the practical instruction provided by the matron of the lying-in house. The cost would have been at least thirty pounds for a minimum stay of four months. This was probably the

⁴⁷⁴ Donnison, *Midwives and Medical Men: A History of Inter-Professional Rivalries and Women's Rights*; Murphy-Lawless, *Reading Birth and Death: A History of Obstetric Thinking*.

⁴⁷⁵ Murphy-Lawless, *Reading Birth and Death: A History of Obstetric Thinking*; Katz Rothman, *In Labour: Women and Power in the Birth Place*; Donnison, *Midwives and Medical Men: A History of Inter-Professional Rivalries and Women's Rights*; Allotey, "English Midwives' Responses to the Medicalisation of Childbirth (1671-1795)."

⁴⁷⁶ *Ibid.*; Towler and Bramall, *Midwives in History and Society*.

⁴⁷⁷ Donnison, *Midwives and Medical Men: A History of Inter-Professional Rivalries and Women's Rights*; Cody, "Living and Dying in Georgian London's Lying-Hospitals"; Cody, *Birthing the Nation: Sex, Science and the Conception of Eighteenth Century Britons*.

⁴⁷⁸ Donnison, *Midwives and Medical Men: A History of Inter-Professional Rivalries and Women's Rights*.39.

reason that only three to four pupils a year attended rather than the twelve expected.⁴⁷⁹ Some lying-in houses provided out-door charities or services; these services enabled midwives to attend women in their own homes and this provision of skilled birth attendant seemed to make the biggest difference to birthing women. The midwives were supervised by the institution's man-midwife whom they could call to difficult cases if needed.⁴⁸⁰ The overall cost to the institution, in providing the outdoor service option, was much less than women attending the lying-in houses. This reduced cost was because the lying-in homes did not have to pay for the woman's board and lodging if she remained at home. Therefore, there were many more births in the out-door charities. The outcomes for the women attended at home were also much better than the women giving birth in the lying-in institutions. The main reason for this was 'childbed' or puerperal fever.

Puerperal fever is a bacterial infection of the genital and urinary systems. The uterus and tissues of the genital tract, particularly if they have been damaged during birth or by instruments such as forceps, are extremely vulnerable to infection.⁴⁸¹ The cause of Puerperal fever was not discovered until the late 19th century—however it was suspected by some such as Hungarian doctor Ignaz Semmelweis⁴⁸²—that it was transmitted from woman to woman by the medical men who performed post mortems and then examined women without washing their hands or wearing gloves.⁴⁸³ When working at the Vienna General Hospital in the 1840s, Semmelweis observed the stark difference in mortality rates amongst women who birthed in different settings. Each morning the male medical students performed post mortems and dissections in the mortuary of the hospital before attending the women in the first clinic, this clinic had an average death rate of 10 % from Puerperal fever. Mortality was much lower in the female midwifery-run second clinic of the hospital (3.4%) and less than 1% for the women who gave birth at home.⁴⁸⁴ In May 1847 he commenced a trailblazing clinical trial when he introduced hand washing with chlorine of

⁴⁷⁹ Donnison, *Midwives and Medical Men: A History of Inter-Professional Rivalries and Women's Rights*.

⁴⁸⁰ *Ibid.*; Towler and Bramall, *Midwives in History and Society*; Murphy-Lawless, *Reading Birth and Death: A History of Obstetric Thinking*.

⁴⁸¹ Tew, *Safer Childbirth?: A Critical History of Maternity Care*. 112.

⁴⁸² Manor, Joshua, Nava Blum, and Yoav Lurie. 2016. "'No Good Deed Goes Unpunished': Ignaz Semmelweis and the Story of Puerperal Fever," *Infection Control and Hospital Epidemiology* 37 (8): 881.

⁴⁸³ Tew, *Safer Childbirth?: A Critical History of Maternity Care*.

⁴⁸⁴ Semmelweis, Ignac Fulop. 1983. *The Etiology, Concept, and Prophylaxis of Childbed Fever / Ignaz Semmelweis*. Madison, Wisconsin: University of Wisconsin Press; Manor, Blum, and Lurie, "No Good Deed Goes Unpunished": Ignaz Semmelweis and the Story of Puerperal Fever."

lime techniques to the medical men of the first clinic and no change to the second clinic.⁴⁸⁵ There was an immediate decrease in the mortality rate in the first clinic to an average of 3.2 percent in the second half of the year—in the previous twelve months the death rate had been 10.5% in the first clinic. The death rate continued to decline in the following 12 months (1848) to an average of 1.2 % in the first clinic and 1-1.3 % in the second clinic.⁴⁸⁶ Although his clinical trial was a success, his hypothesis was unpopular with some of the medical men who refuted that they were causing the deaths and he stepped down from his post in 1849.⁴⁸⁷ Bacteria flourished in the dirty, overcrowded and badly ventilated lying-in houses and hospitals of the 19th century, leading to frequent closures due to the deaths of women caused by outbreaks of Puerperal Fever.⁴⁸⁸

The outdoor charities also provided another option for training the midwives. The pupil midwives were women from similar backgrounds to the pupil midwives in the lying-in hospitals. However, the training provided was free in return for the midwives agreeing to work for a period of time for the charity. Once they had completed their training the midwives were also able to set up in private practice.⁴⁸⁹

The Arrival of the New Nurses; Allies or Foes of the Midwife?

By the mid-1850s the role of the midwife was not seen as a dignified profession and was only suitable work for 'Gamps' who were lower class older women. Midwifery was not an option for women of higher classes as the subject of birth and all it contained was not talked about in 'polite' Victorian society.⁴⁹⁰ However, from the mid-1800s a new type of 'respectable' nurse was emerging in Britain and starting to challenge and change the cultural attitudes to nursing. In 1838 a group of nuns, The Catholic Irish Sisters of Mercy, established a convent in London and became highly respected in the communities they provided nursing to. From the mid-1800s, The Protestant Sisterhood—groups of respectable and affluent women—formed nursing training schools. These nursing schools were a two-tiered system with the 'genteel' ladies—the Sisters—offering training, discipline

⁴⁸⁵ Manor, Blum, and Lurie, "No Good Deed Goes Unpunished": Ignaz Semmelweis and the Story of Puerperal Fever."

⁴⁸⁶ Ibid.

⁴⁸⁷ Ibid.

⁴⁸⁸ Towler and Bramall, *Midwives in History and Society*.

⁴⁸⁹ Ibid.

⁴⁹⁰ Duffin, "The Conspicuous Consumptive: Woman as an Invalid."

and guidance to the working-class 'nurse' who would provide the actual nursing care.⁴⁹¹ The higher social standing of this new type of nurse was largely due to the work of these Sisterhoods and of one nurse in particular. Florence Nightingale, an upper-class woman, took an unconventional path for a woman of her social class, and devoted herself to nursing and hospital reform. In 1854, Nightingale and thirty-eight volunteer nurses travelled to Scutari to care for soldiers fighting in the Crimean War. On arrival she found horrifying conditions, with soldiers dying from diseases caused by the unsanitary conditions rather than their battle wounds. Nightingale and her nurses worked to improve the conditions; their successes were largely due to the sanitation measures Nightingale implemented along with her organisational and leadership skills.⁴⁹²

Nightingale's work in the Crimean War brought the issue of public health and sanitation to national and international attention and had great consequences for women, as the role of the nurse was now seen as an option for women's employment.⁴⁹³ As show above, prior to the mid-1800s the work associated with the nurse was done by older, working class, married or widowed women, some seen as of "low character and given to drink"⁴⁹⁴; now it would be an option for younger women from higher social classes. Nightingale's training for nurses became famous and raised the social status of nursing, thereby attracting a new type of nurse, young educated women, unlike the older working-class women who worked as handywomen and were associated with the immoral characters of the 'Sariey Gamps'. In contrast to midwifery, the occupation of the nurse was considered appropriate work for the women during the 19th century. The nurse was a more appealing prospect for the medical men as the nurses, unlike the midwives, were considered subordinate to them. The new nurse was trained to follow documented orders thereby setting up a new hierarchal relationship where doctors were superior to nurses.⁴⁹⁵

In 1861, Nightingale also tried to develop a school for midwifery. She hoped to train midwives for work amongst the poor. As there was still no government school for

⁴⁹¹ Hallett, Christine E. 2012. "Nursing, 1830-1920: Forging a Profession," in *Nursing and Midwifery in Britain since 1700*, ed. Anne Borsay and Billie Hunter, UK: Palgrave Macmillan.

⁴⁹² Fee, Elizabeth and Mary E. Garofalo. 2010. "Florence Nightingale and the Crimean War," *American Journal of Public Health* 100 (9): 1591.

⁴⁹³ Ibid.

⁴⁹⁴ Donnison, *Midwives and Medical Men: A History of Inter-Professional Rivalries and Women's Rights*.

⁴⁹⁵ McKay, Katrina Anne and Seshasayee Narasimhan. 2012 "Bridging the Gap between Doctors and Nurses," *Journal of Nursing Education and Practice*, 2 (4): 52-55; Hallett, "Nursing, 1830-1920: Forging a Profession."

midwifery, Nightingale anticipated that her school would serve as a model that others would copy throughout the country.⁴⁹⁶ A strategy adopted by Nightingale that would substantially impact the role of the midwife was that pupils to be trained at the Nightingale School of Midwifery would not be known as midwives but midwifery-nurses. Nightingale also believed these midwifery-nurses should be able to deal with all cases of childbirth, even the difficult ones, and that the training should be not less than two years. Unfortunately, due to consistent outbreaks of 'childbed fever' the training school was closed in 1867.⁴⁹⁷

During the late 19th and early 20th century in the UK, there was a plan to try and incorporate midwives' education and ultimately their registration into nursing. Medical opposition, although the most serious obstacle to midwifery registration, was not the only one; many midwives themselves did not support registration. The nurses were also aligned with the medical men against the midwives as they felt they had a privileged position and wanted to maintain this. For these reasons the midwives' registration while anticipated to be straightforward was much more difficult to attain than previously thought.⁴⁹⁸

In 1872, in an attempt to control the education of midwives, the British Obstetrical Society developed a midwifery examination. The examination was open to women aged 21-30 (thereby excluding the older women). By excluding the mature and experienced women who posed a threat to the authority of the medical men, they were able to mould a new style of midwife; young, inexperienced and subordinate.⁴⁹⁹ The applicants also needed to produce a certificate of good character and must have undergone a course of instruction approved by the Medical Obstetric Society. The courses also incurred a cost that would exclude women of lower social class who would not be able to afford to pay for the instruction. Pupils were also expected to attend 25 labours under satisfactory supervision. This was far more than the number required by medical students. The diploma received criticism as it only qualified the holder to attend normal labours.⁵⁰⁰

⁴⁹⁶ Donnison, *Midwives and Medical Men: A History of Inter-Professional Rivalries and Women's Rights*.77.

⁴⁹⁷ Ibid.80.

⁴⁹⁸ Nuttall, Alison, 2012. "Midwifery, 1800-1920: The Journey to Registration," in *Nursing and Midwifery in Britain since 1700*, ed. Anne Borsay and Billie Hunter, UK: Palgrave Macmillan.

⁴⁹⁹ Leap and Hunter, *The Midwife's Tale*; Donnison, *Midwives and Medical Men: A History of Inter-Professional Rivalries and Women's Rights*; Towler and Bramall, *Midwives in History and Society*.

⁵⁰⁰ Donnison, *Midwives and Medical Men: A History of Inter-Professional Rivalries and Women's Rights*.

In the same year, English obstetrician Dr James Hobson Aveling wrote *The English Midwives, their History and their Prospects*. The book was primarily a plea for the legislation to control midwives. In his preface he states that:

to arouse an interest in the midwives of this country – to show what misery may result from their ignorance – and to gain sympathy, advice, and assistance in endeavouring to raise them to a more refined and intellectual position, has induced the author to present this little volume to English readers.⁵⁰¹

In his book Aveling argued that the midwives were incapable of bettering themselves without help from the public and their “stronger brothers of the medical profession”.⁵⁰² Aveling was also convinced that people were unaware of the spreading of evil resulting from the ignorance of the midwives who were hindering society, posing the question “is it a matter of no importance whether a woman who professes midwifery, and upon whose knowledge and skill depend the life or death of two individuals, is the competent practitioner or an ignorant impostor?”⁵⁰³

In 1880, in the continuing quest to keep control of midwifery and prevent the medical doctors from governing it, The Midwives’ Society was founded in England by Louisa Hubbard and three midwives: Mrs Hornby-Evans, Mrs E.J. Freeman and Mrs Zepherina Smith. The work of these women was to be far reaching, and this society would eventually become The Royal College of Midwives (RCM). The Midwives’ Society’s ultimate aim was to increase the status of the midwife, by recruiting and furthering the training of educated women and the state registration of midwives.⁵⁰⁴ The realisation that to achieve its aims The Midwives’ Society would need the approval of leading obstetricians differed from any attempt made by midwives before them. From the beginning the Society declared its intention of working in harmony with the medical profession. However, in agreeing that the midwives would attend only normal labour and births, they altered the path of midwives forever, as once the medical profession came to be socially defined as having expertise in

⁵⁰¹ Aveling, James H. 1872. *English Midwives: Their History and Prospects*. London: Churchill.

⁵⁰² Ibid.

⁵⁰³ Ibid.170.

⁵⁰⁴ Donnison, *Midwives and Medical Men: A History of Inter-Professional Rivalries and Women's Rights*; Towler and Bramall, *Midwives in History and Society*.

the management of difficult or abnormal labour and birth, midwifery effectively lost control over even normal birth.⁵⁰⁵

The Midwives' Society had strict selection criteria for members. They had to be over 25 and of the 'highest character and competence'.⁵⁰⁶ Members had to follow a code of conduct. This code of conduct included abstinence from alcohol, for themselves and their patients. Midwives also had to refrain from discussing the details of their work with non-professionals, guarding their lives and conversations not only "from evil but the appearance of it"⁵⁰⁷ and remembering that their reputation and that of the society depended on their behaviours.⁵⁰⁸

It slowly became more acceptable for middle class women to practice as midwives, and they were over represented in The Midwives Society.⁵⁰⁹ However, the majority of midwives remained working class women, living and working in their local communities, earning low wages, and formal training continued to be the exception rather than the norm. The majority of women still birthed at home with the local midwife. 'Risk' was not a term used at this time, however the safeguarding of women and infants' health was increasingly emphasised by the medical doctors. The discourse around 'risk' has already been discussed in the literature review (Chapter Two).

The Midwives Acts, Midwives in Britain in the Early 20th Century

In 1902 The *Midwives Act* was passed in England after a bitter and prolonged debate. The Act was full of rhetoric about social responsibility and the health of the nation, in particular infant welfare.⁵¹⁰ The *Midwives Act* was the precedent for the *Nurses Act* that followed in 1919. The 1902 *Midwives Act* was unlike any act before it and put the midwife at a unique disadvantage amongst other professions. This was due to the following reasons: Firstly, the Act subjected midwives to local authority supervision, normally associated with the

⁵⁰⁵ Katz Rothman, *In Labour: Women and Power in the Birth Place*.51; Donnison, *Midwives and Medical Men: A History of Inter-Professional Rivalries and Women's Rights*; Towler and Bramall, *Midwives in History and Society*.

⁵⁰⁶ Towler and Bramall, *Midwives in History and Society*.

⁵⁰⁷ Donnison, *Midwives and Medical Men: A History of Inter-Professional Rivalries and Women's Rights*.113.

⁵⁰⁸ *Ibid.*.113.

⁵⁰⁹ McIntosh, *A Social History of Maternity and Childbirth*.

⁵¹⁰ *Ibid.*; *Midwives Act 1902, The (UK)*. *British Medical Journal* 2 (2278) (1904): 461-462.

licensing of tradesmen. Secondly, as in other professions, midwives could be removed from the register if found guilty of misconduct, although compared to other professions the misconduct was defined more widely and in much more detail and also took into account their private lives. Thirdly and possibly most importantly, the midwives were not to regulate themselves and in fact their rival profession, nursing — which was subordinate to medicine — was to have a dominant voice in their governing body, the Central Midwifery Board (CMB).⁵¹¹ A positive aspect of the Act was for the first time midwifery gained the status of a legitimate profession, albeit controlled by nursing and medicine. The road to registration had been a long one and the reliance on support from the medical profession now meant that the medical profession had a substantial degree of control over midwifery. The doctors were supportive because they wanted to have a body of adequately trained midwives to serve the poor. However, the doctors were also anxious to restrict the midwives' independence and ensure that the midwives were subordinate to the medical doctors.⁵¹²

The UK's first Midwives Register of 1905 contained 22308 names; 7465 held the Obstetrical Society's certificate, 2322 held a hospital certificate, and 12521 were midwives in 'Bona Fide' practice (sometimes called traditional or lay midwives or handywomen). Bona Fide midwives held no certificate of training; however, they could prove they had been in practice as a midwife.⁵¹³ Registration also opened a way for midwives to be strictly monitored by doctors. Local authorities could suspend their registration for not keeping the many rules of the Act. Many of the 'Bona Fide' midwives were suspended in this way. There are records of midwives being removed from the register for not wearing a 'washing dress, [or] carrying the right equipment', or midwives who had 'lapsed from the path of virtue,' or were perceived to be acting 'immorally'.⁵¹⁴ In the early 20th century in England there was a perceived difference between these handywomen midwives and the certified State registered midwives. The State registered midwives were more likely to be middle class and not from the local community. Due to the differences in class some of these certified state registered midwives may well have seen themselves as 'saviours' of the poor and lower-

⁵¹¹ Donnison, *Midwives and Medical Men: A History of Inter-Professional Rivalries and Women's Rights*.

⁵¹² Towler and Bramall, *Midwives in History and Society*.

⁵¹³ Donnison, *Midwives and Medical Men: A History of Inter-Professional Rivalries and Women's Rights*.179.

⁵¹⁴ *Ibid.*; Leap and Hunter, *The Midwife's Tale*.

class communities.⁵¹⁵ The Midwives' Society also sought to 'reform working class habits and values'. Central to their campaign was the "wish to drive out the handywomen, whom they saw as a great evil and a danger to childbearing women because they were untrained and had no academic knowledge about the prevention of infection".⁵¹⁶ Following the introduction of the Midwives' acts, a strict method of supervision entailed the handywomen/lay midwives being subjected to investigations into their practice, their homes and even their moral lives. Again, a set of middle class values and morality was applied to these midwives who could, for example, be taken off the register for having children out of wedlock.⁵¹⁷

Although the UK's 1926 *Midwives Act* banned untrained midwives from attending women in birth unless it was an emergency, these midwives often colluded with doctors and continued to attend births.⁵¹⁸ While many untrained midwives were prosecuted and fined for practising midwifery illegally, the doctors were not prosecuted if found to be working with the untrained and unregistered midwives; they were merely warned by their medical societies.⁵¹⁹

One of the concerns cited by the certified midwives and the medical profession regarding the British handywoman was her association with laying out the dead, and the risk of infection, particularly childbed (puerperal) fever. However, laying out the dead incorporated rituals around handwashing that were passed down through the ages and therefore the potential transferring of infections from the deceased to the labouring women would have been avoided long before any understanding of sepsis and the transfer of infections. This was supported by the fact that fewer childbearing women died at home than in hospitals.⁵²⁰ During the late 19th and early 20th century hospitals in the Western World were being closed due to infections.⁵²¹ In 1934 deaths from puerperal fever in Britain were three times higher in the affluent areas of London, where many women could afford

⁵¹⁵ Donnison, *Midwives and Medical Men: A History of Inter-Professional Rivalries and Women's Rights*.

⁵¹⁶ Leap and Hunter, *The Midwife's Tale*.3.

⁵¹⁷ Ibid.

⁵¹⁸ Ibid.7.

⁵¹⁹ McIntosh, *A Social History of Maternity and Childbirth*; Donnison, *Midwives and Medical Men: A History of Inter-Professional Rivalries and Women's Rights*.

⁵²⁰ Tew, *Safer Childbirth?: A Critical History of Maternity Care*.

⁵²¹ Donnison, *Midwives and Medical Men: A History of Inter-Professional Rivalries and Women's Rights*; McCalman, *Sex and Suffering: Women's and a Women's Hospital: The Royal Women's Hospital Melbourne 1856-1996*; Leap and Hunter, *The Midwife's Tale*.

to have a doctor attend them or to give birth in hospital, than in the poverty-stricken areas where women were attended at home by midwives.⁵²²

From a professional point of view, the updated *Midwives Act* of 1936 signalled that UK midwifery was now not only a profession but a 'respectable' profession, and part of the provision of maternity services. Despite this, some still saw midwifery as a semi-profession, in the service of the male dominated 'true profession' of medicine, specifically in the case of obstetrics.⁵²³

The 1936 *Midwives Act* had the most significant influence on the working lives of independent midwives in the UK, much of it for the better. The handywoman tended to be an older woman who had birthed babies herself, the new trained and employed midwife was likely to be young, middle class and wearing a uniform. There was sometimes an acrimonious relationship between the new midwives and the women due to the recent memory of a known handywoman losing her livelihood. Even local women who became the new certified midwives experienced resistance to the changes, as women valued experience rather than the formal training. There were also stories of the handywomen working alongside the new midwives, however they were often relegated to 'doing the donkey work' and carrying out practical tasks such as cleaning and washing rather than the actual midwifery care of the women.⁵²⁴

Following the implementation of the National Health Service (NHS) in Britain in 1947 the independent autonomous midwife was no longer the only option for women and this led to a decline in their numbers. Rather than families having to pay for their healthcare there was free healthcare for all, including all care related to childbirth, an organised, state-funded home help system and increased hospitalisation for both birth and death. Midwives continued to attend the majority of births in the UK. However, most of these births now took place in the hospital with the midwife employed by the institution and working in the hierarchal team with doctors. The UK midwife may have maintained her autonomous profession but the move to State employment and institutional births contributed to less autonomous practice and the increasing medicalisation of birth.⁵²⁵

⁵²² Leap and Hunter, *The Midwife's Tale*.15.

⁵²³ McIntosh, *A Social History of Maternity and Childbirth*.

⁵²⁴ Leap and Hunter, *The Midwife's Tale*.

⁵²⁵ McIntosh, *A Social History of Maternity and Childbirth*; Leap and Hunter, *The Midwife's Tale*.

Some historians argue that it was the general practitioner doctor (GP) who was the loser in the battle for birth in the UK, not midwives.⁵²⁶ GPs' access to women was impacted by midwives and obstetricians, with midwives taking control of normal births and obstetricians taking women with acknowledged risk.⁵²⁷ Although what was considered normal became less easily identified and the changing parameters of low, medium and high risk continued to cause conflict; this continually evolving assessment and definition of risk was to have particular repercussions in Australia, which will be discussed in more detail in the succeeding chapters of this thesis.

Midwifery in Other Parts of the Western World

No matter what we think of the attitudes and class-ridden tactics of the midwifery reformers, without their campaigning and manoeuvring due to the powerful position in society their status gave them, the midwifery profession would not exist in the UK with its autonomous practitioner status.⁵²⁸ According to Leap and Hunter, in comparison to the UK, countries such as America, Canada, Australia and New Zealand had no opportunity for campaigners to "bend the ear of the boys at the top" or to fight the rising tide of capitalist enterprise on the behalf of doctors.⁵²⁹ From the 1900s the role of the midwife became relegated to the handmaiden or the obstetric nurse. In these countries midwives have had to fight to build or rebuild a midwifery profession with the same potential and status as the British midwife.

Until 1850, traditional independent midwives were still common place in Australia, New Zealand, Canada and America and, in some areas in these countries, into the early decades of the 20th century. The majority of midwives were untrained, independent, or as they were sometimes known 'lay' midwives, whose practice had been passed down through the generations, or ones who had brought with them skills and training from Europe. The majority of pioneer women were assisted in childbirth by other women whose skill and expertise in childbirth were recognised and respected by their communities.

⁵²⁶ McIntosh, *A Social History of Maternity and Childbirth*; Donnison, *Midwives and Medical Men: A History of Inter-Professional Rivalries and Women's Rights*.

⁵²⁷ McIntosh, *A Social History of Maternity and Childbirth*; Murphy-Lawless, *Reading Birth and Death: A History of Obstetric Thinking*.

⁵²⁸ Donnison, *Midwives and Medical Men: A History of Inter-Professional Rivalries and Women's Rights*; Towler and Bramall, *Midwives in History and Society*; Leap and Hunter, *The Midwife's Tale*.

⁵²⁹ Leap and Hunter, *The Midwife's Tale*.16.

Without this assistance, some women gave birth alone, were assisted by Indigenous women or helped only by their husbands.⁵³⁰

In Canada, the midwifery profession was first regulated in 1993.⁵³¹ Although this process varied across Canada, the legislation and organisation of the model of midwifery is similar across all regulated jurisdictions (although not all jurisdictions have legislation for midwifery). Midwives provide care to women and their infants from early pregnancy until six weeks post-partum.⁵³² The number of midwives has increased dramatically in recent years; the number of registered midwives in 2016 was 1,547, attending approximately 10 per cent of the births.⁵³³ In New Zealand the midwives gained independent autonomous status in 1990, when legislation was changed to enable them to become the lead carer for women during pregnancy, birth and postpartum. Prior to this change in legislation, from the 1970s legislation dictated that midwives were subordinate to doctors and required medical practitioners to supervise all births.⁵³⁴ In the United States, midwifery failed to survive the medicalisation of childbirth and the rise of the obstetrician.⁵³⁵ From the late 18th century the number of midwives began to decline in America because they had not been organised and had never developed any leadership. These disorganised midwives were an easy target for the medical men because although medicine had minimal scientific authority in America, it was organised and had started to develop social and professional organisations.⁵³⁶ However, due to the large amount of ethnic immigration particularly from southern Europe, American midwives were still attending half of the births in the early 1900s. Midwives were also still attending the births of poor, socially disadvantaged and

⁵³⁰ Wertz and Wertz, *Lying-In: A History of Childbirth in America*; Strachan, Glenda. 1999. "The Reproduction of Labour Power: The Work of Midwives and 'Handywomen' in Rural New South Wales, 1850-1880."

⁵³¹ Bourgeault, Ivy Lynn, Cecilia Benoit, and Robbie Davis-Floyd 2004. "Reconceiving Midwifery in Canada" In *Reconceiving Midwifery* ed. Ivy Lynn Bourgeault, Cecilia Benoit, and Robbie Davis-Floyd; Biggs, Lesley. 2004. "Rethinking the History of Midwifery in Canada." in *Reconceiving Midwifery*, ed. by Ivy Lynn Bourgeault, Cecilia Benoit and Robbie Davis-Floyd, 17-45. Montreal: McGill-Queen's University Press.

⁵³² Bourgeault, Ivy Lynn, Elena Neiterman, and Jane LeBrun. 2011. "Midwives on the Move: Comparing the Requirements for Practice and Integration Contexts for Internationally Educated Midwives in Canada with the U.S., U.K. And Australia." *Midwifery* 27 (3): 368-75; Murray-Davis et al., 2012. "Why Homebirth? A Qualitative Study Exploring Women's Decision Making about Place of Birth in Two Canadian Provinces" *Midwifery*, 28 (5): 576-581."

⁵³³ Canadian Midwives Statistics. 2016. Registered Midwives and Midwifery-led Births.

⁵³⁴ Fleming, Valerie E. M. 1996. "Midwifery in New Zealand: Responding to Changing Times," *Health Care for Women International* 17 (4): 343-359.

⁵³⁵ Katz Rothman, *Recreating Motherhood: Ideology and Technology in a Patriarchal Society*; Wertz and Wertz, *Lying-In: A History of Childbirth in America*.

⁵³⁶ Wertz and Wertz, *Lying-In: A History of Childbirth in America*.77.

black American women. During the 19th and 20th centuries in America, midwives and physicians were in direct competition for clients, not only for the monetary reward but as teaching subjects. The doctors needed the women to birth in the institutions so that they could practice their newly acquired clinical skills. Even immigrant and poor women, previously the territory of the midwife, were desired as patients.⁵³⁷ Doctors had access to the power of the State, unlike the unorganised and disenfranchised midwives. Therefore, they were not only able to control licensing of midwives, they were also able to restrict the midwives practice and impose legal sanctions against them.⁵³⁸ Formal midwifery training did not start in North America until 1848 when Boston Female Medical College was opened. In Utah, Mormon pioneers also started midwifery schools around Salt Lake City in the mid-19th century. Male doctors continued to object to midwifery in America, and within a few decades — by the early 20th century — midwifery almost ceased to exist in the United States as doctors gained almost complete control in childbirth for women from all parts of society.⁵³⁹ The progression of midwifery in Australia and Western Australia will be discussed in Chapter Five.

Choice and Control: Moving Midwifery Forward into the 21st Century

One area of social debate that would have a big impact on the history of midwifery is feminism. During the 1970s, and the second wave of feminism, community midwifery re-emerged in the Western World as part of a social movement devoted to exploring and promoting low technology and woman-centred alternatives to the standard obstetric care. The relationships between UK midwives and women had become strained during the middle of the 20th century, due to the midwives focus on their training, education and professional status which took them away from women's needs.⁵⁴⁰ This became more acute by the 1970s when consumer groups started to form. These consumer groups and the second wave of feminism would have a profound influence on the politics of childbirth.⁵⁴¹

⁵³⁷ Wertz and Wertz, *Lying-In: A History of Childbirth in America*; Katz Rothman, *Recreating Motherhood: Ideology and Technology in a Patriarchal Society*; Katz Rothman, *Giving Birth: Alternatives in Childbirth*; Ehrenreich and English, *Witches, Midwives and Nurses: A History of Women Healers*.

⁵³⁸ Katz Rothman, *In Labour: Women and Power in the Birth Place*.57.

⁵³⁹ Ibid.; Wertz and Wertz, *Lying-In: A History of Childbirth in America*.

⁵⁴⁰ McIntosh, *A Social History of Maternity and Childbirth*.

⁵⁴¹ Ibid.; Kitzinger, *The Politics of Birth*.

During the latter part of the 20th century, the language around maternity care began to change in the UK with the words 'choice', 'control' and 'continuity' being used increasingly to describe what should happen in birth.⁵⁴² Women argued for informed choice and informed consent, to birth where they wanted to and for maternity care to be more individualised, and for the midwife to work autonomously and to her full scope of practice.⁵⁴³

The 1993 UK government report *Changing Childbirth* argued that the medicalisation of birth had gone too far, and for many women the over medicalisation of birth was unnecessary and undesirable.⁵⁴⁴ The language used in *Changing Childbirth* impacted the language used in the Western World to describe maternity care and the debate about how care should be provided and by whom.⁵⁴⁵ Following this review, in the late 20th and early 21st century midwives attempted to re-launch their professional identity and UK midwives reinvented themselves as professionals focusing on normal pregnancy and birth.⁵⁴⁶ The midwives were largely successful in being described as the lead in normal pregnancy and birth. Although there was an increased interest in returning to natural and normal birth, the language of science, technology and risk was still at the forefront of birth and maternity care. The implications of these different ways of looking at birth, risk and safety, technology and appropriate care providers are far reaching and relevant throughout midwifery in the Western World.

Summary

This chapter provided a brief history of the progression of the midwifery profession, with a focus on the UK, as the UK has had the biggest influence on Australian midwifery. The next chapter will provide a history of midwifery in Australia, with a focus on Western Australia therefore providing the historical context of this current study.

⁵⁴² McIntosh, Tania. 2014. "Delivering the Impossible? The Contradiction of Maternity Care Provision," *MIDIRS Midwifery Digest*, 24 (1): 7-12.

⁵⁴³ McIntosh, *A Social History of Maternity and Childbirth*.

⁵⁴⁴ Ibid.; UK Department of Health. 1993. "Changing Childbirth, Parts I & II," London: HMSO.

⁵⁴⁵ McIntosh Tania. 2013. "Changing Childbirth: Consigned to the 'Shelf of History'?" *MIDIRS Midwifery Digest*, 23 (4):415-420; *ibid.*

⁵⁴⁶ McIntosh, *A Social History of Maternity and Childbirth*; Leap and Hunter, *The Midwife's Tale*.

Chapter Five – Midwifery in Western Australia

Chapter Overview

This chapter will discuss a history of midwifery in Australia, with a focus on Western Australia (WA) therefore providing the historical context of this current study. It will discuss the development of midwifery in the context of the invasion of Australia by the British. It will begin by providing an outline of the arrival of the British to Australia in 1788 and the occupation of the British in WA and the development of the Swan River Colony. The history of midwifery in WA will then be presented. Midwifery from 1829-1950 is presented within the periods first described by Australian Sociologist Evan Willis in 1989.⁵⁴⁷ These are: The Pioneer Period (beginning later than Willis described as WA was colonised later) 1829-1880; the Transitional Period 1880-1910; the Takeover Period 1910-1950. For a more in-depth discussion of early midwifery in WA, Briony McKenzie's PhD thesis *Place and Power: A History of Maternity Service Provision in Western Australia, 1829-1950* presents a history of maternity services up to 1950.⁵⁴⁸ The final part of this chapter will focus upon midwifery in WA from 1950-2018.

Invasion and Colonisation of Australia

Australia was invaded by the British in 1788, when the British 'First Fleet' arrived in Botany Bay. Botany Bay was occupied by more than 700 male and female convicts (including nearly two dozen children) and two hundred and fifty guards with some bringing their own wives and children.⁵⁴⁹ John White, Principal Surgeon, was sent on the first Fleet aboard *The Charlotte* to establish the Colonial Medical Service. He had a first assistant surgeon, two other assistant surgeons, one naval surgeon and one convict interested in medicine to assist him. It is doubtful whether they knew much about midwifery.⁵⁵⁰

⁵⁴⁷ Willis, *Medical Dominance*. Willis describes 4 timelines in his book: the evolution of the English midwife until the 1930s; then the Australian midwife is described in three periods as outlined above, although I have used slightly different dates.

⁵⁴⁸ McKenzie, "Place and Power: A History of Maternity Service Provision in Western Australia, 1829-1950".

⁵⁴⁹ Peel, *History of Australia*.26.

⁵⁵⁰ Adcock, et. al. 1984. *With Courage and Devotion: A History of Midwifery in New South Wales*. Wamberal, New South Wales: Anvil Press.22.

On the voyage to Australia, the records from *The Charlotte* indicate that eighteen babies were born, two babies were stillborn and there was one miscarriage.⁵⁵¹ Although there were no midwives recorded amongst the passengers of the First Fleet, it is evident that convict women assisted birthing women during the voyage. For example, Phoebe Norton, who arrived with the First Fleet, assisted at some of the births on the journey.⁵⁵² This practice extended to subsequent convict voyages. Mrs Barnsley, who following a conviction of shoplifting was transported to Australia on *The Lady Juliana* in 1790, acted as midwife on that voyage to assist fellow convicts during their births and continued practising following her arrival in the colony.⁵⁵³

Consequently, the first non-Indigenous midwives in Australia were untrained convict women; they came on the ships bringing the prisoners to Australia and can be described as 'accidental midwives'; assistance in childbirth came from whomever was available at the time.⁵⁵⁴ The 'accidental midwives' expertise in midwifery is unknown but there was no other option for women, but for friends, relatives and neighbours to help each other during birth, thus they became midwives through need rather than vocation. This early colonial situation was followed by what was called the 'Aunt Rubina' period where older married women helped younger women in childbirth.⁵⁵⁵ Throughout the early 1800s untrained or 'lay' midwifery care continued alongside the trained midwives who had begun to arrive as free settlers.⁵⁵⁶ Lesley Potter describes three types of midwives in the early days of occupation in Sydney. The first group were the convict 'accidental' midwives. The second group comprised free migrant women; many were widows with children to support, who would have practised midwifery in their home country. The third group were certified and trained midwives, who had obtained their midwifery qualifications overseas.⁵⁵⁷ These early

⁵⁵¹ Adcock, et. al. *With Courage and Devotion: A History of Midwifery in New South Wales*.14.

⁵⁵² Ibid.

⁵⁵³ Ibid.51.

⁵⁵⁴ Barclay, "A Feminist History of Australian Midwifery from Colonisation until the 1980s."

⁵⁵⁵ Thornton, A. 1972. "The Past in Midwifery Services," *The Australian Nurses Journal*, 1 (9):19-23. Thornton named the 'Aunt Rubina midwives', after her Great-great Aunt.

⁵⁵⁶ Barclay, "A Feminist History of Australian Midwifery from Colonisation until the 1980s."; Grehan, "Heroes or Villains? Midwives, Nurses, and Maternity Care in Mid-Nineteenth Century Australia."

⁵⁵⁷ Potter, Lesley. 2017. *Mistress of Her Profession: Colonial Midwives of Sydney 1788-1901*, New South Wales, Australia: Anchor Books Australia.17.

midwives of Australia, unlike their British and European sisters, lacked organisation, cohesion and consistency.⁵⁵⁸

Settlement of Western Australia

In May 1829 Captain Fremantle of H.M.S. *Challenger* took possession of the western part of Australia, when he landed at Garden Island. He was joined on the 1st June 1829, by Captain James Stirling. This site became known as Fremantle Port. From here the Swan River Colony was established in Western Australia, and unlike the eastern settlements, this was the first colony settled by free settlers—people who chose to travel to Australia and had the means to support themselves— in Australia.

In 1850, twenty-one years after the establishment of the Swan River Colony as a free settlement, Western Australian became a British penal settlement. Convicts had a significant impact on the colony's demographic growth; they contributed a large proportion of the growth in population between 1850 and 1868. All the convicts transported at this time were male, exacerbating the existing imbalance of the sexes. Since occupation by the British the ratio of British male to female colonists was already high; by the 1850s males exceeded females by 2:1.⁵⁵⁹ Some settlers were in favour of female convicts being brought to the colony; however, the misogynistic belief that the female convict was 'morally dubious' compared to her male counterpart was also widely held. For example, in 1854 *The Perth Gazette* stated, "a bad woman as likely to do more mischief than a bad man; a woman must be very bad indeed to get transported".⁵⁶⁰

From 1850 to 1868 assisted free migrants came as part of the transportation arrangements of the British Government. Included in this scheme were women recruited for employment in WA as domestic helpers. Many of these migrant women were from the poor and famine affected British slums and poor houses, the majority illiterate and some female convicts are reported to have arrived within this scheme. Many of the women were

⁵⁵⁸ Summers, ""For I Have Ever So Much More Faith in Her Ability as a Nurse": The Eclipse of The Community Midwife in South Australia 1836-1942"; Davies, "She Did What She Could: A History of the Regulation of Midwifery Practice in Queensland 1859-1912"; Potter, "Weaving the Threads: A Tapestry of Sydney's Colonial Midwives, 1788-1901."

⁵⁵⁹ Appleyard, R.T. 1981. "Western Australia: Economic and Democratic Growth, 1850-1914," in *A New History of Western Australia*. ed. C.T. Stannage. 211-236. Nedlands, Western Australia: University of Western Australia Press.

⁵⁶⁰ *The Perth Gazette*. 1854. "Female Convicts." March 17, 1854.

not told that they would be emigrating to a penal colony or that the distance to the other colonies in Australia was so vast.⁵⁶¹

The Pioneer Period: Midwives of the New Colony 1829-1880. 'Neighbouring, Aunt Rubinas' or Nothing?

Stirling and his men arrived on *The Parmelia* with their wives and families; about sixty staff and settlers as well as stores and equipment. Some babies were born at sea and the captain's wife, Mrs Ellen Stirling, was among the women to give birth on the voyage. Anecdotal evidence indicates that many of the new arrivals were pregnant, therefore midwifery care was needed from the moment the settlers arrived in the Swan River Colony.⁵⁶² Compared to the services that were available in Britain, the pioneer women had to 'make do' with help from whomever could provide it and if no help was forthcoming, they had to birth alone. Some historians assert that medical men provided assistance in birth from the beginning of the settlement; however, there were few of them and their midwifery skills were questionable.⁵⁶³ As highlighted in the previous chapter, in Europe by the mid-1800s medical men had started to become involved in the provision of midwifery; however, it was still not a universally accepted practice.

Like much of women's history of this time, there is little documented evidence of early colonial midwives. There are no surviving documents from the midwives themselves from this era. Other researchers have also found a lack of documents such as personal records, diaries and letters, not only from midwives but other women in Australia.⁵⁶⁴ Many of the working-class women would have had minimal literacy skills. There are some records that have survived, however, in the diaries and letters of the middle and upper-class pioneer women and from the histories of pioneering families. These records illustrate that in the early days of the colony as described above, women had help in childbirth from anyone who was available at the time. Birth took place in the home, as was the norm in this

⁵⁶¹ Stannage, C.T. 1979. *The People of Perth: A Social History of Western Australia's Capital City*, Perth: Carroll's for Perth City Council.

⁵⁶² Ibid.

⁵⁶³ Cohen, B. C. 1975. *A History of Medicine in Western Australia*. Nedlands: University of Western Australia; Forster, Frank M. C. 1967. *Progress in Obstetrics and Gynaecology in Australia*, Sydney, Australia: John Sands Pty. Ltd.14.

⁵⁶⁴ Potter, "Weaving the Threads: A Tapestry of Sydney's Colonial Midwives, 1788-1901"; Summers, ""For I Have Ever So Much More Faith in Her Ability as a Nurse": The Eclipse of The. Community Midwife in South Australia 1836-1942'."

era. These case studies will be used to paint a picture of the early colonial days of childbirth and midwifery for the women of Western Australia.

Using the diaries of Georgiana Molloy, an early pioneer woman and amateur botanist, Alexandra Hasluck documented Georgiana's life in *Portrait with Background*.⁵⁶⁵ Georgiana arrived in Western Australia with her husband, Captain John Molloy, on 12th of March 1830, aboard *The Warrior* which dropped its anchor in Gages Road, Fremantle Harbour. The next day the passengers landed at Fremantle and had their first sight of the port of the colony. Unaccustomed to the heat, Georgiana, pregnant with her first child, did not cope well and on the 29 April 1830, Georgiana and her husband again set sail to journey south to Cape Leeuwin. On the evening of Sunday 2 May, *The Emily Taylor* dropped anchor in Flinders Bay at the mouth of an inlet near Augusta and the passengers disembarked to the tents that had been erected on the shore. Hasluck paints a vivid picture of the circumstances of Georgiana's first birth:

On a day when the shafts of rain were needling the tent, she asked Molloy to stay with her. There is nothing to tell what arrangements they had made for a midwife — there may have been one amongst the servants of the various establishments — for a doctor there was none. It may have been Anne Dawson who helped. She had lost her first child on the voyage out. On a day when it was so wet that an umbrella had to be held over her as she lay on the rough bed, Georgina's daughter was born. Not many days later it died.⁵⁶⁶

It was nearly 3 years before Georgina wrote about the experience in a letter to her friend, Helen Storey, who had recently lost a child herself. Georgina's letter states:

I was indeed grieved, my dear Nelly, to hear of your poor infant's demise... I could truly sympathise with you, for language refuses to utter what I experienced when mine died in my arms in this dreary land, with no one but Molloy near me. O, I have gone through much and more than I would ever suffer anyone to do again. I fear — I need not say fear — I know, I have not made the use of these afflictions that God designed. It was so hard I could not see it was in love. I thought I might have had one little bright object left me to Solace all the hardships and privations I endured and have still to go through. It was wicked, and I am not now thoroughly at peace.⁵⁶⁷

⁵⁶⁵ Hasluck, Alexandra. 2002. *Georgiana Molloy: Portrait with a Background*. Fremantle: Fremantle Arts Centre.

⁵⁶⁶ *Ibid.* 99.

⁵⁶⁷ *Ibid.* 99.

Many historians use the term nurse, nurse midwife and midwifery nurse interchangeably, attendants at births were also often referred to as 'nurses' and this has contributed to the lack of awareness of the role of the independent midwife in Western Australia. Although it was not uncommon for babies to die in other countries such as Britain at that time, the conditions the Australian pioneer women were living in and the lack of skilled support during childbirth, contributed to the high level of infant mortality in the new colony. Georgiana Molloy stayed in the south west of Australia, initially at Augusta and then moving to Bussleton.⁵⁶⁸ She had more children, her last child (her seventh pregnancy) being born on the 7 December 1842. During this birth the doctor was sent for, although, as reported by their friend the Anglican Minister John Wollaston, "the doctor from Vasse was drunk"⁵⁶⁹ and therefore did not attend. According to Hasluck, "Soon after the birth she was seized with shivering and other dangerous symptoms"⁵⁷⁰ and help was sent to get another doctor. Two other doctors in the area were engaged in a difficult birth that they could not leave, and another doctor could not to be found, but eventually a doctor was located the next day and he came to see Georgiana. Although she initially survived, she did not recover and died three months later on the 8 of April 1842.⁵⁷¹

The letters of Eliza and Thomas Brown also illustrate the life of early settlers in WA. In a letter, dated March 21 1841, Eliza described how her family and all passengers disembarked the ship, and how a woman was left aboard to attend to Mrs Forster, the chaplain's wife in her approaching birth: "Ann was left behind to attend on Mrs Forster the chaplain's wife who is in a very sad state of health."⁵⁷² She will remain to nurse her in her approaching confinement and join us when the ship has discharged cargo which will take three or four weeks yet to accomplish."⁵⁷³ The letter does not state whether Ann was in fact a midwife or acting in the 'Aunt Rubina' role and supporting Mrs Forster.⁵⁷⁴

Although there was a high infant mortality rate, this was more likely due to the health of the pioneer women and their living conditions, which will be discussed later in this chapter, rather than problems associated with the actual birth. Childbirth itself was

⁵⁶⁸ Hasluck, *Georgiana Molloy: Portrait with a Background*.

⁵⁶⁹ *Ibid.*309.

⁵⁷⁰ *Ibid.*309.

⁵⁷¹ *Ibid.*310.

⁵⁷² Cowan, Peter. 1977. *A Faithful Picture: The Letters of Eliza and Thomas Brown at York in the Swan River Colony 1841-1852*. Fremantle, Western Australia: Fremantle Arts Centre Express.19.

⁵⁷³ *Ibid.*19.

⁵⁷⁴ Many historians use the term nurse, nurse midwife and midwifery nurse interchangeably, attendants at births were also often referred to as 'nurses'.

generally uneventful and considered a part of everyday life in the colony. Occasionally complications did arise during the birth. Josephine Prinsep gave birth in June 1869, the birth was recorded in detail by her husband, Henry Charles Prinsep, in his diary:

25th of May 1869. Josephine awoke much pain in her side so we got in readiness for coming events — sent Lutta with the trap for Mrs Jessie Gardiner, who arrived around midday. Mrs B (Bussell) got the room ready but she (J) felt better towards evening.

30th of May. Josephine again much pain in her side. Mrs Gardiner sent for again and managed to relieve her towards nightfall...

17th of June. About one in the morning J awoke me to go to her mother as she was suffering so much.... I then got up and called her mamma... We lighted a fire and Josephine went to bed again, her mother and Catherine (the maid) doing what they could to soothe her. I sent Lutta for Mrs Gardiner at once and then lay down and fell fast asleep. During my sleep Josephine's pain increased till my poor darling could scarcely bear it, till about 5 o'clock and then I awoke and heard her wailing — which made me so miserably unhappy. But I was not kept so long for on the third fit of pain about a quarter of an hour after I woke, I heard Josephine's cries replaced by those of a much smaller pair of lungs, which evidently had not had much practice and after a few minutes I heard my dear wife's cheerful voice telling me her trials were over. The baby did not cry much and an hour after I was by my dear one's side and had seen such a sweet, clean, perfect, little baby's face in her grandmother's lap.⁵⁷⁵

Unfortunately, the birth became difficult when the delivery of the placenta was delayed, and the doctor was sent for.⁵⁷⁶ This evidence again highlights that in general midwives attended most births in the early years of the colony and doctors were only sent for if there were complications:

We were all so happy, but after Mrs Gardner's arrival, about 7, Mrs B came to me with tears in her eyes to say all had not yet taken place that should and that no time more should be allowed. We knew we were powerless to assist refusing nature and were agonised. I sent Mark Lyons off instantly to Bunbury and Chas. Neeschen to Brookhampton to catch Lovegrove wherever he might be (the doctor). We consulted Nicholson's cyclopaedia which told us what had to be done and how but did not feel equal to the task.... Lovegrove with the greatest kindness and speed readout from Bunbury in 50 minutes which Mark had reached in 55 — 10 miles much mud. In a few minutes he had put all things to rights and made tears of

⁵⁷⁵ *Westralian Voices*. 1979. Nedlands, WA: University of Western Australia Press.242.

⁵⁷⁶ *Ibid*.

joy run down our cheeks....Josephine lay as calm and happy with the little sweet by her side.⁵⁷⁷

Josephine Prinsep was fortunate to have skilled midwifery attendance during her birth and when things did not go to plan and more help was needed, skilled and safe medical care was also available. This was not the case for many women, both rich and poor. In particular, the women who lived in remote areas of Western Australia had no skilled assistance, and gave birth either alone, or with assistance from Indigenous women, or neighbouring women.

Medical Doctors of the Colony 1829-1880

Some historians have argued that from the beginning of European occupation in Australia, childbirth attendance was predominantly by medical doctors;⁵⁷⁸ however, the events above highlight that, contrary to this belief, the doctors were not called to all births, and even when they were called they did not always attend. In these cases, the doctor was sent for only once it became apparent that the birth was becoming difficult. It is also worth noting that the skills that these doctors possessed would have been vastly different from our expectations today. Few of the colony's doctors had 'recognised' qualifications.⁵⁷⁹ In Britain until the introduction of the *Medical Registration Act (1858)*,⁵⁸⁰ British doctors were not registered, and only since 1815, were British doctors required to follow any recognised course of study or apprenticeship.⁵⁸¹ Medical registration laws were not passed in Western Australia until 1870.⁵⁸² The first *Medical Register* was published in the Government Gazette on 20th April 1870. Seventeen doctors were listed; of these, only ten were documented as having any formal qualifications, the remaining seven were able to register as medical practitioners due to their long and proven service in the profession.⁵⁸³ The population census of 31st March 1870 recorded a total population of 24,785 European settlers, of

⁵⁷⁷ *Westralian Voices*.243.

⁵⁷⁸ Cohen, A *History of Medicine in Western Australia*; Forster, *Progress in Obstetrics and Gynaecology in Australia*.

⁵⁷⁹ Martyr, Philippa. 2002. *Paradise of Quacks: An Alternative History of Medicine in Australia*, Sydney: Macleay.

⁵⁸⁰ *Medical Registration Act 1858* (UK).

⁵⁸¹ Hansford-Miller, Frank. 1995. *A History of Medicine in Western Australia 1829-1870: Volume Nine. Medical Treatment in Early Colonial Western Australia*, Perth, Western Australia: ABCADO Publishers.13.

⁵⁸² *Ibid*.14.

⁵⁸³ *Westralian Voices*.231-232.

which 9410 were female;⁵⁸⁴ therefore, it is unlikely that doctors attended many births in the colony. The small number of doctors in the colony also had more than their fair share of ill fortune and 'bad luck'. Many died through disease, accidents and other causes, reducing their number further.⁵⁸⁵

It is evident that some settlers had doubts about the quality of medical care offered by practitioners in the colony. Louisa Clifton settled at Australind, south of Perth, with her husband in 1841.⁵⁸⁶ Louise was concerned about the lack of medical care and the level of skills of the medical men in her community. She wrote that she had observed the local doctor, Dr Carpenter, on the voyage to Australia and was deeply concerned by his lack of hygiene, particularly the state of his hands, and she found him lacking in medical skills and unprofessional.⁵⁸⁷ Following their settlement, Louisa continued to have concerns about the doctor. After a young woman, Mary McGlashen, died, Louisa was highly critical of the doctor's involvement in her care as she did not believe the woman received proper medical treatment. She blamed Dr Carpenter for McGlashen's death, because he "said one thing, then another" in his diagnosis.⁵⁸⁸ Louisa repeated what she said many times before that the poor women deserved better than the incompetent doctor.⁵⁸⁹

Living Conditions and the Impact of Health on Childbearing Women

According to medical historian Frank Hansford Miller (1990)⁵⁹⁰, Western Australia was not invaded to prevent the French from colonising it as other historians claim, but for two main reasons. The first reason was for the supposedly healthy climate and disease-free country and the second reason put forward by Hansford Miller, was that Captain Stirling himself wanted to settle in Western Australia.⁵⁹¹ Therefore, it is argued that many of the first colonists had chosen to resettle in Western Australia to escape the disease and

⁵⁸⁴ Hansford-Miller, *A History of Medicine in Western Australia 1829-1870: Volume Nine. Medical Treatment in Early Colonial Western Australia*.17.

⁵⁸⁵ Hansford-Miller, Frank. 1990. *A History of Medicine in Western Australia 1829-1870: Volume Three. The Grim Reality of Life for the Early English Settlers of Western Australia 1829-1850*, Perth, Western Australia: ABCADO Publishers.

⁵⁸⁶ Russo, George. 1995. *A Friend Indeed: Louisa Clifton of Australind WA*. Perth, WA: Vanguard Press.

⁵⁸⁷ Ibid.127.

⁵⁸⁸ Ibid.196.

⁵⁸⁹ Ibid.197.

⁵⁹⁰ Hansford-Miller, *A History of Medicine in Western Australia 1829-1870: Volume Three. The Grim Reality of Life for the Early English Settlers of Western Australia 1829-1850*.

⁵⁹¹ Ibid.7.

overcrowding in the cities of England, although unlike the settlement of South Australia, 'good health' was not a requirement for emigration.⁵⁹²

The first colonists in Western Australia were the affluent middle to upper-class, as only those with sufficient funds would have been able to sustain themselves during the early days of the colony. Even though medical men as birth attendants were becoming more popular with the wealthy in Britain by the mid-1800s, for most women in their home countries, birth would have been at home, attended by a midwife. It must have been unexpected for the women to realise that, not only were there no midwives, but there were also few skilled doctors in the community. Initially, many of the colonists lacked even basic necessities such as adequate housing and access to fresh water. Most people were unaccustomed to the harsh Australian climate. Poor health was exacerbated by poor shelter, inadequate sanitation, irregular food and water supplies including a restricted diet lacking in fresh fruit and vegetables— at least until adequate food supplies could be grown. Isolation from friends and family, particularly for families that were living in the rural and remote areas would also have been challenging. The distances between settlements in Western Australia were vast, and women may have spent many months alone on farms and cattle stations. Even in more established communities, distances were not easily travelled, due to the marshes, rivers and inhospitable land.

The climate did not provide the disease-free environment that the settlers had hoped for, in fact the extremes of heat and cold contributed to ailments. Illness caused by malnutrition, and diseases such as scurvy, tuberculosis, cholera, typhus, typhoid, scarlet fever and dysentery were present in the colony. However, as medical statistics were not recorded it is not easy to assert how prevalent they were in the early days of the colony.⁵⁹³ Ophthalmia —the collective term used for eye problems— was widespread in the colony. Ann Whatley, the wife of Dr Whatley, documented the high incidence of the disease in her diary. An entry in March 1830 states "John is gone up the river to see some patient. So many are now suffering from scurvy and ophthalmia that hardly a day passes without his being obliged to take journey."⁵⁹⁴ The earliest statistical data available for Western Australia are in the annual *Blue Books* produced by the colonial authorities. The *Blue Books*

⁵⁹² Hansford-Miller, *A History of Medicine in Western Australia 1829-1870: Volume Three. The Grim Reality of Life for the Early English Settlers of Western Australia 1829-1850*.15.

⁵⁹³ Hansford-Miller, Frank. 1994. *A History of Medicine in Western Australia 1829-1870: Volume Eight. Disease in Early Colonial Western Australia*, Perth, Western Australia: ABCADO, Publishers.

⁵⁹⁴ *Ibid.*16.

commenced in 1834 and includes a list of the civil establishment of the colony as well as various statistics. The *Blue Books* list pulmonary Tuberculosis as the leading cause of death from 1860 to 1868.⁵⁹⁵

As the population expanded sanitation became an increasing problem for the residents of the colony, particularly the poor, with diseases such as typhoid, dysentery and gastroenteritis rife in their communities. From the 1860s the lack of sanitary arrangements was highlighted by the Colonial surgeons, who saw an association between the increase in disease and the lack of clean water and the inadequate disposal of waste and sewerage. In 1874, Dr Shaw, acting as Colonial Surgeon, reported:

There is plenty of water to be obtained in Perth by sinking wells; it is more or less pure, but sometimes of an opalescent or muddy colour, nauseous taste, and putrescent smell; this is no doubt to be ascribed in a great measure to the absence of any kind of sanitary precautions, in preventing the contamination of the water by soakage from cesspools into the wells; often indeed this occurrence is favoured by the construction of cesspits close to and on higher ground than the well... a few yards behind each house is a closet, with an open unbricked cesspit, and a few yards from this the well, usually about twelve feet deep, from which water is drawn for drinking and all other purposes. The cesspits are sometimes emptied...⁵⁹⁶

Dr Waylen was Colonial Surgeon from 1872-1875. In 1875 he described the areas worst afflicted by disease, the low-lying portions of the city inhabited by the poorer residents:

...who live in cottages built with little regard for sanitation. There is an often a total absence of ventilation, as well as of 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.⁵⁹⁷

In March 1876, *The Western Australian Times* Health Report documents the colonial Surgeons review of 1875 and states that "our wells are nearly all more or less

⁵⁹⁵ *Western Australian Blue Books Years 1860-1868*. Battye Library. Accessed in 2016.

⁵⁹⁶ Shaw, S. C. 1978. Annual Report of the Colonial Surgeon, 1874, cited in Su-Jane Hunt and Geoffrey Hunt, "Cleansing the Dunghill: Water Supply and Sanitation in Perth 1878-1912," *Studies in Western Australian History* 2 (March): 1-17.

⁵⁹⁷ Waylen, Alfred. 1875. "Annual Report of the Colonial Surgeon: "Correspondence and Reports upon the Sanitary Conditions of the Colony".10.

contaminated".⁵⁹⁸ Despite these concerns it was not until the end of the nineteenth century that conditions improved.⁵⁹⁹

Midwives as Working Women and the Arrival of Overseas 'Trained' Midwives

The first census for the Swan River Colony was completed in 1859 and although its records employment, it only records males; therefore, there are no recorded figures of midwives working within the colony until much later when the *Australian Post Office Directory* was established in 1893. As the population expanded more midwives were available in the colony, by the 1860s women had begun to earn a living as midwives, advertising their services in the newspapers. In 1863, Mrs Gaunt advertised her services in *The Perth Gazette*, to inform the ladies of Perth that she intended "to practice the office of a midwife in the city of Perth".⁶⁰⁰ The advertisement also highlighted her association with medical doctors as a reference for her skills as a midwife.⁶⁰¹ Another advertisement in the same year, published the services of a medically trained midwife, Mrs McNee, "A Matriculated Nurse and Midwife, from the Royal Maternity and Inlying Hospital, Edinburgh, pupil of Alexander Keiller M.D".⁶⁰² A third midwife, Anne Louisa McCaffrey, advertised her services to the women of Perth as a "fit and proper person to act as a midwife".⁶⁰³ McCaffrey also detailed her experience and training — four years of working in a lying in hospital and under the guidance and supervision of two medical doctors—attempting to create a distinction between the untrained midwife and the trained midwife and to highlight her expertise.⁶⁰⁴

In paying for newspaper adverts, all three midwives demonstrated their attempts to differentiate between the 'accidental' and 'Aunt Rubina' midwives and the more affluent and professional midwives. Advertising their services in a newspaper had associated costs; therefore, it indicates that these midwives had the funds to promote themselves and their midwifery services. They were advertising their services to women who could afford to buy and read the newspapers, and who were willing to pay for attendance at their births, unlike

⁵⁹⁸ *The Western Australian Times*, "Health Report."

⁵⁹⁹ Hunt, Su-Jane, and Geoffrey Hunt. 1978. "Cleansing the Dunghill: Water Supply and Sanitation in Perth 1878-1912." *Studies in Western Australian History*, 2 (March): 1-17.

⁶⁰⁰ *The Perth Gazette*. 1863. "Mrs Gaunt Midwifery Services." May 8, 1863.1.

⁶⁰¹ *Ibid.*

⁶⁰² *The Perth Gazette*. 1863. "Mrs Mcnee". May 29, 1863.2.

⁶⁰³ McCaffrey, Anne Louisa. 1863. *The Inquirer and Commercial News*, May 13, 1863.

⁶⁰⁴ *Ibid.*

the reciprocal 'neighbouring' described in the letters and diaries (discussed earlier in this chapter), which would not usually have a fee associated with the care provided. The apparent need for these midwives to promote their association and training with medical doctors highlights the changing society and expectations of care in childbirth, and again the type of women that the midwives were attempting to attract. These three women were the only midwives who advertised their services in the press during the mid-1800s in Western Australia, with advertisements appearing in newspapers throughout the 1860s and into the 1870s. There would be no need for constant advertisements to maintain a clientele, however, as midwifery was often a 'word of mouth' profession. Midwives would not need to continually advertise for clients, as once the midwife was established within the community, the women knew where to find her. This is demonstrated by the advertisements that Mrs Gaunt placed in *The Inquirer and Commercial News* in 1863 and 1865 to inform women that she had moved residence.⁶⁰⁵

With the increase in population and social changes in Perth, benevolent charities were needed. The first of these was known as 'The Servant Home', designed to provide a refuge for destitute single women. Within a few years the Servants Home became known as the 'Poor House' and became one of the first lying-in homes in WA although this was not the intention of its establishment.⁶⁰⁶ Many women did not have the money to pay for care during childbirth, and it appears that, where possible, they sought help from the Poor House, with the risk of being turned away. Concerns about the 'wrong' sort of women seeking the assistance of the Poor House existed from the beginning. In 1856, the Immigration Officer, Mr Alfred Durlacher, wrote to the Governor regarding the use of the Poor House: "if every woman who pleads poverty or inability to work be admitted into the Poor House in Murray Street without regards to character, the establishment will soon not only be a refuge for the honest and unfortunate, but a Magdalen and a lying in hospital".⁶⁰⁷ In 1864, John Stone, the officer in charge of the Poor House, detailed concerns about women seeking to be admitted to the Poor House to give birth. He stated in a letter to the Colonial Secretary that, "A woman named... had applied for admission into the Poor House for a short time, and from the inquiries I have made, I have ascertained that she seeks

⁶⁰⁵ *The Inquirer and Commercial News*. 1863. "Mrs Gaunt House Move Advert" December 23, 1863; *The Inquirer and Commercial News*. 1865. "Mrs Gaunt House Move", December 13, 1865.

⁶⁰⁶ Hobbs, *But Westward Look: Nursing in Western Australia 1829-1979.4*; Flanagan, "Lying-in (or Maternity) Homes in Western Australia from About 1860-1960,"; *Westralian Voices*.

⁶⁰⁷ "Mr Alfred Durlacher, Colonial Secretary's Office Inward Correspondence," (State Record of Western Australia). Magdalen is a term used to describe a 'fallen' woman or prostitute, it comes from the reformed prostitute, Mary Magdalen, in the Bible.

admission for the purpose of being properly attended to during her confinement shortly expected...".⁶⁰⁸ Rather than admit her to the Poor House, Stone sought "the approval of His Excellency, if I direct the Poor House Midwife, Mrs Gaunt, to attend the woman at her own house, which is at no doubt all that is required; or, on the other hand, if I'll inform her that no assistance can be given her by the government".⁶⁰⁹

In the colony, having a child out of wedlock was deemed shameful. Poor single women with no family or means to support themselves, may have felt they had no other option than to resort to infanticide. Multiple cases of this are recorded. In July 1840, a young woman was charged with "wilful murder" of her "illegitimate child"⁶¹⁰ and another woman Catherine Kelly, was charged and brought to trial for "wilfully murdering her newly born male child on 18 September 1862".⁶¹¹ Kelly had given birth unaided in the lavatory of the Poor House and the child had been found in the pit underneath the lavatory. She was found not guilty, as it was difficult to prove that the infant was wilfully killed.⁶¹² By the middle of the nineteenth century the lesser charge of 'concealment of birth' was more likely, if a woman was charged regarding the death of her infant. Mary Allen in 1859 and Louisa Lund in 1867 were both charged and found guilty of concealment of birth.⁶¹³

As the population of the colony expanded there were not enough trained midwives or doctors to attend all births; therefore, the empirically trained midwives and the Aunt Rubinas continued to provide midwifery along with the trained midwives until the early twentieth century. The Annual Report of the Colonial Surgeon for the year 1875 details how health and sanitation in the colony was improving.⁶¹⁴ The death and birth rates for the year 1875 were reported as; registered births, seven hundred and sixty; registered deaths, four hundred and seventy-three. Therefore, the death rate was recorded as seventeen in every thousand. Of these deaths, ninety-six were of infants under the age of one and sixty-five of children aged one to five.⁶¹⁵ It is worth noting that it is unlikely that all deaths and births were recorded or registered. The Health Report also highlights the "difficulty in procuring

⁶⁰⁸ Daniels, Kay and Mary Murnane, 1980. "Destitute Women and Benevolence," in *Uphill All the Way: A Documentary History of Women in Australia*. Queensland: University Of Queensland Press.

⁶⁰⁹ Ibid.

⁶¹⁰ *Westralian Voices*.314.

⁶¹¹ Ibid.78.

⁶¹² Ibid.78.

⁶¹³ *The Perth Gazette and Independent Journal of Politics and News*. 1859. "Infanticide, Mary Allen.", September 23, 1859; *Westralian Voices*.315.

⁶¹⁴ *Western Australian Times, The*, "Health Report."

⁶¹⁵ Ibid.

medical aid in widely scattered district"⁶¹⁶. The high infant mortality was appropriately highlighted as an area for concern; however, this was to have repercussions on midwives and their practice in the following decades.

The Transitional Period 1880-1910

The period from the late nineteenth century into the early twentieth century is described by Willis (1989) as the "Transitional Era". During this period nursing began to evolve as an occupation and the medical profession gained power and influence within the State and the community.⁶¹⁷ In Australia, both these events and the changes in the socio-political environment led to the absorption of midwifery into nursing and the associated subordination to medicine.⁶¹⁸ This enabled nursing and medicine to gain increased control over midwifery and led to legislation which placed restrictions on midwives' practice, leading to the loss of autonomous midwifery practice and ultimately their distinct role as a separate to nursing. The subordination of midwifery was achieved in Australia, as unlike the British and European midwives, the Australian midwife did not have a strong foundation and had very little professional credibility. Of particular relevance to the ease in which the subordination of midwifery was achieved, is the gender and class divides between medicine on the one hand, and nursing and midwifery on the other. The majority of independent midwives in Australia at the end of the nineteenth century were still working-class and all were women.

Changes in WA and the Development of the Hospitals

In 1890 a government was formed in WA, and a parliament replaced the existing system of Governor and Council. Although the Governor remained as head of state, WA had its first premier, Mr John Forrest. In January 1901 the federation of the 'Commonwealth of Australia' was formed and the colonies became states within the Commonwealth. This led to the formation of both State and Commonwealth parliaments.⁶¹⁹

With the discovery of gold and the resulting 'gold rush' of the late 1880s and 1890s, another major increase in the population occurred in WA; although the increase was mainly

⁶¹⁶ *Western Australian Times, The*, "Health Report."

⁶¹⁷ Willis, *Medical Dominance*.

⁶¹⁸ *Ibid*.

⁶¹⁹ Appleyard, "Western Australia: Economic and Demographic Growth, 1850-1914."

due to the influx of gold prospectors, some men brought their families with them. In the early 1890s gold was found about six hundred miles east of Perth which led to the establishment of the gold towns of Kalgoorlie and Coolgardie. The population quadrupled in WA from 49,782 in 1882 to 179,967 in 1900. This substantial and rapid change in population and the associated poor living conditions led to widespread disease and poverty. Housing was inadequate, sanitation poor and clean water was scarce. Typhoid was again becoming widespread.⁶²⁰

The worsening public health and poor living conditions, particularly in the goldfields, led to government involvement in sanitation and public health issues and the establishment of public hospitals. Turner and Samson argue that the hospital has no continuous historical evolution, as the form the hospital takes, is reliant on the society it is established in.⁶²¹ In general, pre-industrial hospitals were institutions for the poor, the insane and the destitute. The patients had a variety of illnesses, not treated on a specialist basis, as the aim was not cure but treatment of symptoms.⁶²² In the late 1800s more benevolent societies started to arrive in WA. In 1891, The Salvation Army established its headquarters in Murray Street, Perth and started to aid the poor and disadvantaged of WA, including in the Goldfields region. Other religious benevolent groups, the Sisters of the People and the Sisters of the Order of St John of God also provided nursing care throughout WA establishing hospitals in the Goldfields and Perth.⁶²³

Hospitals and Lying-in Houses

By the 1880s throughout Australia, rather than just the reciprocal 'neighbouring' during childbirth, midwives working within their communities were able to earn a living from attending births. As previously discussed in Chapters Two and Four, the lying-in house had become popular in the eighteenth century in Britain, where its aim was to provide poor women with somewhere to go to birth, and then stay for a period of time following the birth to regain their strength.⁶²⁴ Throughout the nineteenth and early twentieth centuries

⁶²⁰ Appleyard, "Western Australia: Economic and Demographic Growth, 1850-1914."218.

⁶²¹ Turner, B. S. and C. Samson. 1995. "Medical Bureaucracies: The Hospital, the Clinic and Modern Society," in *Medical Power and Social Knowledge*, ed. B. S. Turner, London: Sage Publications.166.

⁶²² *Ibid.*160.

⁶²³ Hobbs, *But Westward Look: Nursing in Western Australia 1829-1979*.

⁶²⁴ Cody, "Living and Dying in Georgian London's Lying-Hospitals"; Versluysen, "Midwives, Medical Men and 'Poor Women Labouring of Child': Lying-in Hospitals in Eighteenth-Century London."

in Australia, the majority of women still gave birth at home; however, the lying-in house was another option for some women. Increasingly, towards the end of the nineteenth century some midwives began to offer this service. Therefore, the midwives, rather than just attending women at home, would also provide midwifery care to women in their own residence; this was the beginning of the Australian lying-in homes and 'private maternity hospitals'. By 1910 there were advertisements for maternity homes and a medical section in most newspapers. As previously seen, some of the midwives who advertised, were clear to distinguish themselves from untrained midwives, listing qualifications, experience and association with medical doctors. These hospitals and lying in homes were owned and operated by the autonomous and independent midwives. However, moving into the 20th century they became larger and more medically controlled.⁶²⁵

Baby Farming

In his 1875 annual report, the Colonial Surgeon, Dr Waylen, considered the infant death rate in WA to be very high.⁶²⁶ In 1875, the infant death rate was 114 deaths per 1000 births which was less than the infant death rate in England during the same period which was 160 deaths per 1000 births.⁶²⁷ Dr Waylen considered the lack of formal training of birth attendants to be one of the causes of the high infant mortality rate⁶²⁸. At this point in time maternal and infant mortality was higher in Western Australia than the other states.⁶²⁹ Maternal mortality was recorded as one mother in every two hundred and seven births: greater infant mortality occurred in babies born to unmarried mothers and that accounted for 10% of births in 1904. However, it was not until 1907 when a woman, Mrs Alice Mitchell, was found guilty of manslaughter after a baby died in her care, that government passed legislation to regulate the baby farming industry⁶³⁰. Baby farming was a term used in the nineteenth century to describe the fostering of an infant for a fee.

Following this high-profile case of baby farming, *The State Children Act* was passed in 1907 and lying-in houses now had to be registered but there was still no official midwifery

⁶²⁵ McKenzie, "Place and Power: A History of Maternity Service Provision in Western Australia, 1829-1950." For more in depth history of lying in homes see Chapter 4; Flanagan, "Lying-in (or Maternity) Homes in Western Australia from About 1860-1960."

⁶²⁶ *Western Australian Times, The*, "Health Report."

⁶²⁷ Donnison, *Midwives and Medical Men: A History of Inter-Professional Rivalries and Women's Rights*.85.

⁶²⁸ *Western Australian Times, The*, "Health Report."

⁶²⁹ McKenzie, "Place and Power: A History of Maternity Service Provision in Western Australia, 1829-1950."67-69.

⁶³⁰ *Western Australian Times, The*. 1907. Baby Farming. April 16, 1907.

training or registration of midwives in Western Australia. Midwifery training had commenced in Australia in the late 1800s in other states; however, the demand for midwifery care was higher than the number of trained midwives, so untrained midwives continued to provide care to women in all states.

The Hierarchy of the Professions

The status of medicine in the nineteenth century was low, therefore to ensure that medicine became a high-status profession it was important for medical doctors to be autonomous and differentiate themselves from the alternative practitioner or 'quack'.⁶³¹ Part of the way in which a high-level status was achieved was by becoming a 'profession'. Many definitions of profession exist, however, the major distinction between a profession and an occupation is the legitimate and organised autonomy accepted by a profession and the recognition of specialised knowledge and skills obtained through formal and supervised education and training. This autonomy ensures that the profession has an occupational monopoly and dominance within the division of labour.⁶³² Furthermore, this autonomy and control are based on certain foundations; esoteric knowledge and the recognition and protection of that knowledge by the State. Therefore, the close links formed between medicine and the State ensure this position is maintained and prevents other 'lesser' professions from achieving the same status.⁶³³ According to Willis, the medical profession dominates the health division of labour; economically, socially and intellectually.⁶³⁴ Medical dominance is a key feature in the production, social structure and organisation of health care in Australia today and was achieved by the medical profession's autonomy and ability to self-govern itself. Historically medicine has also been able to define the conditions under which it will recognise and legitimise other health occupations such as nursing and midwifery. Medicine has also gained the right to deny the legitimacy of some health occupations to ensure that medicine remains dominant.⁶³⁵

⁶³¹ Willis, *Medical Dominance*; Martyr, *Paradise of Quacks: An Alternative History of Medicine in Australia*.

⁶³² Freidson, E. 1977. "The Futures of Professionalisation," in *Health and the Division of Labour*, ed. M. Stacey, et al., London: Croom Helm.

⁶³³ *Ibid.*; Freidson, E. 1970. *Professional Dominance: The Social Structure of Medical Care*, Chicago: Aldine.

⁶³⁴ Willis, *Medical Dominance*.

⁶³⁵ Martyr, *Paradise of Quacks: An Alternative History of Medicine in Australia*; Willis, *Medical Dominance*.

Since the late 1830s a register of doctors had existed in New South Wales and Port Phillip (as Melbourne was then known) when the first legislation was passed, *An act to define the qualifications of medical Witnesses at coroner's inquests and inquiries held before justices of Peace in the Colony of New South Wales 1838*.⁶³⁶ This Act provided a single register for doctors licensed in Britain. The *Medical Act* was introduced in England in 1858 and, in the following years, legislation was introduced into Australia based on this Act. In 1862 the Victorian Government passed the first *Medical Practitioners Act*, followed in 1865 with *the Medical Act of 1865*.⁶³⁷ These Acts provided registration for all legally qualified doctors. The medical profession continued to lobby the Victorian government to add legislation to the 1865 Act to ensure that unregistered practitioners could not practice, thereby ensuring they eliminated any competition. However, this amendment was rejected by the Victorian Government allowing unregistered and unqualified practitioners, such as the female midwives, to continue to practise, providing they did not call themselves doctors. Doctors also unsuccessfully petitioned the government in other states to restrict non-medical practitioners from practising.⁶³⁸ The inability of the medical profession to eliminate unregistered practitioners resulted in them attempting to secure political and legislative advancements for their profession.

Willis argues that once the medical profession had achieved dominance in the division of labour in health, the doctors were placed at a political and social advantage; so, dominance, through their involvement with regulation and legislation, continued in Australian society leading to the enhanced status of the doctor and the power that position entailed.⁶³⁹ This status combined with the advancement of 'scientific knowledge' such as the discovery of anaesthetics in the 1840s and antiseptics in the 1870s led to a new era of medicine. Diseases were treated effectively, and surgery was being conducted safely. In Australia, the medical profession also benefitted from the improvement in public health and sanitation. The introduction of government controlled public health schemes and the implementation of safe sewerage disposal led to general improvements in health and the

⁶³⁶ Lewis, Milton J. 2014. "Medicine in Colonial Australia, 1788-1900," *The Medical Journal of Australia*, 201 (1): 5-10; Willis, *Medical Dominance*.47.

⁶³⁷ Willis, *Medical Dominance*; Lewis, "Medicine in Colonial Australia, 1788-1900."

⁶³⁸ Willis, Evan. 2006. "Introduction: Taking Stock of Medical Dominance," *Health Sociological Review: The Journal of the Health Section of the Australasian Sociological Association*, 15 (5): 421-32.

⁶³⁹ Willis, *Medical Dominance*.

accompanying reduction in disease.⁶⁴⁰ The fall in mortality was more likely attributed to the overall improvement in general living conditions in most of Australia,⁶⁴¹ rather than the advances in the 'scientific' profession of medicine. However, there is no denying that the medical profession gained more professional credibility, in conjunction with their gender and social class, from these public health advancements.⁶⁴²

The Arrival of the Nightingale Nurses in Australia

Formal nursing was introduced into Australia in the 1860s, when Lucy Osborne, a Nightingale trained nurse established a training school at Sydney Hospital in 1868.⁶⁴³ Previously, hospitals existed only as charitable institutions for the destitute and care was provided by untrained men or Catholic nursing sisters. The arrival of the Australian Florence Nightingale trained nurses, who worked within hospitals, led to nursing being accepted as a suitable type of employment for middle-class young women. This new style of nursing began to change how nursing was understood previously—care provided by untrained and uneducated workers— to a profession of 'ladies' that required education and training.⁶⁴⁴ The new nurses had to attain a certain level of education but also to maintain certain social and moral standards. In contrast, the independent midwife was more likely to be older, working-class and 'untrained', having learned her trade by experience.

Unlike the autonomous community midwives, nurses were not expected to make independent clinical decisions; their role was to observe and report their findings and observations to the medical doctors. Thorogood states this was an important extension of the surveillance role that medical doctors incorporated into their practice. This surveillance role is one of the reasons why some medical doctors supported midwives within the community.⁶⁴⁵ Moreover, Thorogood believes that medicine's acceptance of hospital based midwives provides unequivocal evidence that the early struggle between medicine and midwifery, was not about the midwives' competence but due to their status as independent practitioners.⁶⁴⁶ The doctors, therefore, were opposed to any move to make

⁶⁴⁰ Hunt and Hunt, "Cleansing the Dunghill: Water Supply and Sanitation in Perth 1878-1912"; Barclay, "A Feminist History of Australian Midwifery from Colonisation until the 1980s."

⁶⁴¹ Appleyard, "Western Australia: Economic and Demographic Growth, 1850-1914."

⁶⁴² Barclay, "A Feminist History of Australian Midwifery from Colonisation until the 1980s."

⁶⁴³ Connerton, Winifred and Patricia D'Antonio. 2012 "International Comparisons: The Nursing and Midwifery Interface," in *Nursing and Midwifery in Britain since 1700*, ed. Anne Borsay and Billie Hunter. UK: Palgrave Macmillan.180.

⁶⁴⁴ *Ibid.*181.

⁶⁴⁵ Thorogood, "Politics and the Professions: Homebirth in Western Australia."43.

⁶⁴⁶ *Ibid.*43.

midwifery an independent profession as they wanted to prevent the independent midwives from improving their status and standing in the community. Ultimately, the move to incorporate midwifery into another female dominated occupation—nursing— would ensure that the working-class female midwives would continue to be excluded from medicine (as midwifery was now being defined as part of medicine under the new speciality of ‘obstetrics’) and bring the midwives under medical control. In Australia, towards the end of the nineteenth century there was a push for the registration of nurses and midwives. A Bill to register midwives was presented to the New South Wales Government in 1898. The conversation relating to this Bill demonstrates the belief that medicine already controlled nursing and highlighted the need for medicine to subordinate midwifery, or risk repercussions:

A nurse always means one who is subordinate to the doctor, who acts under his orders, and has no independent authority. A midwife is one who does not necessarily act under the supervision of a doctor (so long as the case remains uncomplicated). She is individually responsible for the case under her charge. To call her a nurse, with whatever qualifying adjective, is to confuse one who has independent charge with one who has not, but who receives her orders from a superior.⁶⁴⁷

The only way that medicine could control midwifery was through nursing. If midwifery became a branch of, or was included in nursing, then it too would fall under the control of medicine. To be able to control midwives, the medical doctors also had to control who could train and practice as a midwife. Consequently, medicine encouraged the training of midwives, albeit with a minimal amount of training and skills. This training was enough to enable them to provide care within the medically controlled and supervised institution but not enough to enable them to provide the full scope of midwifery practice, thereby discouraging them from entering into autonomous independent practice.

Training of Midwives Begins in Australia

The teaching of midwifery developed alongside the training of medical students in obstetrics during the late nineteenth century in Eastern Australia, but midwifery training did not commence in WA until the early twentieth century. The male medical staff provided

⁶⁴⁷ *The Australasian Medical Gazette*. 1898. "Report of a Meeting of the Medical Profession to Discuss Proposed Midwifery Nurses' Bill." November 21, 1898: 481. cited in Summers, Annette. 1998. "The Lost Voice of Midwifery: Midwives, Nurses and the Nurses Registration Act of South Australia," *Collegian*, 5 (3): 16-22.

formal education and instruction to the female midwifery students; however, Willis argues that their intent was not to educate the independent midwife, but to create the subordinated maternity nurse.⁶⁴⁸ The first midwifery school was opened in Melbourne at the Lying-in Hospital which eventually became the Women's Hospital.⁶⁴⁹ The medical staff however were opposed to the training of independent midwives. The 'Diploma in Midwifery' began in 1893, yet this training was offered only to formally trained nurses, and this enabled the medical doctors to keep close control over the midwives and their training. Throughout the late 1880s and 1890s midwifery training was increasingly incorporated into nursing. Henceforth the term 'obstetrical or obstetric nurse' became popular. Midwifery training began to be offered in other states, but again was offered only to qualified nurses. It was available in New South Wales from the 1880s and in South Australia from 1902.⁶⁵⁰ It was also decided that only those with general nursing training could be employed in a hospital's midwifery department.⁶⁵¹

The introduction of these medically-run, midwifery training schools created a new type of midwife, who specialised in hospital-based midwifery and therefore was familiar with the medical model of care. This contributed to the divide between hospital-based midwives and the independent community midwife. The working-class community midwives were also seen as a hindrance to the new nurses and were excluded from many training schools due to their social class and age. They did not fit the new image of the new trained nurse-midwife.

Formal midwifery education commenced in WA in 1909 and, as in the other states, was completely controlled by the medical doctors and nurses. After much debate and discussion, the first government Maternity Training School was established in the former Old Women's Home in Fremantle. The building had originally been used as an asylum and had to be adapted for the new purpose; these renovations enabled the government to reduce costs by not having to erect a new building. Prior to the official Fremantle course some doctors such as Dr Haynes had provided unofficial training to midwives. With the

⁶⁴⁸ Willis, *Medical Dominance*.105.

⁶⁴⁹ McCalman, *Sex and Suffering: Women's and a Women's Hospital: The Royal Women's Hospital Melbourne 1856-1996*.

⁶⁵⁰ Summers, "'For I Have Ever So Much More Faith in Her Ability as a Nurse": The Eclipse of The. Community Midwife in South Australia 1836-1942'."; Barclay, "A Feminist History of Australian Midwifery from Colonisation until the 1980s."

⁶⁵¹ McCalman, *Sex and Suffering: Women's and a Women's Hospital: The Royal Women's Hospital Melbourne 1856-1996*; Summers, "'For I Have Ever So Much More Faith in Her Ability as a Nurse": The Eclipse of The. Community Midwife in South Australia 1836-1942'."

increase in demand for skilled birth attendants, particularly in rural areas it was imperative that more midwives were trained.⁶⁵²

The course was run by Dr Williams of Fremantle, supported by a board consisting of a group of doctors known as the 'Fremantle medical men'. These men decided on the requirements of admission. Thus, as in other countries and areas of Australia, the requirements for admission were prohibitive for many poor older, working class women. The government in Western Australia was under pressure to train midwives due to the perceived role of untrained midwives in increasing infant mortality, therefore, in contrast to the Eastern State's midwifery schools, applicants did not need to have formal nursing education. Applicants, however, must be aged between 24-45. This requirement ruled out many of the existing empirically trained WA midwives, who were older than 45, from seeking a formal midwifery education. The applicants were also required to provide a letter, signed by a clergy man, declaring them of moral character and physical fitness. The fee was initially ten pounds, but they received no applicants, so this was reduced to three pounds.⁶⁵³

The midwifery course itself was based on similar British courses and lasted six months initially, increasing to 12 months in 1912. It consisted of a series of ten lectures and clinical instruction covering topics such as anatomy and physiology of the female pelvis, normal and abnormal labour, antisepsis and care of the newborn infant. All lectures and clinical instruction were conducted by the doctors. In addition to the theory, midwifery students were required to attend and assist the doctor at 20 labours and births and complete an examination paper. Once training was completed, the midwife received a certificate and thus became a certified midwife. Initially the demand for the course was very low, however following the implementation of legislation requiring registration of midwives' (which will be discussed later in this chapter) demand increased.⁶⁵⁴

Midwifery education continued at the Fremantle School until 1916, when it was transferred to the newly opened King Edward Memorial Hospital (KEMH) for women. The length of training was dependent on whether the student was already a trained nurse; six months for students who had already completed three years of general training and 12

⁶⁵² McKenzie, "Place and Power: A History of Maternity Service Provision in Western Australia, 1829-1950."

⁶⁵³ Ibid.

⁶⁵⁴ Ibid.

months for non-nurse applicants. The fee at KEMH was ten pounds and the eligible age was extended to 21-45. Although the course was available to older women, the requirement for students to live on site, ruled out the possibility of older married working-class women being able to access training.⁶⁵⁵

Education of Midwives in WA 1950-2018

Midwifery education in WA moved from hospital-based to university based in the mid-1980s but both types of training were offered until the early 1990s. The only way to become a midwife in WA during this time period was to first complete nursing education and then once registration as a nurse was achieved, apply to complete a recognised midwifery education program.⁶⁵⁶ In 2008 Curtin University became the first university to offer a three-year undergraduate midwifery course, which enabled non-nurses to become midwives.⁶⁵⁷ This was achieved following the implementation of the *Nurses and Midwifery Act 2006*, as prior to this legislation there was no provision on the nurses register for midwives who were not nurses to be registered.⁶⁵⁸

In 2018 there are three universities offering post graduate education to registered nurses wishing to become midwives. Curtin University offers a Post graduate Diploma, lasting 18 months with concurrent employment as a student midwife at a hospital in WA; this is called the paid employment model. Edith Cowan University (ECU) offers a similar course, however ECU's course runs over two years and leads to a Master level Degree. Notre Dame University offers an 18 month Post Graduate Diploma, however, unlike Curtin and ECU the students are not employed, and clinical experience is organised at any hospital in WA by the university. There are two undergraduate degrees leading to registration as a midwife in WA. ECU offers a four-year double degree, leading to registration as both a nurse and a midwife and as previously mentioned Curtin commenced an undergraduate midwifery degree in 2008, however, it is not currently open to new enrolments at the time of writing.

⁶⁵⁵ Hobbs, *But Westward Look: Nursing in Western Australia 1829-1979*; McKenzie, "Place and Power: A History of Maternity Service Provision in Western Australia, 1829-1950"; Carter and Carter, *King Eddies: A History of Western Australia's Premier Women's Hospital 1916-2016*.

⁶⁵⁶ Thorogood, "Politics and the Professions: Homebirth in Western Australia."

⁶⁵⁷ Curtin University. 2008 "Midwifery Education Reborn in WA." News release, April 23, 2008.

⁶⁵⁸ *Nurses Act 1992 (WA)*; *Nurses and Midwives Act 2006 (WA)*.

The Impact of the Australian Trained Nursing Association

The first Australian nursing association, the Australian Trained Nursing Association (ATNA), was established in New South Wales in 1899 with other branches developing throughout Australia in the following years: Queensland in 1904; South Australia in 1905; WA in 1907; and Tasmania in 1908. Victoria had formed its own nursing association, the Victorian Trained Nursing Association (VTNA) in 1901, which worked closely with ATNA. The formation of these associations, like the medical associations before them, was a move to develop nursing as a profession and gain higher social standing. Although it was not compulsory to be a member, membership was recognised as a status symbol.⁶⁵⁹ ATNA was also established to promote the interests of all trained nurses, and their aim was to establish a system for registration, another step towards professionalisation and to provide set standards of education. Only nurses trained at ATNA accredited hospitals were able to become members once they had completed their training. This led to greater associations between the ATNA approved training hospitals and the nursing association, which enabled them to establish nursing training standards throughout Australia. ATNA also developed and published a journal; *The Australasian Nurses' Journal*. The KEMH midwifery school was recognised by the Australian Trained Nursing Association (ATNA), enabling midwives who had trained at KEMH to become members and increased the power of the ATNA over midwifery in general. The decline of midwifery as an independent profession had begun as nursing and medicine began to encroach on traditional midwifery practice.⁶⁶⁰

The Takeover Period 1910-1950

The 1912 the Commonwealth-funded *Maternity Allowance Act* gave a financial payment of five pounds to all European women following the birth of a child. Indigenous and women of other ethnicities were not entitled to the payment.⁶⁶¹ This demonstrates that the government initiative was aimed at reducing infant mortality and only increasing the white population of Australia. The payment was considered a radical measure as it was paid directly to both married and unmarried mothers, therefore it undermined the traditional

⁶⁵⁹ Hobbs, *But Westward Look: Nursing in Western Australia 1829-1979*.

⁶⁶⁰ Fahy, "An Australian History of the Subordination of Midwifery."

⁶⁶¹ *Maternity Allowance Act 1912* (Cth).

patriarchal role of the husband.⁶⁶² The payment was considered a large amount of money, the equivalent to two weeks wages for a man and five weeks wages for a woman, and paying the money directly to the women was to ensure that it was used specifically for the welfare of the woman and the child.⁶⁶³ This payment enabled the woman to pay for skilled birth attendants.⁶⁶⁴ Thus, the early 20th century became a period of intense competition between the midwives and doctors. An editorial in the *Medical Journal of Australia* claimed that the lavish payment would lead to women being lured by the “midwife, keen as any shark in the cities” at the prospect of making money out of the birthing women and that the consequences would mean an increase in puerperal fever.⁶⁶⁵ Some women did use the money to pay for a midwife to provide care during birth, either at home or in a midwifery run lying in home. However, increased regulation in lying in homes and pressure from the medical profession led many midwifery-run lying in homes to close, therefore, women were left with few choices of birth attendant and place of birth.⁶⁶⁶

Furthermore, although there was a large increase in doctor attended births in institutions there was no significant corresponding reduction in maternal mortality.⁶⁶⁷ Approximately one woman in 200 died in from puerperal fever in 1912 and a decade later the number remained the same.⁶⁶⁸ Despite the lack of evidence and contrary to the actual statistics, independent midwives remained the scapegoat for maternal and infant deaths.⁶⁶⁹ Independent midwifery was in serious decline by the early to mid-20th century. The establishment of publicly funded maternity hospitals in Australia was a crucial obstacle to autonomous midwifery practice. The medicalisation of birth and medical dominance within the hospitals, led to the state and medical control of the training and regulation of midwives. Once women began to birth in hospital the specialisation of obstetrics completed the medical dominance of birth. As seen in other states, with the centralisation of

⁶⁶² Lake, Marilyn. 2012. "State Socialism for Australian Mothers: Andrew Fisher's Radical Maternalism in its International and Local Contexts," *Labour History*, 102: 55-70.

⁶⁶³ McKenzie, "Place and Power: A History of Maternity Service Provision in Western Australia, 1829-1950."

⁶⁶⁴ Ibid.

⁶⁶⁵ *Medical Journal of Australia*, 1915. Editorial, 13 (2): 151. cited in Willis, *Medical Dominance*.112.

⁶⁶⁶ McKenzie, "Place and Power: A History of Maternity Service Provision in Western Australia, 1829-1950"; Flanagan, "Lying-in (or Maternity) Homes in Western Australia from About 1860-1960."

⁶⁶⁷ Willis, *Medical Dominance*.110.

⁶⁶⁸ McKenzie, "Place and Power: A History of Maternity Service Provision in Western Australia, 1829-1950."

⁶⁶⁹ Ibid.

maternity services into the bigger hospitals, the smaller nursing homes and smaller hospitals began to close.⁶⁷⁰ In Perth the main maternity units were the public hospital King Edwards Maternity Hospital (KEMH) and the private hospitals of St John of God and St Anne's.

Health Act of 1911; the Registration and Regulation of Midwives

The *Health Act of 1911* was the first legislation aimed at controlling and regulating midwives' practice in WA. Included as part of the bill under the title '*protection of life*' was the introduction of legislation requiring midwives to be registered. A Western Australian Midwifery Board was appointed under section 252 of the *Health Act*.⁶⁷¹ This board consisted of five members and was dominated by medical doctors from the beginning. The Chairman of the board, Dr Hope, was the principle medical officer and the board consisted of two other medical doctors; Dr White and Dr Hicks; and two midwives; Matron Tate and Matron Harris. The legislation dictated that:

from and after the first day of January one thousand nine hundred and twelve, no woman shall be entitled to take or use the name or title of midwife or midwifery nurse or to keep, conduct or manage a private hospital wherein maternity cases are received, or to act as an assistant nurse in any such hospital unless she is registered under this Part of this Act. ⁶⁷²

A midwife who was unregistered and attended a birth risked a fine of two pounds for a first offence and a fine of ten pounds for any subsequent offences. However, this part of the legislation also provided a loophole for unregistered midwives attending a birth if there was no registered practitioner within a five-mile radius of the residence.⁶⁷³ Registration required the midwife to prove her qualifications and training and pay a fee of five shillings or prove that she had "been for at least two years in bone fide practice as a midwife and satisfies the board of her competence, cleanliness, and repute".⁶⁷⁴ Trained midwives were required to have undergone at least 12 months training at an approved institution and provide evidence that they had attended a prescribed number of cases. The Board also

⁶⁷⁰ Selby, "Motherhood in Labour's Queensland 1915-1957"; Summers, ""For I Have Ever So Much More Faith in Her Ability as a Nurse": The Eclipse of The. Community Midwife in South Australia 1836-1942'."

⁶⁷¹ *Health Act of 1911* (WA).252.

⁶⁷² *Ibid.*253.

⁶⁷³ *Ibid.*

⁶⁷⁴ *Ibid.*255.

attained the right to remove a midwife from the register and to “make regulations for supervising, regulating, and restricting within due limits the practice of midwives, and for any other purpose tending to protect the lives of mothers and infants”.⁶⁷⁵ Following the implementation of the *Health Act* more restrictions and conditions were placed upon midwives, including what they should wear to births and what equipment they should carry:

The Midwife must be scrupulously clean in every way, including her person, clothing, appliances and house.....when attending to her patients she must wear a clean dress of washable material that can be boiled, such as linen, cotton etc. And over it a clean washable apron or overall.⁶⁷⁶

Like the depiction of the Gamps it was assumed that the midwives were sloppy and dirty and needed direction to maintain appropriate standards; no equivalent orders were placed on medical doctors attending births in WA, which demonstrates that the standards placed on midwives were not about improving maternal and infant safety, but were a method of control. The *Health Act* also determined the scope of midwifery practice and defined the situations in which the midwife should call the doctor to attend, including all deaths, as midwives were not allowed to complete a death certificate.⁶⁷⁷ The midwife was also legislated to complete a birth notification for each birth attended.⁶⁷⁸

The first register of midwives was published in the Government Gazette on 2 January 1913 and listed 2 types of midwives; qualified midwives and unqualified midwives.⁶⁷⁹ The ‘grandmother’ clause allowed ‘unqualified’ midwives to register. These women did not have formal qualifications but were empirically trained. Of the 863 registered in January 1912 only 122 held any certificates of training recognised by the Midwifery Board, 28 of these qualified midwives had trained at Fremantle midwifery training School and the remainder had obtained their certification from the eastern states of Australia or Britain.⁶⁸⁰ Subsequent midwifery registers showed the increase in qualified midwives, however many unqualified midwives remained on the register; after 1915 no new unqualified midwives

⁶⁷⁵ *Health Act of 1911 (WA)*.262.

⁶⁷⁶ *Government Gazette, The*. 1912. Western Australia. Section E. Supervision and restrictions within due limits the practice of midwives.

⁶⁷⁷ *Health Act of 1911 (WA)*.

⁶⁷⁸ *Government Gazette, The*.1077.

⁶⁷⁹ *Ibid*.

⁶⁸⁰ McKenzie, "Place and Power: A History of Maternity Service Provision in Western Australia, 1829-1950"; Hobbs, *But Westward Look: Nursing in Western Australia 1829-1979*; "The Government Gazette."

were able to register in WA. Nurses in WA were not registered until the 1920s when the Nurses Registration Board began in 1921.⁶⁸¹ Unlike the other Australian states, whereby the 1930s midwifery was incorporated into nursing as a specialised branch of nursing, WA midwives retained their independent status from nursing until the 1940s. In 1944 the Midwifery Board was abolished, and the regulation of midwifery practice was incorporated under the *States' Nurses Registration Act Amendment Act 1944*.⁶⁸² Midwives were registered under Part V, The Midwifery Section of the Nurses Board Register, and the subordination of midwifery into nursing was complete.⁶⁸³ After 1945 unqualified midwives were no longer included on the register.

The Formation of Associations and Colleges

From the 1970s the International Confederation of Midwives (ICM) have supported the concept that the midwife is an autonomous health professional. Following a group of Australian midwives attending an ICM meeting in 1975, Australia was asked to become a member of the ICM. This inclusion in the ICM eventually led to the formation of the Australian College of Midwives Incorporated (ACMI). The ACMI was founded nationally in 1987, when midwifery associations in several states and territories came together to create a national peak body for Australian midwives.⁶⁸⁴

Various medical groups and associations have existed in Australia since the 1800s. In 1962 these eventually merged to become the most powerful professional medical organisation in Australia, the Australian Medical Association (AMA).⁶⁸⁵ The AMA has substantial influence on the legislation, division and distribution of health care in Australia. From the early 19th century Australian doctors were member of the British Colleges however it was not until the 1940s that Australia formed their own branch of the Royal College of Obstetricians and Gynaecologists (RCOG).⁶⁸⁶ Australian obstetricians remained members of the British College until 1978 when they established their own college, The Royal Australian College of Obstetricians and Gynaecologists.⁶⁸⁷ In 1998 they amalgamated

⁶⁸¹ *Nurses Registration Act 1921 (WA)*.

⁶⁸² *Nurses Registration Act Amendment Act 1944 (WA)*.

⁶⁸³ *Ibid.*

⁶⁸⁴ Reiger, Kerreen. 2000. "The Politics of Midwifery in Australia: Tensions, Debates and Opportunities," *Annual Review of Social Science*, 10 (1): 53-64.

⁶⁸⁵ Sena-Becker, Tara, ed. 2012. *More than Just a Union: A History of the AMA*. Australia Fair Count Media Group.

⁶⁸⁶ *Ibid.*

⁶⁸⁷ *Ibid.*

with New Zealand and became the Royal Australian and New Zealand College of Obstetricians and Gynaecologists (RANZCOG).⁶⁸⁸ The RANZCOG has many guidelines and position statements that guide medical practitioners; The RANZCOG also has a profound influence on midwifery practice not only in the institutions but also by being involved in the decision making around policies and guidelines. In 1987, The RANZCOG released their first position statement on homebirth, The RANZCOG does not support homebirth with a midwife as a safe option for any women including those considered low risk.⁶⁸⁹

Midwifery in WA 1950-2018

Legislation to control Midwifery continued throughout the second half of the 20th century with regular updates and amendments to The *Health Act of 1911*. These changes included who the midwife must inform of her intention to commence private practice; the situations when a midwife must consult a medical practitioner; what drugs the midwife could and could not administer; the contents of her midwifery bag; and the paperwork the midwife was required to complete.⁶⁹⁰ From the 1930s most women in WA gave birth in hospital; women still received midwifery care from midwives, although the care administered was ordered and directed by doctors. As discussed in Chapter Four, the medicalisation of birth was becoming the norm in most Western countries, and although midwives were still autonomous practitioners in some countries this was not the case in Australia. However, some midwives did still work privately and attended homebirths during this time, but there are few records available.

In Australia, the state-supported health system's main aim was to provide state funded services for those who do not have private insurance. The development of Medibank, Medicare and the compulsory health insurance schemes of the 1970s and 1980s led to many women choosing to birth in a private maternity hospital under the care of a private obstetrician. Medicare began in 1984 and is the Commonwealth funded health insurance scheme that provides free or subsidised health care services. It provides free hospital services for public patients and subsidises some private medical cost. Medicare

⁶⁸⁸ Sena-Becker, *More than Just a Union: A History of the AMA*.

⁶⁸⁹ Royal Australian and New Zealand College of Obstetricians and Gynaecologists. 2017. "Homebirth Statement."

⁶⁹⁰ *Health Act Midwives Regulations 1959 (WA); Government Gazette of Western Australia*. 1968. "Health Act Midwives Regulations 1968," Perth, WA; *Health Act Midwives Regulations 1976 (WA); Health Act (Midwifery Nurses) Regulations 1982 (WA); Health (Notifications by Midwives) Regulations 1994*," ed. Government of Western Australia.

coexists with a private health system. Funding for Medicare is offset by a Medicare levy (with exceptions for low-income earners), with the balance being provided by government from general revenue. An additional levy is imposed on high-income earners without private health insurance.⁶⁹¹

Community-based services have largely been ignored by government, and state funding has generally been linked to large tertiary hospitals, leading to a centralisation of services and the closure of many smaller hospitals.⁶⁹² Historically, women wanting to give birth in an out-of-hospital setting in WA had very few options and there were no government funded options until the early 2000s.⁶⁹³ The AMA and RANZCOG consistently argued that the care of women during pregnancy, labour and birth is appropriately given only by a doctor, and this rhetoric strengthened the belief that birth was safest in hospital and that doctors were the appropriate maternity care providers. For Australian women, attempting to choose care from a midwife was considered a radically different choice compared to the mainstream options of medicalised birth in a private or public hospital, under care directed by an obstetrician.

By the mid-1970s consumer and political pressure for birthing alternatives began to mount in Australia. Homebirth continued to be strenuously opposed by the medical profession. Until the 1990s the only non-medicalised option for women in WA was a homebirth with a PPM. Unfortunately, this option was not available for a lot of women as cost, access and availability of PPMs were prohibitive factors. Another less 'radical' option for women wanting a non-medicalised and physiological birth was to give birth in a birth centre. Birth centres in Australia are generally controlled by obstetricians, who decide who can and cannot birth there.⁶⁹⁴ The centres are usually attached to hospitals, thus enabling quick access to the 'safety' of the hospital and the supervision of the doctors.⁶⁹⁵ In 1989, The Alternative Birthing Services Program (ABSP), a Commonwealth government initiative, aimed to provide funding to develop alternative birth choices for women including birth

⁶⁹¹ Australian Government Department of Human Services. Medicare."

⁶⁹² Thorogood, "Politics and the Professions: Homebirth in Western Australia."

⁶⁹³ Ibid.

⁶⁹⁴ Ibid.

⁶⁹⁵ Government of Western Australia. 2018. "Family Birth Centre Application Form Version 5," ed. Department of Health.

centres and homebirth.⁶⁹⁶ Many planned programs across Australia were not implemented and ones that were did not continue once the ABSP funding ran out.⁶⁹⁷

In WA two alternative birth service initiatives received commonwealth funding. These two alternative birth services were the Family Birth Centre (FBC) and the Community Midwives Program (CMP). The FBC opened in 1992 and was the first government funded birth centre in WA. The FBC is situated on site at KEMH, and only women classed as 'low risk' can birth at the centre. The classification of 'risk' is problematic, as it has been, and continues to be, a continually changing classification defined by the obstetric profession and not by midwifery or women themselves. The Community Midwives Program (CMP) was the result of many years of lobbying by midwives providing homebirth services to women privately and was the first government funded homebirth program in Australia.⁶⁹⁸ Again the CMP has many restrictions on the type of women that can access this service.

The Maternity Service Review

In 2009 the Australian government released a report aiming at improving maternity services across Australia. *The Maternity Service Review* report included many midwifery related recommendations including increased maternity care options for women such as midwifery led care and increasing the scope of practice for midwives.

In relation to midwifery the report recommends:

- changes to improve choice and availability of a range of models of maternity care for Australian mothers by supporting an expanded role for midwives, including consideration of changes to Commonwealth funding arrangements and support for professional indemnity insurance for midwives
- changes including an expanded role for midwives to take place within a strong framework of quality and safety.⁶⁹⁹

⁶⁹⁶ Thorogood, "Politics and the Professions: Homebirth in Western Australia."8.

⁶⁹⁷ Ibid.

⁶⁹⁸ Thorogood, "Politics and the Professions: Homebirth in Western Australia." provides an in-depth review of the ABSP.

⁶⁹⁹ Commonwealth of Australia. 2009. "Improving Maternity Services in Australia: The Report of the Maternity Services Review.2.

It is clear from the foreword written by Rosemary Byrant, the Commonwealth Chief Nurse and Midwifery Officer, that the report highlighted problems between the midwifery and medical professions:

there is a lack of unanimity within and between some groups of the medical and midwifery professions on the issue of how to deal with risk and consumer preferences. While it is acknowledged that safety and quality of care is an overarching goal, it would be remiss to always use it as an excuse not to change practice. In maternity services, where most pregnancies follow a normal pattern, we must ensure, first, that practice is based on evidence and, second, that we are not allowing our safety and quality concerns to prevent us acting on evidence that supports changes to practice. Risk must always be a carefully monitored balance of safety and informed choice.⁷⁰⁰

Unsurprisingly, the report did not include homebirth in its recommendations. This was of particular concern and highlights the power and influence of the medical profession on government policy. Prior to the report being developed, consultation was sought from stakeholders and consumers. The subsequent submissions included over 470 responses from the 900 received that specifically called for funding and homebirth options for women. According to the report, many of the consumers who participated in the review consultations had strongly held views about government funding for midwifery led models of care including homebirth, and many submissions included evidence of positive outcomes.⁷⁰¹

The report stated that it did not include homebirth in its recommendations as homebirth in Australia is “a sensitive and controversial issue” and that “the relationship between maternity health care professionals is not such as to support homebirth as a mainstream Commonwealth-funded option”.⁷⁰² It also stated that providing funding for homebirth had the potential to polarise the professions rather than allowing for an expansion of collaborative approaches.⁷⁰³ This drew criticism from many as it clearly highlighted that rather than responding to the submissions and clear evidence of homebirth’s safety, the report held the medical profession’s views that homebirth is unsafe, and that midwives are unable to work autonomously. Consequently, the decision by

⁷⁰⁰ Commonwealth of Australia, "Improving Maternity Services in Australia: The Report of the Maternity Services Review.iii.

⁷⁰¹ Ibid.

⁷⁰² Ibid.21.

⁷⁰³ Ibid.21.

the report's authors to not deal with the issues relating to homebirth reinforces the hierarchal nature of obstetric care in Australia.

One of the key recommendations and a promising step forward for midwifery were the recommendations that the government would support “an expanded role for appropriately qualified and skilled midwives, within collaborative team-based models” to access the Pharmaceutical Benefits Scheme (PBS) enabling midwives to provide prescriptions for women in their care and the Medicare Benefits Schedule (MBS) which would allow women who received care from a midwife to be reimbursed for some of the cost associated with their care.⁷⁰⁴ One of the concerns however, was the need for collaboration with the medical profession, who clearly opposed the recommendations to increase the scope of the midwife.

Following the release of the Maternity Service Review, government reforms were legislated that would enable eligible midwives and their clients to access the PBS and MBS. In November 2009, the introduction of more legislation occurred: The Health Legislation Amendment (Midwives and Nurse Practitioners) Act 2010; Midwife Professional Indemnity (Commonwealth contribution) Scheme Act 2010; Midwife Professional Indemnity (Run-off Cover Support Payment) Act 2010 and in WA, the Health Practitioner Regulation National Law (WA) Act 2010 replaced the Nurses and Midwifery Act 2006.

On November 1st, 2010, the first eligible Australian midwives received medical provider numbers and were able to apply for endorsement to prescribe scheduled medicines. To obtain endorsement the midwives had to meet the eligibility criteria. This included proving their competence across the continuum of midwifery practice, the completion of a pharmacology, diagnostic and screening education program and providing evidence of collaboration with a medical practitioner. This created another type of midwife—an endorsed midwife—and as seen throughout the history of midwifery, midwives again had to prove their ‘eligibility’ to be able to provide autonomous midwifery care. Since its implementation, the process has also undergone some adjustments, which included a clause that midwives must have midwifery experience that constitutes the equivalent of three years full time post registration as a midwife to be able to apply for endorsement. Endorsed midwives must also complete regular professional practice peer reviews (every

⁷⁰⁴ Commonwealth of Australia, "Improving Maternity Services in Australia: The Report of the Maternity Services Review.52. for more information about MBS see <https://chf.org.au/publications/what-mbs>

three years) and complete an additional 20 hours of continuing professional development per year.⁷⁰⁵

In 2010, Australia's health regulatory system underwent substantial changes. A National Registration and Accreditation Scheme (NRAS) was created. This change saw the consolidation of 75 Acts of Parliament and 97 separate health profession boards across eight States and Territories into a single National Scheme. The National Scheme set a minimum standard for safe practice by health professionals.⁷⁰⁶ Prior to 2010, each of the Australian states had its own registration scheme for health practitioners and with this a total of 85 professional boards and 66 Acts of Parliament to govern the implementation of legislation in each jurisdiction. With the introduction of the new legislation the National Registration and Accreditation scheme was implemented. In July 2010, the Australian Health Practitioner Regulation Agency (AHPRA) was created as the managing body to support the newly formed health professional registration Boards of Australia. AHPRA, and its functions are governed by the Health Practitioner National Law Act, 2009.⁷⁰⁷ This law means that for the first time in Australia 15 health professions are regulated by one national legislation. The objective of the *Health Practitioner National Law (2009)* is to establish a national registration and accreditation scheme in order to meet the following objectives:

- To provide protection for the public
- To enable workforce mobility and remove the administrative burden for practitioners
- To facilitate high quality education and training to health professionals
- To assess overseas trained health professionals
- To facilitate access to health services for members of public
- To continue to develop a flexible, responsive and sustainable Australian Health workforce.⁷⁰⁸

⁷⁰⁵ Nurses and Midwifery Board of Australia; Nursing and Midwifery Board of Australia. "Fact Sheet: Endorsement for Scheduled Medicines for Midwives."

⁷⁰⁶ Staunton, Patricia and Mary Chiarella. 2017. *Law for Nurses and Midwives*, 8th ed., NSW, Australia: Elsevier.

⁷⁰⁷ Ibid.230.

⁷⁰⁸ Ibid.229.

The Nursing and Midwifery Board of Australia (NMBA)

The Nursing and Midwifery Board of Australia (NMBA) regulates the practice of nursing and midwifery in Australia, and one of its key roles is to protect the public. The NMBA does this by developing registration standards, professional codes, guidelines and standards for practice which together establish the requirements for the professional and safe practice of nurses and midwives in Australia.⁷⁰⁹ Following the formation of the NMBA, midwifery has once again been recognised as a separate profession in Australia, however it is still aligned with nursing.

Insurance

In the 1990s PPMs could access private indemnity insurance (PPI),⁷¹⁰ but following the 2001 insurance crisis in Australia, many insurance companies increased their insurance premiums to an unaffordable level and midwifery insurance ceased to be offered in any form. The government intervened to assist medical doctors in subsidising their insurance premiums, however, no such offer was made to midwives.⁷¹¹ Midwives continued to provide private midwifery care but practiced without insurance. In 2009 The *Maternity Service Review* stated

midwives who provide support for birthing privately do so without professional indemnity insurance. This means that they do so at their own financial risk or, depending on the midwife's financial circumstances, the risk transfers to their clients should an adverse event occur, leaving a woman with no recourse to financial compensation. A situation where a health professional operates without appropriate professional indemnity cover is not considered acceptable.⁷¹²

With the implementation of the Health Practitioner National Law Act, 2009 all registered health professionals were required by law to hold private indemnity insurance (PII). For employed midwives, the insurance was supplied by their employer, however for

⁷⁰⁹ "The Nurses and Midwifery Board of Australia."

⁷¹⁰ Thorogood, "Politics and the Professions: Homebirth in Western Australia."195.

⁷¹¹ Commonwealth of Australia. 2009. "Improving Maternity Services in Australia: The Report of the Maternity Services Review."

⁷¹² Ibid.54.

self-employed PPMs no insurance product existed. Recommendation 18 of the Maternity Service Review stated:

That, in the interim, while a risk profile for midwife professional indemnity insurance premiums is being developed, consideration be given to Commonwealth support to ensure that suitable professional indemnity insurance is available for appropriately qualified and skilled midwives operating in collaborative team-based models. Consideration would include both period and quantum of funding. Private Indemnity Insurance (PII) is a requirement of all registered Midwives providing private care. PII is designed to assist in paying for legal costs and potential damages.⁷¹³

Initially two insurance products were made available, Vero and Medical Insurance Group Australia (MIGA). However, Vero ceased to offer insurance to midwives in 2015 as they stated it was not a viable option.⁷¹⁴ Following the withdrawal of Vero, the only insurance product available for midwives was MIGA. This was problematic as MIGA only provided insurance for midwives who had completed the eligible midwife requirements.⁷¹⁵ Therefore, some midwives in private practice were unable to gain insurance and were forced to cease working as a PPM. Neither Vero, when it was available, nor MIGA offers insurance for homebirth; since 2010, Section 284 of the National Law gives PPMs who provide midwifery care at homebirths an exemption from needing PII insurance for intrapartum care at home until a suitable option is found.⁷¹⁶ For midwives to be exempt they must have no restrictions on their registration that prevents them from attending homebirths; informed consent must be given by the woman and the midwife must practice in accordance with the codes and guidelines of the profession as set out by the NMBA for the exemption to be valid.⁷¹⁷ This exemption has been extended on two occasions and is currently in place until the 31st of December 2021. This situation is problematic as it leaves homebirth midwives and women uninsured.

⁷¹³ Commonwealth of Australia. 2009. "Improving Maternity Services in Australia: The Report of the Maternity Services Review." Recommendation 18.55.

⁷¹⁴ "Vero Cuts Midwives' Insurance Scheme," 2015. News release. May 11, 2015.

⁷¹⁵ MIGA Insurance, "Protection Tailored to Midwifery Practice: Supporting Eligible Privately Practising Midwives across Australia.

⁷¹⁶ *Health Practitioner Regulation National Law (WA) Act 2010* (WA); Nursing and Midwifery Board of Australia. 2016. "Safety and Quality Guidelines for Privately Practising Midwives," ed. Nursing and Midwifery Board of Australia.

⁷¹⁷ *Health Practitioner Regulation National Law (WA) Act 2010* (WA).206.

Collaboration between Midwives and Doctors

In January 2004 the first edition of the Australian College of Midwives *National Midwifery Guidelines for Consultation and Referral* was released. The aim of these guidelines were to “provide an evidence based, national framework for consultation and transfer of care between midwives and doctors”.⁷¹⁸ These guidelines were developed to assist midwives to decide when it was appropriate for them to discuss care with a colleague, medical doctor or specialist obstetrician, and when indicated, transfer the care to a medical specialist.⁷¹⁹ The guidelines are divided into four main sections: indications at booking; indications developed or discovered during pregnancy; indications during labour and birth; indications during the postnatal period.⁷²⁰ Complications and medical conditions are assigned a category; A, B, and C. If a complication or abnormality is found or presents during the woman’s care, the guidelines recommend that the midwife take one of three main steps; category A: discuss the issue/condition with another midwife and/or with a medical colleague; B. Consult with a medical practitioner; C. Transfer responsibility for the woman’s care to a medical specialist.⁷²¹ *The National Midwifery Guidelines for Consultation and Referral* is now in its third edition, which has been ‘endorsed’ by RANZCOG and the Australian College of Midwives (ACM). The third edition is much more detailed in defining the midwives’ scope of practice and what is considered normal and abnormal during pregnancy, labour and birth and the postnatal period. Many categories that had previously been identified as a B have now been moved to a C, thereby reducing the midwives’ scope of practice even more.⁷²²

As previously mentioned, to enable midwives to access insurance, the PBS and MBS they must have a collaborative arrangement in place. This requirement has proven to be problematic with many GPs and obstetricians refusing to enter into a collaborative arrangement with midwives. This led to a change in the wording of the requirement, which now states that midwives may have a collaborative agreement with a health facility rather than an individual.⁷²³ This requirement of collaboration remains problematic however,

⁷¹⁸ Australian College of Midwives Inc. 2004. *National Midwifery Guidelines for Consultation and Referral*.6.

⁷¹⁹ Ibid.

⁷²⁰ Australian College of Midwives Inc., *National Midwifery Guidelines for Consultation and Referral*.10.

⁷²¹ Ibid.11

⁷²² Australian College of Midwives Inc. 2014. *National Midwifery Guidelines for Consultation and Referral*. 3rd ed.

⁷²³ "Collaborative Arrangements for Midwives and Nurse Practitioners," ed. Department of Health.

because the lack of support for autonomous midwifery practice and homebirth by doctors has led to distrust between them and a lack of understanding of the scope of midwifery practice.

Chapter Summary

This chapter has provided a historical context to midwifery in WA from 1829 to 2018. The next four chapters will present the qualitative research findings of this current study on privately practising midwifery in WA.

Chapter Six – Midwives in the Community: the Journey of the Privately Practising Midwife (PPM)

Chapter Overview

The overall aim of this historical qualitative study is to generate new and useful knowledge by documenting and discussing the history of private midwifery in Western Australia (WA) and by exploring the experiences, social pressures, values and attitudes of the privately practicing midwives (PPM), the women they cared for and related health care professionals such as medical practitioners. The qualitative analysis drew upon data predominantly from in-depth interviews with living PPMs who practiced in WA between 1978 and the present day (some midwives were currently practising when the study took place in 2018). This data was also supplemented by interviews with women who had experienced midwifery care from PPMs, as well as interviews with medical practitioners, media reports, archival documents, and National and State maternity health policies and guidelines.

Similar themes were discovered throughout the history of PPMs in WA over this 40 year period, providing rich data that described the experiences of these midwives. Following extensive analysis of the historical archival data and contemporary interview data, four main interrelated themes and subthemes emerged (see Table 1 below). The findings of this study of PPMs in WA are presented in four separate chapters, beginning with this chapter. Interpretation of the qualitative data presented in these findings chapters was taken from the in-depth interviews with fifteen midwives and three doctors. Biographical details of the interviewees are presented in Table 2 and Table 3 in the following pages. Collectively, their experiences covered the 1970s to the present day. Out of the eighteen interviewees, nine midwives and one doctor received maternity care from a PPM and birthed at home (see Table 4). To illustrate the themes, quotes from the PPMs and doctors who were interviewed will be provided in each section. Historical and archival documents will also be presented, where relevant, to provide a historical comparison.

Table 1: Themes and sub themes

Themes	Midwives in the community: the journey of the Privately practising Midwife (PPM)		Trusting women and birth is central to midwifery philosophy		Power and control of the institutions		Breaking through the fear: continuing to support women and each other	
Sub themes	Birth within the home	Building a relationship and providing continuity of carer	Medicalisation of birth	Midwives use of intuition and the concept of authoritative knowledge	Persecution and reporting of midwives	Legislation, red tape and jumping through the hoops	Getting educated and gaining power	Collaboration

Table 2: Biographical details of Midwives interviewed

	Midwife name and nationality	Age	Place and Year completed nurse training	Place and year completed midwifery training	Years of practice as a PPM	Are you still practising as a PPM? If not when did you stop?	Did you receive maternity care from a PPM?	Were your children born at home?
1	Jane Smith Australian	59	Western Australia (Edith Cowan University) 1992	Western Australia (King Edward Memorial Hospital) 1995	1995-2008	2008	Yes	Yes
2	Mary Murphy Australian	76	Western Australia (Fremantle Hospital) 1963	Western Australia (St Anne's Hospital, Mt Lawley) 1978	1983-2009	2009	No	No
3	Bronwyn Key Australian		Western Australia (Royal Perth Hospital) 1973-76 Bachelor of Applied Science, Nursing 1981	Western Australia (Curtin University) 1985	1985-2000	2000	Yes	Yes
4	Enid Facer British	Not given	UK 1960s	UK 1960s	1980s to early 2000s	Early 2000s	No	No
5	Loralee Worrall Canadian	42	Canada (Trinity Western University) 1998	Western Australia (Curtin University) 2009	2012-present	Still practising	Yes	Yes
6	Denise Hynd Australian	66	New South Wales, Australia (Sydney Teaching Hospitals of the University of NSW) 1973	UK (Chace Farm Hospital Enfield Middlesex) 1976	1997-2017	2017	No	No

	Midwife name and nationality	Age	Place and Year completed nurse training	Place and year completed midwifery training	Years of practice as a PPM	Are you still practising as a PPM? If not when did you stop?	Did you receive maternity care from a PPM?	Were your children born at home?
7	Theresa Clifford British	70	UK (County Durham) 1968	UK (Guilford Surrey Part 1; Chertsey Surrey Part 2) 1969	1978 to 2011	2011	Yes	Yes
8	Susanjane Morison Australian	50	Western Australia (Edith Cowan University) 1989	Western Australia (Curtin University) 1991	1998-2005	2005	No	No
9	Nicky Vervest Australian	57	Western Australia (Fremantle Hospital) 1982	Western Australia (St John of God Hospital) 1992	1992-2004	2004	Yes	Yes
10	Emma Ritchie Australian	41	Western Australia (Edith Cowan University) 1998	Western Australia (Curtin University) 2006	2006-2012	2012	Yes	Yes
11	Carol Pinch Australian	66	Perth, Australia (St John of God Hospital, Subiaco) 1974	Western Australia (King Edward Memorial Hospital) 1976	1978-1999 2007 2012	2012	No	No
12	Vanessa Butera Australian	48	Western Australia (Edith Cowan University) 1990	Western Australia (King Edward Memorial Hospital) 1994	2003 to present	Still practising	Yes	Yes

	Midwife name and nationality	Age	Place and Year completed nurse training	Place and year completed midwifery training	Years of practice as a PPM	Are you still practising as a PPM? If not when did you stop?	Did you receive maternity care from a PPM?	Were your children born at home?
13	Naomi Newman Australian	44	Western Australia (Edith Cowan University)1996	Western Australia (Curtin University) 2011	2011-present	Still practising	No	No
14	Sam Mansfield Australian	41	Western Australia (Curtin University) 1999	Western Australia (Curtin University) 2002	2006-present	Still practising	Yes	Yes
15	Mary Jane McNamara Australian	56	New South Wales, Australia (St Vincent's Hospital Sydney) 1983	Western Australia (Curtin University) 2003	2007-present	Still practising	Yes	yes

Table 3: Biographical details of Doctors interviewed

	Doctors Name and Nationality	Place and year completed medical training	Years of practise providing back up support to midwives/providing care to homebirth women	Still practising? If not when did you stop?	Did you receive maternity care from a PPM?	Were your children born at home?
1	Liza Fowler Specialist Obstetrician and gynaecologist (South Africa)	South Africa Stellenbosch University South Africa MBChB 1994, MMED (O+G) 2002, FCOG(SA) 2002, FRANZCOG 2010	15 years, since 2010 in Western Australia	Still providing support to midwives and home birthing women	No, unfortunately not	No, unfortunately not
2	Margaret Trungeon GP obstetrician (British)	Western Australia 1970s Diploma in obstetrics at King Edward Memorial Hospital in 1977	1980s-2000s	No	Yes	Yes
3	Ralph Hicking Specialist Obstetrician and Gynaecologist (British)	Qualified as doctor in UK in 1959, became an obstetrician and gynaecologist in 1963	1982-1996	Retired 1996 (Ralph died in June 2018)	No	No

Table 4: Women interviewed who received care from PPM

	Women	Age	Did you receive maternity care from a PPM?	Were your children born at home?
1	Jane Australian	59	Yes	Yes
2	Bronwyn Australian	Not given	Yes	Yes
3	Loralee Canadian	42	Yes	Yes
4	Theresa British	70	Yes	Yes
5	Nicky Australian	57	Yes	Yes
6	Emma Australian	40	Yes	Yes
7	Vanessa Australian	48	Yes	Yes
8	Sam Australian	41	Yes	yes
9	Mary Jane Australian	56	Yes	Yes
10	Margaret Australian	Not given	Yes	Yes

Midwives in the Community: The Journey of the Privately Practising Midwife (PPM)

The next section will present the major theme 'Midwives in the community: The journey of the Privately Practising Midwife (PPM)' and its subthemes 'Building a relationship and providing continuity of carer' and 'Birth within the home' (see Table 5 below). These themes became apparent throughout the analysis of the historical and contemporary data. From the time of the occupation of WA by the British in the early 19th century to the present day, midwives lived and provided midwifery care within the community, developing relationships with the women they cared for and attending their births at home.

Table 5: Findings part one themes and sub themes

Theme	Midwives in the community: The journey of the Privately Practising Midwife (PPM)	
Sub themes	Birth within the home	Building a relationship and providing continuity of carer

As detailed in the methodology chapter, the midwives interviewed in this study practised private community midwifery from the 1970s to 2018. The WA midwives interviewed stated that they wanted to work within the community, to be part of the community and felt that birth itself was often a community event.

An important part of being community midwives was the ability to provide care in the community, usually in the women’s homes and the midwives provided care throughout the pregnancy, labour and birth and into the postnatal period. The midwives interviewed in this study described how the knowledge of midwifery and birth at home was passed down through the generations. Many of the midwives were themselves born at home and/or had mothers or grandmothers who practised as midwives. Bronwyn said, “Great granny was a midwife, my mother was delivered by her great grandmother so it’s in there (points to heart).”⁷²⁴ Mary also came from a long line of community midwives:

My great-grandmother was a midwife, my mother was a midwife. My great-grandmother looked after my grandmother as a midwife and she delivered my mother and then my mother was a midwife. Now she wasn’t on the register because she did something like a six month course at King Edward and I’ve never been able to chase that down but she was adamant that she did six months training at King Edward before she went to Bunbury and worked in the midwifery home there where I was born. And then I’m a midwife and I was midwife to my daughter for all of her births.⁷²⁵

Many of the midwives who were interviewed shared how they were inspired to become midwives by reading about community midwifery or by receiving community midwifery care themselves from a PPM. Jane decided to become a midwife after receiving midwifery care from a PPM and birthed her son at home in the 1980s:

⁷²⁴ Key, Bronwyn. 2015. "In Depth Interview with Midwife." by Clare Davison, October 27, 2015.

⁷²⁵ Murphy, Mary. 2016. "In Depth Interview with Midwife." by Clare Davison, February 3, 2016.

I became a midwife. I was very passionate about it, basically it was because when I got pregnant with my son it was a homebirth in Sydney and it was such a good experience. I thought this is what I want to do. My midwife, Maggie Lecky Thompson, she was amazing, and she really impressed me. She was probably the first independent woman I'd ever met.⁷²⁶

Nicky had a traumatic birth in hospital with her first baby, for her second birth she chose a home birth with a PPM and this experience inspired her to become a midwife:

It's like this seed was planted and Millie was only weeks old, Theresa was still visiting, and I said to Theresa, I think I want to be a midwife. I think I want to be a homebirth midwife and she said you'll make a great midwife and by her saying that too I thought well maybe I will.⁷²⁷

Mary Jane was inspired by reading about birth when training as a nurse in the 1980s:

In my nurse training I did a maternity placement and I met a student midwife. She said, 'Ah you look like a bit of a hippy, here read this book', and it was Ina May Gaskin's *Spiritual Midwifery*. Well I just loved it and I just thought if I ever have babies, I'll have homebirths and one day I'll be a midwife.⁷²⁸

Mary Jane went on to have all five of her children at home with a PPM before finally becoming a midwife herself in 2000.

In the interviews, the midwives spoke about their journeys to become a PPM. All the PPMs interviewed became midwives with the intention of being a community midwife, working in the community and being part of the community. Many talked about "always being a midwife" and it being "a calling". All the midwives interviewed stated that being a community PPM was more than a job to them. Emma said, "I've always wanted to be a community midwife, I was never going to work in a hospital, although I was already working in Broome, but that was the aim when I finished, to be a community midwife...it felt I was working from the heart, it was like a calling".⁷²⁹ Enid stated, "I'm a midwife, I'm a very proud midwife and I'm a homebirth midwife".⁷³⁰ Naomi reflected, "I felt like I'd come home

⁷²⁶ Smith, Jane. 2015. "In Depth Interview with Midwife." by Clare Davison, October 20, 2015.

⁷²⁷ Vervest, Nicky. 2018. "In Depth Interview with Midwife." by Clare Davison, May 28, 2018.

⁷²⁸ McNamara, MaryJane. 2018. "In Depth Interview with Midwife." by Clare Davison, October, 14, 2018.

⁷²⁹ Ritchie, Emma. 2018. "In Depth Interview with Midwife." by Clare Davison, June 14, 2018.

⁷³⁰ Facer, Enid. 2015. "In Depth Interview with Midwife." by Clare Davison, October 28, 2015.

working in the community because it just made sense and to have that relationship and that rapport was just amazing".⁷³¹ Theresa said:

That's one of the really nice things about being a community midwife, living in the community, working in the community, I still see my babies and their babies. So, it's like sort of being part of the community. I mean I watch *Call the Midwife* [BBC television series] and that's where I came from, that's how it was for me.⁷³²

Even when things did not go to plan, being a community midwife meant that the midwife continued to be present to provide support. Bronwyn said, "we are managing that grief at home and in the community and I guess that's part of the midwife's role".⁷³³ Naomi described caring for a family whose baby had died and the impact it had on her:

We went from having a beautiful homebirth to a palliative care baby with an undiagnosed mosaic trisomy. This involved admission to [Princess Margaret Hospital for children], lots of genetic counselling, lots of support, because all mum wanted was the baby to come home, even though she knew baby wasn't going to stay. That was huge, watching the family, supporting them. That's when I knew private midwifery was what I really wanted to do.⁷³⁴

All the midwives interviewed in this study were also nurses, however, the majority had initially trained as nurses, with the sole aim of becoming midwives. As discussed in Chapter Five the only way to become a midwife in Australia, from the early 20th century until the early 21st century, was following the completion of nursing training. Jane described her passion and her journey to becoming a PPM:

I suppose we were a self-selecting group, women who were really passionate, you know this is what they want to do and they are really there for the women. It was what I really wanted to do, I worked a long time, you know I educated myself went through the nursing. I loved working with the midwives as a group.⁷³⁵

Nicky said, "I just felt like I was the luckiest person in the world to have the most awesome job. Like there's mortals walking around doing their work and then there's

⁷³¹ Newman, Naomi. 2018. "In Depth Interview with Midwife." by Clare Davison, October 10, 2018.

⁷³² Clifford Theresa. 2016. "In Depth Interview with Midwife." by Clare Davison, May 10, 2016.

⁷³³ Key, "In Depth Interview with Midwife."

⁷³⁴ Newman, "In Depth Interview with Midwife."

⁷³⁵ Smith, "In Depth Interview with Midwife."

midwives".⁷³⁶ On reflecting on being a PPM, Sam too felt lucky, and described how being a PPM was difficult to compare to any other work:

It's amazing work that we do, you can't compare it to anything else. We are so lucky. It's so hard to explain it to anyone else what we do. I think women who birth with us get it, often not at the time but sometimes later. All the extra little things, that we take for granted, is just the normal service we offer. There are so many benefits that we forget to mention because we just do it, it's our normal practice.⁷³⁷

Susanjane described how birth at home was often celebrated by the community:

I just loved working in the community. I'll never forget one beautiful birth which was loud and proud, and she birthed beautifully and then, after the birth, there at the front door were flowers and a meal from the neighbours. That amazing community coming in.⁷³⁸

Midwives interviewed in this study would not always charge for their services. Theresa, who practised from the 1970s to 2012, described how when some women could not afford to pay her midwifery fees in cash, but she would be paid in other ways:

There are a couple of women that didn't pay me and they're the women that have just been my rocks. You know they're the ones that I'd come home from a birth and I'd be really, really tired and just thinking oh what am I going to get the kids for dinner or how am I going to get through today or tomorrow and they'd just turn up on my door step with a quiche or a pan of soup and say 'I was just thinking about you' and you think, oh thank God, somebody's got my back.⁷³⁹

Another way for women to pay for the midwifery service was to trade services, Theresa describes the community trading system in Fremantle:

I was in LETS, Local Exchange of Trade Services. So, I would do a birth half LETS half cash, so it would be \$100 for the birth and \$100 cash and I could trade with anybody. I was a LETS millionaire I mean people would say 'I can't afford to have my baby at home' and I'd say 'well you can't afford not to have your baby at home, so don't let money stop you, if you can't

⁷³⁶ Vervest, "In Depth Interview with Midwife."

⁷³⁷ Mansfield, Sam. 2018. "In Depth Interview with Midwife." by Clare Davison, October 12, 2018.

⁷³⁸ Morison, Susanjane. 2016. "In Depth Interview with Midwife." by Clare Davison, September 2, 2016.

⁷³⁹ Clifford, "In Depth Interview with Midwife."

afford it you must be able to afford to pay \$10 a week out of your pension or whatever it is that you're getting and you just pay it off as you can'.⁷⁴⁰

Loralee describes a similar exchange of services in her current midwifery practice, working as a midwife in the South West of WA:

I've got girls that have been paying me over the last couple of years and still have a way to go, which is fine. Or I've done a lot of swaps as well. Girls painted me a picture or swapped surf lessons or a nice website. I've had girls cook for me which has been great as well.⁷⁴¹

The above quotes demonstrate PPMs were prepared to work with the women and their families so that women could still access their services. This is an illustration of the broader implications of being a community midwife, the sense of belonging to the community and of looking after each other.

Some of the midwives interviewed had retired or stopped working in midwifery at the time of this study. All these midwives talked about the strong emotional reactions they felt when leaving midwifery. Enid said:

My husband said I can't believe a midwife who has been a midwife as long as you, 42 years, can just stop like that, I said I had to, I had to go cold turkey. But it took me so long, I grieved for a whole year after I made the decision. I've always said I'd had the most wonderful life, it was the best thing I ever did becoming a midwife. Yes, I was very privileged to be a midwife.⁷⁴²

Nicky had thought she would be a midwife until she retired; however, she had to give up midwifery due to ill health. She described her distress when she stopped practising as a community PPM, "It was just every fibre of my body and I had imagined that I'd be doing it until I couldn't walk anymore, and ... the loss was immense and I'm still trying to this day to find something to do."⁷⁴³ Theresa had also retired at the time of her interview. Looking back on her long career she said:

... it's been a long journey but most of it, I mean for me, most of it has been in private practice and all of it's been homebirth. It's always been homebirths here and it's just part of my life. It's

⁷⁴⁰ Clifford, "In Depth Interview with Midwife."

⁷⁴¹ Worrall, Lorelee. 2016. "In Depth Interview with Midwife." by Clare Davison, January 25, 2016.

⁷⁴² Facer, "In Depth Interview with Midwife."

⁷⁴³ Vervest, "In Depth Interview with Midwife."

been a good journey, I wouldn't have done anything else and I do miss it, I do miss being around pregnant women and birthing women.⁷⁴⁴

For the midwives who were interviewed as part of this study, it was apparent that midwifery dominated every part of their lives and being a community PPM was an experience they were very proud of. The midwives often worked long hours and were 'on call' for births for extended periods. Regardless of the toll on their lives, the midwives were willing to commit themselves to their role as PPMs. As Sam said, "It's really fantastic, there are so many benefits, the positives outweigh the negatives".⁷⁴⁵

Archival evidence also reflects the theme of midwives in the community. Midwives often follow in their mothers or grandmothers' footsteps by becoming midwives and providing midwifery care within their communities. For example; Elizabeth Exley Hampson, worked in the mills in Yorkshire, England, but came from a long line of midwives, including her mother Mary, who attended births and cared for the sick of the community when they could. In 1890 Elizabeth arrived in Midland where she resided in a tent and by 1892, she had also given birth in the tent. Elizabeth was one of the midwives on the first WA midwifery register. She was highly respected in her community. When Elizabeth died in 1923, many of the people she had delivered as babies, attended her funeral. Her great granddaughter Tanya described how she provided care in the community:

My grandad Fred always said people were forever coming to the house asking if she could come because someone was sick, and they had no money for a doctor. I am so proud of her to be on the first registry of midwives in Western Australia, as a mill girl who could not read and write. I think they were all proud of her as on her death notice it reads 'Nurse'. It must have been a very big thing for the family when she became a real nurse.⁷⁴⁶

As demonstrated by both the contemporary and historical quotes above, the midwives provided midwifery care within the community. The work of the PPMs also revolved around the home, which was generally the place of birth for women receiving maternity care from a PPM. 'Birth within the home' is the first subtheme related to the major theme 'Midwives in the community: the journey of a privately practicing midwife' and will be presented in the following section.

⁷⁴⁴ Clifford, "In Depth Interview with Midwife."

⁷⁴⁵ Mansfield, "In Depth Interview with Midwife."

⁷⁴⁶ Hampson, Tanya. 2017. Email May 9, 2017.

Birth within the Home

The findings from the interviews conducted in this current study indicate that even when birth in hospital became the norm for WA women, those who chose a PPM as their birth attendant continued to birth at home. Birth within the home was a tradition passed down through the generations of birthing women. Bronwyn said, "I was born at home, all the women in our family were born at home".

Out of the eighteen participants who were interviewed as part of this study, ten women (nine midwives and one doctor) gave birth to their own children at home with the care of a private midwife. The qualitative data derived from these interviews demonstrated that receiving maternity care from a PPM and planning for the birth to take place within the home, reinforced the importance of home as a site of women's empowerment. All the women described the midwifery care they received from their PPM as a positive experience, using words such as "amazing, life changing and empowering" to describe their births. Like the reciprocal 'neighbouring' seen in the pioneer years and described in Chapter Five, in the late 1980s Bronwyn was the midwife to her mentor midwife, Theresa when she gave birth to her children, and Theresa was in attendance at the birth of Bronwyn's son also in the 1980s:

I had my son at home with a private midwife and then I was the private midwife's midwife. Well, actually it was the other way around. She had hers first and then that was when I decided I'd passed my apprenticeship, when I delivered her daughter (laughs). I was no longer the sorcerer's apprentice, that's it she let me be her midwife and she was happy with the service, so I guess that's the tick.⁷⁴⁷

The PPMs interviewed all provided midwifery care in the home, comprising antenatal care, attending the labour and birth, and postnatal care. Midwives stated that planning for the birth to take place at home meant being in the woman's own environment and enabled them to develop a relationship based on mutual respect. Jane said, "I just think that birth in the home means women are on their own territory. You get to know them better".⁷⁴⁸ In contrast, women attending hospital for maternity care are not on their own territory and this can cause a power imbalance. Nicky talked about the place of birth and its impact on the experience of birth: "You know birth in hospital can be absolutely as fulfilling for

⁷⁴⁷ Key, "In Depth Interview with Midwife."

⁷⁴⁸ Smith, "In Depth Interview with Midwife."

mother and midwife and everything, but you know it's less likely to happen and very likely to happen at home."⁷⁴⁹ Vanessa talked about how providing care in the women's homes enabled a rapport to develop that helped women to discuss fears or concerns, and that there was no time restriction on the duration of the visit which enabled women to be relaxed.

I don't rush it. I go see them. If it takes half an hour that's fine; ... it usually takes about an hour, [or] an hour and a half for each visit. So, I really focus on that with them. I really emphasise that there's lots of stuff subconsciously that they won't be aware of and that may surprise them and the more work that they do antenatally the less that they'll have to do in labour, and there'll be things that are always ongoing but there's a lot of stuff that comes out that helps them [overcome] fear, letting go of a lot of fear and fear releasing stuff we do. You know you develop a rapport, you sometimes more than likely become part of the family. Great to involve the siblings and the partners and being in their own environment really helps. I find the journey is a lot easier and the birth is a lot more— less hours and more, more empowering for them. The best saying I've ever had from one of my mentors, Theresa, was, 'the more cups of teas you have with your women the less time you are at the birth'.⁷⁵⁰

Home was the expected place of birth for the majority of women in WA until the early to middle of the twentieth century as there were few other options. Birth within the home was the norm, and birth itself was generally uneventful and considered a part of everyday life. By the middle of the 20th century, with the increasing medicalisation of birth, the expected place of birth had moved from the home to the institution. The choice to birth at home was not always an easy one and was not considered an appropriate choice by the medical profession (which will be discussed more in the subsequent chapters). With the increasing number of women birthing within the institutions the number of midwives offering midwifery care at home reduced dramatically and by the 1950s it was almost non-existent. This was the case when Henny Ligtermoet arrived in Australia in 1951 with her husband and two children.⁷⁵¹ Henny planned to have more children and wanted to birth them at home as she had done with her first two children in her home county, Holland. This plan proved to be difficult and led to a lifelong passion and fight for midwife-attended

⁷⁴⁹ Vervest, "In Depth Interview with Midwife."

⁷⁵⁰ Butera, Vanessa. 2018. "In Depth Interview with Midwife." by Clare Davison, June 29, 2018.

⁷⁵¹ Ligtermoet, Henny. 1999b. "My Thoughts in the Mid 1950s," in *Ligtermoet, Henny (1921-1999)*, State Library of Western Australia.

homebirth in Australia.⁷⁵² Henny was told by her GP that homebirth was illegal in Australia and it was only after she telephoned the Public Health Department that she was informed that homebirth was not illegal. Nevertheless, during the phone call she was advised that she should not have a homebirth as it was 'highly dangerous'. It took Henny three years to find a midwife.⁷⁵³ According to an interview undertaken by Carol Thorogood in 1999⁷⁵⁴, Henny stated that once she found one midwife— a midwife who attended the Italian women living in WA who wanted a homebirth— she found there was a small underground homebirth movement. However, midwives could be found only by word of mouth, as the medical profession considered the practice of homebirth dangerous. Henny said that until the 1970s many babies were recorded in the official documentation as 'baby born before arrival'; therefore, the name of the attending doctor or midwife was not recorded.⁷⁵⁵

Henny dedicated the rest of her life to birth activism, the fight for women's right to choose to birth at home with a midwife and to promote what she termed 'natural childbirth'. She founded the Midwifery Contact Centre in 1956, based in East Fremantle, Australia's first organised homebirth group.⁷⁵⁶ The Midwifery Contact Centre's aim was to act as the go-between for women seeking midwives to attend their homebirths.⁷⁵⁷ Theresa met Henny when she arrived in Fremantle, WA in the mid-1970s and became involved in the Midwifery Contact Centre:

I met Henny. Henny was a Dutch woman who was organising home births and putting women in touch with private midwives, so they could have their babies at home because she'd had her baby at home in Holland and then came out here and before she had her second baby she was asking everybody, 'Well where are the midwives?' and they said, 'No. You have a doctor'. And she said, 'No, no, no. I'm not sick. I just need a midwife'. And so, she didn't have another baby for I think it was probably three or four years until she found a midwife who was willing to look after her and then she had her baby at home.⁷⁵⁸

⁷⁵² Ligtermoet, Henny. 1999a. "Correspondence, Documents and Submissions by Henny Ligtermoet," in Ligtermoet, Henny (1921-1999), State Library of Western Australia.

⁷⁵³ Ligtermoet, "My Thoughts in the Mid 1950s."

⁷⁵⁴ Thorogood, "Politics and the Professions: Homebirth in Western Australia."

⁷⁵⁵ Ibid.; Ligtermoet, "My Thoughts in the Mid 1950s."

⁷⁵⁶ Ligtermoet, "Correspondence, Documents and Submissions by Henny Ligtermoet."

⁷⁵⁷ Ibid.; Ligtermoet, Henny. 1981. "Record Book of Homebirths Organised 1956-1981," (State Library of Western Australia); Ligtermoet, "My Thoughts in the Mid 1950s."

⁷⁵⁸ Clifford, "In Depth Interview with Midwife."

Theresa, too, thought that birthing in the home was illegal in Australia when she first arrived in the early 1970s.⁷⁵⁹ Theresa attended her first birth in Australia in 1974 after a woman approached her, requesting her to be her midwife and attend her birth at home. Theresa described this conversation:

She was pregnant and asked me if I'd be her midwife and I just said, 'Well, you know, you'd come to Three Springs to have the baby' and she said, 'No, no, I'll have the baby at home', and I just said, 'Oh, I don't think you can, I don't think you can have home births in this country, I don't think it's legal, nobody has home births'.⁷⁶⁰

The Midwifery Contact Centre attempted to collect and record the number of homebirths in WA, however, as described above due to the underground nature of midwifery support for homebirths and the reluctance of both women and their families and the birth attendants to draw attention to homebirth, it is likely that these figures were underestimated. These statistics show that there were 391 homebirths organised by the Midwifery contact center from 1956-1983.⁷⁶¹ From 1975 the Department of Health WA recorded all birth statistics in WA, however homebirth numbers or statistics were not differentiated from hospital births until 1980.⁷⁶² Since 1980 the numbers of homebirths attended by PPMs have been recorded by the Health Department with a small but consistent number choosing to birth at home with a PPM.⁷⁶³

British born Margaret Trudeau is a GP obstetrician, and was interviewed as part of this study. Margaret completed her obstetrical training at KEMH in the late 1970s. Margaret attended antenatal classes with Henny and had her own three children at home with a PPM:

When I actually got pregnant, I said, 'there's no way I'm having my baby at King Edward Hospital. I don't want to have it in an outlying hospital because there's no backup facilities out there, so it makes much more sense to have it at home because I can be in theatre quicker from home than I could from the ward'. So, then I started looking around for a midwife, that's when I met Henny and I did Henny's antenatal classes which were very different for the time.

⁷⁵⁹ Clifford, "In Depth Interview with Midwife."

⁷⁶⁰ Ibid.

⁷⁶¹ Ligtermoet, Henny. 1988. "Homebirth Statistics 1956-1983," in *Ligtermoet, Henny (1921-1999)*, State Library of Western Australia.

⁷⁶² Department of Health. 1978. "Perinatal Statistics in Western Australia 1975-1978." Western Australia.

⁷⁶³ Department of Health. 2018b. "Mothers and Babies, Western Australia: Perinatal Statistics 1980-2018." Western Australia.

Her focus was totally on relaxation and we spent lots of time, both partners doing relaxation together, training the partner to support the woman in labour and, and really normalising labour and pregnancy. Lots of good advice about pregnancy, she was very, very good as an antenatal teacher and she was running the midwifery contact centre, so she put people in touch with the midwives who were providing homebirth services.⁷⁶⁴

Margaret described how Henny put a lot of pressure on her to support homebirths and provide backup for PPMs. There was very little support from the medical profession which caused Margaret anxiety. "I was really anxious because there was so much negativity about doing this [providing homebirth support to PPMs]".⁷⁶⁵ Margaret worked with the PPMs throughout the 1980s and 1990s by providing back up support at Woodside hospital in Fremantle:

In my argument, right at the beginning was when people said how can you support homebirths, I said 'look there's lots of women out there going ahead and giving birth on their own or with lay midwives because the doctors won't support them and I am providing a service to women who choose to do that because it's safer for me to be working with them and advising them and gaining their trust so that when there's something really wrong they will listen to me and go to hospital'.⁷⁶⁶

Margaret chose to attend homebirths herself as a medical practitioner in an attempt to get to know the midwives and see how they practised. She gained insight from these experiences stating:

I went to the home – yes. The medical profession was so derogatory about the whole thing, but I knew I was putting myself out on a limb and I wanted to make sure that I knew what was going on and that I was happy with it and I also didn't know the midwives. And so, I wanted to see how the midwives operated at home and make sure that I was happy with the safety of what was going on at home and I learnt more about birth and labour doing that than I learnt in my entire six months at King Edward.⁷⁶⁷

Henny was passionate about supporting the women and midwives to enable them to have safe and supportive homebirths. She campaigned to raise the public's awareness of the safety of midwife attended homebirth. She wrote articles and letters to the media and

⁷⁶⁴ Trungeon, Margaret. 2017. "In Depth Interview with Doctor." by Clare Davison, March 16, 2017.

⁷⁶⁵ Ibid.

⁷⁶⁶ Ibid.

⁷⁶⁷ Ibid.

ran a regular local radio program in Rockingham in the 1980s.⁷⁶⁸ During this period Henny recruited another homebirth advocate, Ralph, a specialist obstetrician working in the Rockingham area. Ralph qualified as a doctor in Britain in 1959, specialising in obstetrics and gynaecology. He emigrated to WA in 1969. Henny made a lasting impression on Ralph, who dedicated his book *Childbirth Today*⁷⁶⁹ to her. During the interview, Ralph described meeting Henny in the late 70s and the impact she had on him:

Well she met me actually. She asked me for an interview you know and talked to me about homebirth as a whole and you know when I first met her I thought she was a bit of a bore really, banging on about something which was sort of way out of what was being done at the moment but I very soon changed my mind and found that what she said was very logical. So that I soon found myself sort of joining in. I mean she sort of led a movement.⁷⁷⁰

Ralph soon started to support the midwives, attending births and providing back up obstetric support until his retirement in 1996. PPM Bronwyn felt that encouraging others to attend home visits and births at home was a way to dispel the myths and fear around community midwives and homebirth. During her practise as a PPM from 1985 to 2000, Bronwyn actively engaged with GPs and medical students, although very few attended the births with her:

We would work with GPs and students and try and get medical students along to a homebirth and people going into general practice to get to one where possible. So there is that thing, that if you have actually been there and been part of a homebirth or seen the relationships with the women and a privately practising midwife, you get a totally different picture than the media, so I mean there is so much to learn from being present at a prenatal visit or the birth and a postnatal visit to get a you know realisation that birth can be a totally different experience than a hospital birth that is fear driven.⁷⁷¹

Fear and risk perception are issues that are often raised when discussing the place of birth and this will be covered in more detail in the next chapter under the theme 'Trusting women and birth is central to midwifery philosophy' and its subthemes 'Medicalisation of

⁷⁶⁸ Ligtermoet, "Correspondence, Documents and Submissions by Henny Ligtermoet"; Ligtermoet, Henny. 1992. "Radio 101 FM Transcribes." in *Radio Talks Henny Ligtermoet: State Library of Western Australia, 1988-1992*.

⁷⁶⁹ Hickling, Ralph. 2010. *Childbirth Today: Too Many Caesars, Not Enough Joy?* Western Australia: Ralph Hickling.

⁷⁷⁰ Hickling, "In Depth Interview with Doctor."

⁷⁷¹ Key, "In Depth Interview with Midwife."

birth based on risk perception' and 'Midwives use of intuition and the concept of authoritative knowledge'.

When discussing work as a PPM, providing community midwifery care and attending births at home, midwives and women talked about the relationship they had with each other and this will be described in the following subtheme.

Building a Relationship between the Woman and the Midwife and Providing Continuity of Carer

The second subtheme to be discussed under the theme 'Midwives in the community: the journey of a privately practicing midwife' will be presented now and is titled 'Building a relationship between the woman and the midwife and providing continuity of care'. Providing midwifery care in the community illustrates a very different picture to the institutional birth, where care is often fragmented with multiple care providers.

The data from the midwives' interviews demonstrates that all the midwives who were interviewed chose to provide midwifery care as PPMs because they valued the opportunity to build a relationship with the women and provide continuity of carer. The relationship between the woman and her midwife is central to the care provided to the women.

Carol, who practised as a PPM from 1978 to 2012, believes that the relationship between herself and the women she provided midwifery care for, was at the core of midwifery: "I think for midwifery to actually work well for you as a midwife you do have to have that sort of connection with the woman, it was amazing and I've met women now, like 40 years later...that remember me looking after them".⁷⁷² Carol also talked about the importance of the continuity of carer, "I loved the autonomy... seeing your women in antenatal and being with them at birth and seeing them post birth for as long as necessary."⁷⁷³ Susanjane, who practised in the 1990s and 2000s, also valued continuity of carer. "What I loved about community, is that I could have that continuity of care relationship. Families working together with you for the best possible outcome."⁷⁷⁴ Vanessa described getting the right balance in the relationship. "I feel it's really important to get

⁷⁷² Pinch, Carol. 2018. "In Depth Interview with Midwife." by Clare Davison, June 27, 2018.

⁷⁷³ Ibid.

⁷⁷⁴ Morison, "In Depth Interview with Midwife."

that right midwife for you and vice-versa, the right client for the midwife. Being such a sacred time, you really need to have, have those right people and the right balance in there".⁷⁷⁵ These examples clearly demonstrate that the need to build a relationship with the women and provide continuity of care was an essential component of care that continued throughout the time period of over forty years that these midwives practised as private midwives.

It was not only midwives who believed that relationship-based continuity of carer is important. South African born Liza, who is a consultant specialist obstetrician, also agreed with this stance. Liza has collaborated with the PPMs in the Perth metropolitan area since she arrived in WA in 2010. Liza provides specialist obstetric back up if needed. She said:

I believe that women should be able to choose wherever and whoever they want to have their babies with, but still be supported and be able to do it safely. So, by having midwives that are willing to support women at home and making sure that the right women birth at home and that the midwives are supported in supporting the women, it just made sense to me. And, I just think building a relationship between the woman and the carer is really important.⁷⁷⁶

Naomi, who is currently practising as a PPM, believed that having the continuity of carer relationship was of paramount importance as it enabled her to provide support to all the family:

The relationship obviously (laughs) isn't it obvious? You get to know your women, you get to know your families, you get to be part of that whole journey, not just popping in to hear a baby's heartbeat, you're there listening to them having a moan about their toddler being feral or their husband being an arse, or all the other dynamics and dramas that go on with normal family, and when you're having a baby that ups the anti-for changing family dynamics because sometimes people struggle with the different roles. But you get to see all that, you get to support them.⁷⁷⁷

Midwife Sam, who has been practising since 2006 and also had her children at home with a PPM, described how women and midwives value the relationship formed with the person who will be with them during labour: "they prefer the personal care and getting to know one person, knowing I'm going to be the one there with them and having a

⁷⁷⁵ Butera, "In Depth Interview with Midwife."

⁷⁷⁶ Fowler, "In Depth Interview with Doctor."

⁷⁷⁷ Newman, "In Depth Interview with Midwife."

relationship. That strong bond and friendship and trust."⁷⁷⁸ Sam went on to elaborate that, although the majority of women plan to birth at home, ultimately it is the continuity of carer and the relationship that is the most important aspect of the care, particularly if things do not go to plan:

It's all about the relationship and the continuity. It's not all about the homebirth, obviously we'll give it our best shot but if it doesn't work, I'm still going to be there. I've had women have emergency caesareans that were totally unforeseen, but they are so grateful for the continuity. Them saying, 'I couldn't have imagined going through that without someone by my side that I knew, it just takes a lot of the scary stuff out of it'. I think no matter what kind of birth they have, having their own midwife there can make everything so much more personal and relaxed.⁷⁷⁹

Obstetrician Ralph thought that all women should have continuity of carer with a midwife rather than with a doctor:

Much better with the other way around, you book with a midwife and you make sure the midwife's going to be with you and if there is an emergency you take whatever doctor happens to be available. It made much more sense that way.⁷⁸⁰

It is apparent from the archival documents that continuity of carer is not a modern-day phenomenon. From the time of colonisation in Western Australia midwifery care was usually provided from a known midwife or neighbour, therefore a relationship would be formed between the woman and the midwife. Until birth moved to the hospital, in the early to mid-20th century, maternity care was not fragmented. Birth normally took place in the home or in small lying in homes, and the midwives lived in the same community as the women. It is apparent from the archival documents that although the woman would not normally receive antenatal care from their midwives (as until the 1920s women generally received little to no antenatal care),⁷⁸¹ the woman would usually know the midwife or birth attendant prior to the birth and would often have multiple births with her in attendance, thereby building a relationship and continuity of carer.⁷⁸² The type of relationship is difficult

⁷⁷⁸ Mansfield, "In Depth Interview with Midwife."

⁷⁷⁹ Ibid.

⁷⁸⁰ Hickling, Ralph. 2017. "In Depth Interview with Doctor." by Clare Davison, March 13, 2017.

⁷⁸¹ McKenzie, "Place and Power: A History of Maternity Service Provision in Western Australia, 1829-1950."

⁷⁸² Ibid.

to ascertain from the archival data, although there are documented examples of continuity of carer.

An example of these historical continuity of carer relationships is midwife Emma Withnell, who was the first white woman to live in the north west of Western Australia following colonisation by the British in the mid-1800s. Emma had eleven children, including twins, and became the Aunt Rubina of the district. She attended most of the women of the area in childbirth, becoming known historically in Western Australia as 'Mother of the North West'.⁷⁸³

Emma Withnell was highly respected in her community. The importance of the relationship between the woman and her care giver is illustrated by the events triggered by the arrival of a medical officer, Dr Mayhew, and his wife in 1868.⁷⁸⁴ The doctor and his wife made many complaints about the community and living conditions, however, trouble escalated when Emma Withnell was criticised by the doctor. Dr Mayhew was angry that he had not been called to attend a local woman, Mrs Hooley, during her birth. Dr Mayhew wrote a long letter of complaint to Mr R.J. Sholl, the district magistrate, in which he stated, amongst other things, "some female" had delivered the child. Mrs Hooley gave birth the day after Dr Mayhew arrived in the district, so it is not unexpected that she objected to his attendance, as this would not have been the norm for working class women. In response to the criticisms, Mr Sholl, the magistrate wrote a long letter of complaint:

She [Mrs Hooley] objected to the attendance of a strange man, and appealed to Mrs Sholl as a neighbour and friend, to comfort her in her trouble. The "female" spoken of by him is Mrs Withnell, well known and respected by everyone in the place with her good neighbourly qualities, her hospitality, her friendliness and her humanity. As a wife, a mother and a neighbour, she's so highly esteemed that any slight offered her will be received with general indignation. For my part, while I can treat with contempt the injurious terms applied by my subordinate officer to myself, "I cannot" be restrained from expressing my regret that Mr Mayhew (who had been long enough in the place to know her universally admitted character) should thus have slightly and contemptuously alluded to her for preforming an act of

⁷⁸³ Withnell, Nancy E. 1980. *A Saga of the North-West Yeera Muk a Doo: The First Settlement of the North-West Australia Told through the Withnell and Hancock Families 1861-1890*, Fremantle: Fremantle Arts Centre Press.

⁷⁸⁴ *Ibid.*; *Westralian Voices*.

Christian kindness towards an afflicted neighbour. There was moreover, no occasion for referring.⁷⁸⁵

This letter by Mr Sholl, the magistrate, supports the belief that doctors were not expected to attend normal labour and births and that midwives were not always subject to the whims of doctors. It also highlights that help during birth was provided by neighbours and friends and that not only did the midwives have community support, but they also had support from people in positions of power. Emma Withnell became a midwife through need rather than vocation, as there was no one else to provide care and assistance to women during labour and birth in her community. She became an experienced midwife by 'doing'; she had no formal training but had birthed eleven babies of her own and attended many other births.

Emma Withnell's experience is comparable to the participants in this study and illuminates how the themes of midwives in the community, birth within the home and the relationship between midwife and woman are apparent throughout the history of PPMs in WA. These examples, both historically and contemporary, highlight the vital impact to the community, the connections and relationships formed between the midwives and the women they attended.

Summary

To conclude, this chapter has presented the first major theme 'Midwives in the community: the journey of the Privately Practising Midwife (PPM)' and its subthemes: 'Building a relationship and providing continuity of carer' and 'birth within the home'. The next chapter will present the second major theme 'Trusting women and birth is central to midwifery philosophy' and its subthemes 'Medicalisation of birth' and 'Midwives use of intuition and the concept of authoritative knowledge'.

⁷⁸⁵ *Westralian Voices; Withnell, A Saga of the North-West Yeera Muk a Doo: The First Settlement of the North-West Australia Told through the Withnell and Hancock Families 1861-1890.*

Chapter Seven – Trusting Women and Birth is Central to our Midwifery Philosophy

Chapter Overview

The following chapter will present and offer supporting quotes for the second theme, ‘Trusting women and birth is central to our Midwifery Philosophy’ and its corresponding two subthemes: ‘Medicalisation of birth’ and ‘Midwives use of intuition and the concept of authoritative knowledge’, illustrated in Table 6 below.

Table 6: Findings part two theme and sub themes

Theme	Trusting women and birth is central to our midwifery philosophy	
Sub themes	Medicalisation of birth	Midwives use of intuition and the concept of authoritative knowledge

In this thesis I use the term ‘patriarchy’ in its feminist definition. Patriarchy was defined by Adrienne Rich in 1976 as “a familiar-social, ideological, political system in which men —by force, direct pressure, or through ritual, tradition, law, and language, customs, etiquette, education, and the division of labour, determine what part women shall or shall not play, and in which the female is everywhere subsumed under the male.”⁷⁸⁶. A patriarchal society values and promotes male privilege, is male dominated and male centred and is where women have been, and still are, subordinated to men. Walby describes patriarchy as “a system of social structures and practices [by] which men dominate, oppress and exploit women”.⁷⁸⁷ However, Barbara Katz Rothman believes that male dominance and patriarchal rule are not the same⁷⁸⁸. This is particularly relevant when it comes to the area of childbirth. Katz Rothman states that “patriarchal kinship is the core of what is meant by patriarchy: the argument that paternity is the central social

⁷⁸⁶ Rich, Adrienne. 1986. *Of Women Born: Motherhood as Experience and Institution*, 10th anniversary ed., New York: Norton, 1986.57.

⁷⁸⁷ Walby, Sylvia. 1991. *Theorizing Patriarchy*. Cambridge, UK: Basil Blackwell.

⁷⁸⁸ Katz Rothman, Barbara. 1994. “Beyond Mothers and Fathers: Ideology in a Patriarchal Society” In *Mothering: Ideology, Experience and Agency*, Edited by Evelyn Nakano Glenn, Grace Chang and Linda Rennie Forcey, 7: 141. New York Routledge.

relationship... In a patriarchal kinship system, children are born to men, out of women. That is women, in this system, bear the children of men⁷⁸⁹. Therefore, to maintain a patriarchal system men must control women and childbirth⁷⁹⁰. Women suffer under patriarchy, facing ideological, institutional and practical barriers in society but they are not passive victims of these oppressive structures; women are also resisters and survivors.⁷⁹¹ However, women's agency is also part of the strength of patriarchy, where some women have colluded and benefited from the patriarchal society.⁷⁹²

Trusting Women and Birth is Central to our Midwifery Philosophy

As described in the context chapters (Chapters Four and Five) and literature review (Chapter Two), there are different ideologies and models in maternity care, each with their underlying assumptions and philosophies relating to women and the care provided to them during the childbirth continuum. To briefly summarise, medical ideology and the 'medical model' of maternity care is based on a technocratic and patriarchal world view. Rich states, "There is nothing revolutionary whatsoever about the control of women's bodies by men. The woman's body is the terrain on which patriarchy is erected."⁷⁹³ The underlying philosophy within the medical model is the assumption that pregnancy and birth are pathological conditions that need to be closely monitored and medically managed to avoid catastrophe.⁷⁹⁴ In contrast, the 'midwifery model' or 'social model' of care and its associated philosophy share the common ideology that birth is a normal physiological process that most women can achieve without intervention.⁷⁹⁵ Recognising the differences between the different ideologies and their associated philosophies is essential to understanding the way in which maternity care is provided to women. It is also essential to

⁷⁸⁹ Katz Rothman, "Beyond Mothers and Fathers: Ideology in a Patriarchal Society".

⁷⁹⁰ Ibid.

⁷⁹¹ Bennett Judith M. 2006, "Patriarchal Equilibrium." In *History Matters: Patriarchy and the Challenge of Feminism*. Pennsylvania: University of Pennsylvania Press.59.

⁷⁹² Bennett, "Patriarchal Equilibrium"; Rich, *Of Women Born: Motherhood as Experience and Institution*.

⁷⁹³ Rich, *Of Women Born: Motherhood as Experience and Institution*.

⁷⁹⁴ Katz Rothman, *In Labour: Women and Power in the Birth Place*; Katz Rothman, *Recreating Motherhood: Ideology and Technology in a Patriarchal Society*; Davis-Floyd, *Ways of Knowing About Birth: Mothers, Midwives, Medicine and Birth Activism*.

⁷⁹⁵ Katz Rothman, *In Labour: Women and Power in the Birth Place*; Katz Rothman, *Recreating Motherhood: Ideology and Technology in a Patriarchal Society*; Davis-Floyd, *Ways of Knowing About Birth: Mothers, Midwives, Medicine and Birth Activism*; Wagner, *Pursuing the Birth Machine: The Search for Appropriate Birth Technology / Marsden Wagner*.

understand that it is not as simple as midwives following the midwifery model and doctors following the medical model, as the health practitioner's philosophy and practice is closely connected to their own personal ideologies and world-view. Therefore, many doctors may practice according to the midwifery model and many midwives may practice in accordance with the medical model.

Prior to presenting the theme 'Trusting women and birth is central to our Midwifery Philosophy', it is important to highlight what a midwifery philosophy is—a set of assumptions that underpin a midwife's practice—and how it is articulated within the Australian context. The Australian College of Midwives (ACM) states that midwifery philosophy:

- Is founded on respect for women and on a strong belief in the value of women's work, bearing and rearing each generation.
- Considers women in pregnancy, childbirth and early parenting to be undertaking healthy processes that are profound and precious events in each woman's life. These events are also inherently important to society as a whole.
- Protects and enhances the health and social status of women, which in turn protects and enhances the health and wellbeing of society.
- Is a woman-centred, political, primary health care discipline founded on the relationship between a woman and her midwife.
- Focuses on a woman's health needs, her expectations and aspirations.
- Encompasses the needs of the woman's baby, and the woman's family, her other important relationships and community, as identified and negotiated by the woman herself.
- Is holistic and recognises each woman's social, emotional, physical, spiritual and cultural needs, expectations and context as defined by the woman herself.
- Recognises every woman's right to self-determination in attaining choice, control and continuity of care from one or more known caregivers.

- Recognises every woman's responsibility to make informed decisions for herself, her baby and her family with assistance, when requested, from health professionals.
- Is informed by scientific evidence, by collective and individual experience, and by intuition.
- Aims to follow each woman through pregnancy, labour and birth and the postnatal period, across the transition between institutions and the community, so she remains connected to her social support systems; the focus remaining on the woman, not on the institutions or the professionals involved.
- Includes collaboration with and consultation between health professionals.⁷⁹⁶

The midwives interviewed as part of this study all spoke about having a distinct philosophy that was central to their practice of being a PPM. Midwives described their midwifery philosophy as being holistic and woman centred whereby the woman was always at the centre of care. This philosophy resulted in a partnership-based relationship, which enabled the midwife to provide the woman with relevant information enabling her to make informed choices. Therefore, all decisions relating to her care were made by the woman, not the midwife. Bronwyn said, "the philosophy of the independently practicing midwives is that the service focuses on the woman, and the decisions are made by the woman and what she wants, rather than what's best for the midwife".⁷⁹⁷

A component of the midwifery philosophy shared by midwives in this study was the belief that birth was a normal physiological process, with included the midwives trusting women's knowledge and instinct to birth their babies. Midwives trusted birth itself as a normal physiological function that needed little, if any, intervention for the majority of women. All the midwives interviewed spoke of the woman being the expert, not the midwife, as they believed she knew her body better than the midwives or anyone else. They believed their midwifery role was to support the woman and work with her to achieve the best outcomes for both her and the baby. Denise said:

My philosophy is that if we, as midwives, do our job properly we'd be out of a job. Because it's about giving people back responsibility and the ability to look after themselves. Because

⁷⁹⁶ Australian College of Midwives, "Midwifery Philosophy."

⁷⁹⁷ Key, "In Depth Interview with Midwife."

nursing and midwifery started in the home. We learn with every woman so much, being with women and watching them become empowered by their experiences... the other thing that I learnt [as a PPM], was that women could give birth and really, we just needed to be with them and being a real midwife is about being with the women on their journey.⁷⁹⁸

Mary Jane said, "I really trust birth. I trust that your body knows what to do and if you are supported your body will do it, and the women trust their bodies and just do it".⁷⁹⁹ All the midwives talked about listening to women. As Jane said, "Listen to women as they are the experts in their own bodies not us".⁸⁰⁰ Susanjane reflected on her midwifery philosophy and the concept of learning from the women:

I think the other part of my philosophy is that the women are the experts of their own bodies, so they know their bodies far more intimately than I do and I work with them, not on them or to them and always discuss why we have to do an intervention, giving them choices and presenting those. That's where I often found it hard in the hospitals because sometimes, I don't think it was informed consent. And is it informed when it could be under duress? I think in recognising that women are the experts in their own bodies, they are your greatest teachers... And that's what I struggled with sometimes when I was working with some health care professionals, because they didn't see that, and I would often refer to the women and say what do you think, where they were used to saying, you will think this way.⁸⁰¹

As described by Susanjane and Denise above, this belief and trust of women was often at odds with the philosophy of the patriarchal institutionalised maternity system. The philosophy of the medical model is that birth is a medical event, which requires an expert to preside over it. Therefore, in this model the woman is not the expert, the expert is the care giver — and obstetricians are considered as the most appropriate care givers — therefore, birth is presented as inherently dangerous and the assertion is that it should take place in the hospital. Obstetrician Ralph described how the obstetric world thinks—with its patriarchal ideology, focus on pathology, reliance on technology and lack of trust in women's ability to have a normal physiological birth. He said, "There's a lot of droning along that you can never be sure that disaster isn't going to happen, but it means having to go into hospital and a pregnancy or a birth can only be considered normal in retrospect."⁸⁰²

⁷⁹⁸ Hynd, Denise. 2016. "In Depth Interview with Midwife." by Clare Davison, March 15, 2016.

⁷⁹⁹ McNamara. "In Depth Interview with Midwife."

⁸⁰⁰ Smith, "In Depth Interview with Midwife."

⁸⁰¹ Morison, "In Depth Interview with Midwife."

⁸⁰² Hickling, "In Depth Interview with Doctor."

A patriarchal medical model does not trust birth or recognise women as experts and decision makers. By the mid twentieth century, when birth moved to the institutions in Western Australia (WA), it had become the cultural norm for women to 'hand themselves over' to the medical experts and be told what to do and where to do it. An example of the lack of trust in women to make informed decisions demonstrated by a patriarchal maternity service are inclusion criteria for particular clinical services. For example, in Western Australia (WA), for women to be eligible to give birth at the Family Birth Centre (FBC) or with the government funded Community Midwifery Program (CMP), they must agree to have certain screening and diagnostic testing.⁸⁰³ This example reflects a medical model embedded in a patriarchal system, not just one professional group. It also demonstrates that this philosophy does not trust women to make their own decisions and is a product of the underlying patriarchal assumptions about women, their bodies and their capabilities. In making testing compulsory, a women's autonomy is not supported to make informed decisions or to choose to decline particular screening or diagnostic testing. By insisting on inclusion criteria this decision is already made for the women and dictates that if they do not comply with the criteria they are restricted in their choices, particularly around place of birth and choice of care provider. This example of inclusion criteria is a demonstration of women being compelled into making decisions that they may not have chosen if the inclusion criteria did not exist. In contrast, the midwives interviewed in this study provided women with access to information so that they could make an informed choice about screening and diagnostic testing and other decisions relating to their care during pregnancy and birth. Women's choices were not conditional on their complying with medical screening.

Obstetrician Ralph also described how the patriarchal institution led to a culture with a different philosophy, around birth and trusting women: "Basically it's very largely a cultural thing. Because when you look at obstetrics and particularly what they quote, they say birth is dangerous. All they seem to look at is, is the mum alive, is the baby alive at the end of it".⁸⁰⁴ Bronwyn agreed, stating, "That fear of something going wrong is all

⁸⁰³ Government of Western Australia, "Family Birth Centre Application Form Version 5"; Government of Western Australia. 2017. "Community Midwifery Program Application Form." edited by Women and Newborn Health Services. Western Australia.

⁸⁰⁴ Hickling, "In Depth Interview with Doctor."

prevailing".⁸⁰⁵ Denise said, "our [Western] culture is that you're lucky to survive birth, but in actual fact we're meant to thrive. It's all part of the foundations of a good, healthy life".⁸⁰⁶

The difference in philosophies between the PPM and the midwives employed and working within the mainstream maternity and hospitals system (both public and private) was apparent to the midwives. Enid felt she could not be a real midwife and practice her midwifery philosophy working as a midwife in the Australian hospital maternity system:

I only did 6 weeks. I couldn't cope, I did 2 nights and then handed my notice in. I thought, I can't do this. When I left, the day staff gave me a present. They said, "you're the first midwife we've ever met. You've had more births in 6 weeks than we have had in 12 months". So, I said, "stop being nurses and be midwives".⁸⁰⁷

The midwives interviewed in this study shared how they did not fear birth, they trusted the birth process. They believed in the woman's ability to birth unassisted. Mary described listening to the women and how this belief in women and birth led to her assisting a woman to birth in water in the mid-1980s, when waterbirth was not a common practice. "If ever you have a doubt, like for instance with my first water birth. I doubted whether this was safe or not, even though I'd done a lot of research. But she was quite clear, and I listened to what she had to say, and I listened to her in labour".⁸⁰⁸ Denise described her first waterbirth at home in the late 1990s:

I have to be honest, I've never done a water birth before, but Mary had, and she helped me, yes that was my first water birth. When I got there she was in the spa with the jets going and Mary came along and she said you got to turn off the Jets so I reach over and try and get them off, and I can't get it off, so I take off my pants, get in the spa and turn off the jets. And no sooner had I turned off the Jets, I turnaround and out comes this baby.⁸⁰⁹

Nicky described the women she provided midwifery care to as her "heroes". She felt that in trusting women and the process of birth, working with women and seeing their ability to birth unhindered, she ultimately became empowered as a woman and midwife herself:

⁸⁰⁵ Key, "In Depth Interview with Midwife."

⁸⁰⁶ Hynd, "In Depth Interview with Midwife."

⁸⁰⁷ Facer, "In Depth Interview with Midwife."

⁸⁰⁸ Murphy, "In Depth Interview with Midwife."

⁸⁰⁹ Hynd, "In Depth Interview with Midwife."

Having respect and trust for women's ability to give birth. Just because you're not recognising this to be how you want it to be, that you can fall back in the faith, and that every birth is unique and different. Sure, lots will fit into a relatively text book situation but you're going to meet births which don't and actually who are you to say that's abnormal. Witnessing how women can do that (birth) using the power of their mind to birth and overcome really big challenges really empowered me ultimately. Women are my heroes, they were such good role models.⁸¹⁰

Enid too talked about the empowerment of women, she said:

I now realise that if you can empower women, they are so strong. If you care for a mother, I mean really care for her. She doesn't need us to look after the baby. So, by the time I'd finished, I very rarely even birthed the baby, the mothers did it or the dad...I never weighed them, I never bathed them. I got the parents to do it, they're as capable as I am. So usually by day ten we'd weigh the baby again and I'd say, "can I have a cuddle of your baby" and then I'd say, "you do realise this is the first time I've held your baby".⁸¹¹

The ability to trust in women, also leads to midwives feeling empowered. This in turn increases the midwives trust in women and birth. The previous quote demonstrates the woman being regarded as the expert, which is a central assumption in these midwives' philosophies. Providing this woman-centred, holistic midwifery care, ensured that the women felt strong and capable and able to start motherhood empowered. Emma received care from a PPM for all her four births. Her first birth resulted in a transfer to hospital with a persistent posterior positioned baby and an assisted vaginal birth. When Emma reflected on this birth, she realised how different the outcome may have been if her midwife did not trust women and birth, because, although she did need some medical assistance to birth her baby, in the end she had a vaginal birth. This example is a demonstration of how the PPM will continue to support the woman in whatever context (home or hospital) and remain with her throughout her journey. Emma went on to have three more babies, all born at home with a PPM. Reflecting on her first birth Emma said:

I'd realised and done my statistics on what posterior births are like and I remember realising that, if I hadn't had my midwife, the chance of me having a Caesarean would have been quite high.... I remember thinking, "oh actually my midwife did a remarkable job and so did I". So, I remember writing [to her midwife], "in hindsight I look back now and know that if I hadn't of had you [her midwife] the chances of me having a Caesarean birth would have been

⁸¹⁰ Vervest, "In Depth Interview with Midwife."

⁸¹¹ Facer, "In Depth Interview with Midwife."

incredibly high". So, there was a lot of acknowledgement on my part and a lot of gratitude. I'm so grateful for that birth now, incredibly grateful as a midwife and as a mother.⁸¹²

Emma's experience is an illustration of how the PPMs philosophy and the subsequent empowerment of women and midwives can be transferred into a hospital context. Emma went on to describe the empowering birth she experienced with her second daughter and the trust in women and birth that she gained from it so that she was able to apply this in her role as a midwife:

And she's like [the midwife] 'are you having the baby on the bed or in the pool' and I remember thinking 'now?' and thinking 'she [the midwife] doesn't know what she's on about'. And she goes 'you've got to get in the pool' because she knew that was what I wanted. I said 'I can't walk' and they hobbled me over into the pool and I think the next contraction or the one after that Fraya was born, just in one big woosh and out she came and I remember just being so shocked. It was such a beautiful birth, I was so proud of myself and we were crying and laughing, and we got a video... my midwife got the video of the birth, which was just amazing because it was all in a hurry, she thought for me...it was just an incredible, very spiritual, very sacred birth and, it was just amazing... It was a really beautiful experience for my mum too, just the normality of it that...very much the happiest day of my life that night, it was just incredible. It was a good life lesson for me not only as a midwife but as a human, that if you trust and just allow things to unfold, they can be just as good, if not better than if you're trying to control people and resources and events.⁸¹³

This theme is a clear demonstration that the midwives' philosophy was built around their trust and belief in women, their ability to birth and was central to how the midwives provided maternity care. This led to empowerment of both the women and the midwives and their rejection of the patriarchal medical model and its corresponding medicalisation of birth.

Medicalisation of Birth

The first sub-theme 'Medicalisation of birth' will now be discussed. Recent statistics demonstrate the medicalisation of birth in Australia; according to the Australian Institute of Health and Welfare 2015 report, 97 percent of Australian women gave birth in hospital, 1.8

⁸¹² Ritchie, "In Depth Interview with Midwife."

⁸¹³ Ibid.

percent gave birth in birth centres and 0.3 percent gave birth at home.⁸¹⁴ Only 50 percent of Australian women experienced a spontaneous labour, 29 percent had their labour induced and 21 percent did not experience labour. Labour was augmented for 16 percent of women which suggests that only 32 percent of mothers had a spontaneous onset of labour.⁸¹⁵ In 2015, only 54 percent of women experienced a spontaneous vaginal birth and although the birth may have been spontaneous, labour may have been spontaneous, induced or augmented. One in eight (12 percent) women experiencing a vaginal birth were assisted by either vacuum extraction or by forceps. Four out of five women (77 percent) who laboured received pharmaceutical pain relief. A third of Australian women experienced birth by caesarean section.⁸¹⁶

With less than 50 percent of women giving birth spontaneously, a 'normal' birth in Australia could be interpreted as a medically managed or operative birth. For the midwives interviewed for this study, medicalisation of birth was at odds with their midwifery philosophy. As discussed in the previous section, these midwives trusted women and birth and most women in their care gave birth spontaneously at home with no medical intervention. Although the statistics provided above refer to all women, including women who may be experiencing more 'complicated' pregnancies and births, the fact remains that the majority of the women birthing within the Australian maternity system should be 'uncomplicated' and this is not reflected in their birth outcomes.⁸¹⁷ In fact this medicalisation of birth could also be harmful as according to the World Health Organisation (WHO) (2015) caesarean sections are effective in saving maternal and infant lives, but only when they are required for medically indicated reasons; caesarean section rates higher than 10 percent are not associated with reductions in maternal and newborn mortality rates or benefits to women and newborns.⁸¹⁸ The contrast between the medicalisation of birth reflected in the mainstream care options reinforces the importance of the midwives' philosophy of providing woman-centred, individualised and holistic care and to support women to experience a normal physiological birth. For these midwives, the medicalisation

⁸¹⁴ Australian Institute of Health and Welfare. 2017. "Australia's Mothers and Babies 2015—in Brief. Perinatal Statistics Series." Canberra.

⁸¹⁵ Ibid.

⁸¹⁶ Australian Institute of Health and Welfare, "Australia's Mothers and Babies 2015—in Brief. Perinatal Statistics Series."

⁸¹⁷ Shaw et al., "Drivers of Maternity Care in High-Income Countries: Can Health Systems Support Woman-Centred Care?" McDougall, Campbell, and Graham, "Maternal Health: An Executive Summary for the Lancet's Series."

⁸¹⁸ World Health Organisation. 2015. "Who Statement on Caesarean Section Rates."

of birth contributed to their seeking alternative ways beyond the mainstream maternity systems of working as a midwife. The only way they believed they were able to provide midwifery care that was in keeping with their ideology, philosophy and beliefs around birth was by working as a PPM within the community.

Denise described how when she started to work as a PPM she found many of her midwifery skills unnecessary, so felt she had to change her practice, "This is the way it should be, the rest you just have to unlearn".⁸¹⁹ Susanjane could not understand the medical way of looking at birth with the belief that birth was a dangerous process: "I think that's why I hit the wall with the doctors, because my philosophy was birth is natural until it proves it isn't, whereas they were coming from [a perspective that] birth is not natural until it proves it is".⁸²⁰ Susanjane's quote provides a succinct description of the differences between the philosophies.

Confirming this differing approach to supporting birthing women, GP obstetrician Margaret described her medical training in the only tertiary maternity hospital in Western Australia, King Edward Memorial Hospital (KEMH) in 1977, where she gained her post graduate qualification in obstetrics:

I did my medical training here and I was preparing to go out into the country so as a postgraduate I did my diploma in obstetrics at King Edward. There were 10 of them or there may have been 12 [birthing cubicles] and there was a corridor along by the windows, along the ends of the cubicles which the staff patrolled so they could view all these women in labour. There was very little room for equipment if you had an emergency. And at that time, they were starting to experiment with epidurals and foetal scalp monitoring... '77 I was up there and the whole atmosphere at King Edwards was misogynistic.⁸²¹

The medicalised view of birth, described in the above quote by Margaret, demonstrates how different birth in the institutions was compared to birthing at home. The medicalisation of birth described here —with its total lack of privacy and conveyor belt approach—shows a lack of respect for women. Margaret also described a patriarchal and misogynist atmosphere that included experimenting with technology on women, demonstrations of the inherent sexism of the institution, and a lack of woman centred and

⁸¹⁹ Hynd, "In Depth Interview with Midwife."

⁸²⁰ Morison, "In Depth Interview with Midwife."

⁸²¹ Trungeon, "In Depth Interview with Doctor."

individualised care.⁸²² Although Margaret was a qualified doctor with a post graduate diploma in Obstetrics, once she was qualified, she chose to also work with PPMs in the community. Margaret shared how she learnt to trust birth and women when attending home births with PPMs in the 1980s, "Because I learnt what normal birth is, I learnt to be able to recognise the different stages of labour from the end of the bed and I learnt different ways of doing things from midwives".⁸²³

When working within hospital institutions during their midwifery training, Mary and Nicky were chastised as their philosophy, views and beliefs around birth were different to the institution's.⁸²⁴ For example, Mary described how, during her time as a midwifery student in 1978, the medicalisation of birth was the normal process in the hospital and how some of the obstetricians she worked with used drugs to speed the birth process up, thereby making birth work to their own timetables not the woman's body. Mary said:

I got myself into quite a bit of trouble with the obstetricians in the administration because they were doing things like, 'oh it's nearly 3 o'clock, I'm going off at 3 o'clock I'll just speed this oxytocin drip up so that the baby'll be born before I go'. So, I got into lots of trouble by challenging the senior midwives for doing things like that. An obstetrician threw a chair at me because I didn't quickly enough get him to the hospital and a multip [multipara] birth before he arrived. Then someone wanted a pair of forceps to put on a baby who was almost born, and I wouldn't get them and then he turned around to me and said, 'what would you know about this you're just a student', and I said, 'I've got 4 kids. I'd know 4 times more about it than you know'.⁸²⁵

The above quote highlights the hierarchical nature of the professions—with the obstetrician at the top and the female midwifery student at the bottom. It also provides an example of how the medicalisation of birth enables the birth process to be manipulated to suit the needs of the care provider rather than the woman. In this example, the woman is the passive recipient of care that is deemed appropriate by the care provider. The birth is hastened, not because it is medically necessary, but because the care provider is in control, not the woman. The overarching medicalisation of birth with the obstetrician as the expert in birth, not the woman, disregards any other form of knowledge and classes the woman's own knowledge or experience as unimportant or irrelevant.

⁸²² Trungeon, "In Depth Interview with Doctor."

⁸²³ Ibid.

⁸²⁴ Vervest, "In Depth Interview with Midwife"; Murphy, "In Depth Interview with Midwife."

⁸²⁵ Murphy, "In Depth Interview with Midwife."

Denise reflected on how unusual the medicalisation of pregnancy and birth and the lack of belief in physiological labour and birth seems to the PPM, "It is a crazy culture that says to a woman, you know, the whole doubt about whether you can grow a baby and birth the baby. Or even grow it [the baby] and then you get to 40 weeks and your body just starts forgetting how to do things, it's just bizarre".⁸²⁶ Emma reflected on the different ways of looking at birth. "it was like we were talking two different languages. Hospital midwives and community midwives are quite different".⁸²⁷ When Susanjane stopped working as a PPM she was unable to work as a midwife in the hospital due to the level of intervention. "I worked as a midwife in NICU [neonatal intensive care unit] because at least in there, interventions are justified. I tried to work in the hospital system as a midwife and I found I couldn't handle the interventions".⁸²⁸ Nicky, too, struggled with how the medicalisation of birth and its associated interventions, often worked in opposition to the physiology of labour and birth. Nicky had been attending homebirths for a long time prior to her midwifery education and had attended many normal physiological births at home. She found the lack of understanding of the birth process concerning:

Because I mean I'd been like years in homebirth before I went there so it was pretty bizarre and I saw membranes being ruptured with high heads, that used to freak me out. I saw Syntocinon drips going up when I thought ... the contractions are doing this because the baby is not in a birthing position. The womb is behaving like this with short sharp contractions because it's all in order. Up goes the synto drip and bang, wedge, the baby's stuck in the OP [occipital posterior], position and the woman's screaming in agony, just some really basic stuff. The other thing was how confined the women were to bed, the woman's pelvis and the baby's head need to be able to move in order for the baby to find its way out and it just seemed like they were doing everything to lock it up. And yet in homebirth...especially if you've got an OP position and those finnick, short, really painful contractions that the woman's trying to deal with...it's like the hot shower and the massage and the walk...bingo, then the baby starts to move.⁸²⁹

This quote by Nicky highlights the difference in the medical and midwifery philosophy. In the midwifery philosophy shared by the PPMs, the woman is the expert and has embodied knowledge, for example, the need to move in labour and change positions to facilitate physiological birth is observed and facilitated by the PPM in response to the

⁸²⁶ Hynd, "In Depth Interview with Midwife."

⁸²⁷ Ritchie, "In Depth Interview with Midwife."

⁸²⁸ Morison, "In Depth Interview with Midwife."

⁸²⁹ Vervest, "In Depth Interview with Midwife."

woman's behaviour. In contrast, in the medical philosophy, the doctor or midwife is the expert and the rigid system enforces limitations on, using the same example, the woman's ability to move in labour or use an upright position to birth her baby, when it is apparent that this is counterproductive. This is another example of how the birth location can dictate women's experiences of birth. The confinement to bed is for the convenience of hospital staff, thus emphasising their role as being the 'managers' whilst the women are merely 'passive objects' receiving instruction and intervention and 'having things done to them'.

Theresa and Enid also struggled to work within the hospital system in Australia. Both trained midwives from the United Kingdom (UK), they felt the midwives in Australia worked differently to the UK and described them as obstetric nurses, which is a role the early 20th century legislation had attempted to enforce.⁸³⁰ They felt that the hospital midwives did not get the opportunity to work with women and facilitate normal birth.⁸³¹ Theresa said, "They didn't have a lot of hands on. Everything revolved around the doctors."⁸³² Enid described her first night working as a midwife in Australia:

They're not midwives, they're all nurses, I couldn't work there [in the hospitals in Australia]. My first night at the hospital I cared for a young 16-year-old primip [primigravida], she was supported by her mother and boyfriend. She was labouring on her hands and knees when the obstetrician came in. He said, 'Good God sister what are you doing?' I said, 'the baby is in the posterior position, she has got backache'. He said, 'aren't you going to turn her over?' I said, 'what for?' Anyway, he handed me the gloves; she had her birth. He went to walk out the door and I asked him to sign the paperwork. He said, 'I'm just going to get the suture material'. I said, 'what for?' He said, 'a big baby like that coming out of a 16 year old, I think we'll need some sutures'. I said, 'when you birth a woman in this position, it's better for the perineum and she doesn't need stitches!' Nine and a half pounds that baby was.⁸³³

Enid's quote is a reinforcement of the differences in the philosophies and attitudes toward women and birth. The obstetrician did not believe or trust in the woman or her ability to birth physiologically. The belief that childbirth is a pathological process, that can only be declared normal retrospectively concludes that care during normal labours and births should be similar to the care in complicated labours and births and therefore requires expert medical supervision. This retrospective attitude has several disadvantages

⁸³⁰ *Health Act of 1911 (WA)*.

⁸³¹ Clifford, "In Depth Interview with Midwife"; Facer, "In Depth Interview with Midwife."

⁸³² Clifford, "In Depth Interview with Midwife."

⁸³³ Facer, "In Depth Interview with Midwife."

and has the potential to turn a physiological event into a medical procedure; it interferes with the freedom of women to experience the birth of their babies in their own way and in the place of their own choice. This attitude also contributes to unnecessary interventions and reliance on technology. Naomi talked about the difference between the PPMs practice of facilitating physiological birth by looking at the “whole picture” and the medicalisation of birth that uses intervention to facilitate birth:

The difference between private midwifery’s watchful waiting, observing and taking the whole picture in whereas in hospital they tend to just look at one aspect, they just look at one thing like dilation, it is not the whole picture. The woman’s contractions have stopped, that might be because you just had three registrars in here putting a cannula in, which she doesn’t want and you won’t let her get in the bath, which she really wants. But all of a sudden, she is now ‘failing to progress’ and you want to put Synto (syntocinon) up because you haven’t actually supported her to get into a good physiological labour.⁸³⁴

The midwives suggested that this medicalisation of labour and birth transfers the trust into technologies rather than the birthing women. Margaret talked about how the increasing medicalisation of birth meant that most midwives and doctors did not know how to assess or manage labour without interventions, “The only reason that you have to keep doing vaginal examinations is if you don’t know how to manage a labour without it”.⁸³⁵ Carol described how technology changed the way women were treated during birth. She also described how assisted births became routine with no medical indication. They were used to speed up the birth of the baby when she was training to be a midwife in the 1970s:

They used forceps or those awful metal vacuum cups. They’d do Kiellands [a type of forceps] and really rough, really rough assisted deliveries at that point in time. They were also trialling CTGs too at that particular time as well, they were so confident that these machines were going to give them the information that they required that they actually forgot to really listen to people and hear what people were saying. And we didn’t really know what the outcomes were because we never actually saw women after they’d left the hospital. We’d never know what the consequences of these poor women, having this sort of birth and then going home with often disabled children I would imagine.⁸³⁶

Denise described the disbelief from the hospital staff that she could care for a woman at home without technology, “There is a stigma around private midwifery and

⁸³⁴ Newman, "In Depth Interview with Midwife."

⁸³⁵ Trungeon, "In Depth Interview with Doctor."

⁸³⁶ Pinch, "In Depth Interview with Midwife."

homebirth, because I mean the hospital midwives and the doctors are all saving women, so how come someone like me, who is just a midwife, can do that out there with none of what they've got".⁸³⁷ Jane described how during a hospital transfer she observed a lack of understanding of physiological birth and a reliance on technology:

The doctors were going 'epidural, epidural' but she was almost fully [dilated] and I'm going 'are you sure you want an epidural, you are almost there' and the doctor hauled me out into the hallway and said, 'how dare you contradict me', so I just don't take it personally. I don't think he realised how close she was, so I just let it go and the baby was born. I think the issue was with him [the doctor] and his fear of birth without an epidural.⁸³⁸

Control and safety in relation to pregnancy and childbirth have different connotations for individual women. The concept of risk has come to dominate all aspects of institutionalised maternity care with women assessed and categorised according to their perceived risk level during their first contact with the maternity care providers. This risk label attributed to a woman will then define the level and type of care she should— according to the institutionalised maternity care system— receive. For PPMs and the women using their services, what is perceived as 'safe' or a 'risk' is not just the physical aspect and outcomes of birth. Risk perception must also take into account psychological, emotional and social safety. The medical system tends to focus on the physical risk factors in relation to the pregnancy and birth, whereas the women and the midwives consider all the risk factors, including emotional and psychological ones in relation to pregnancy, labour and birth and the postnatal period. Even if they had physical 'risk' factors related to their pregnancy that deemed them unsuitable for a homebirth by the medical system, for some women, birthing in the mainstream system was perceived as much 'riskier' to them than birthing at home with a PPM.

The subtheme 'medicalisation of birth' demonstrated that risk perception was different between the women choosing midwifery care with a PPM, the PPMs and the hospital. A patriarchal maternity culture that is risk focused does not support women's autonomy or ability to make informed decisions. Medicalisation of birth involves control, manipulation and intervention being justified through 'risks' defined by the medical model. The way information is framed can be coercive and pressure women into making decisions that they would not choose if the information was presented in a different way or by

⁸³⁷ Hynd, "In Depth Interview with Midwife."

⁸³⁸ Smith, "In Depth Interview with Midwife."

removing the choice from women altogether. For example, defining women as a combination of 'risk factors' requires that they comply with certain screening and diagnostic tests to assess the level of risk they pose, and this undermines women's personhood reducing them to a group of risk factors and labels. Lorelee talked about different people's perceptions of risk, "You know what you consider risk within the system might be very different to the risk that that women are...perceiving as risk".⁸³⁹ There is often no discussion of risks associated with hospital births or the risks to the women's physical and psychological health resulting from unwanted medical intervention that may be culture based rather than needs based. This can be described as a hierarchy of risks, when the risks the medical ideology sees as important, such as physical risks, are considered more relevant. Emma spoke about the narrowing definition of 'normal' and the difficulty many women experienced trying to meet the risk criteria, "It's a struggle for a woman to have a homebirth with a private midwife who's just 'normal Nancy', let alone someone that's had a Caesarean or doesn't want antenatal care, or lives 100 miles from a hospital".⁸⁴⁰ Margaret feels that "[the medical model] doesn't think that the woman has the right to make choices that might put another life at risk. And it's a moral dilemma about how much right has a woman got to choose over an unborn child? I think that's what lies beneath the surface of this whole homebirth, I won't call it a debate because it's a witch hunt".⁸⁴¹ As previously discussed in this thesis, the perception— that the health professional is the representative of the unborn baby—can lead to the belief that the doctor or midwife needs to intervene on the behalf of the foetus if the woman is deemed to be making decisions that the medical ideology considers unsafe. This belief may contribute to the coercion and bullying of women and the midwives who support them and this will be discussed further in the next findings chapter under the theme 'Power and control of the institutions' and its subthemes 'Persecution and reporting of midwives' and 'Legislation, red tape and jumping through the hoops'.

As previously discussed in Chapter Five, from the early 20th century, the State-supported medical profession encouraged legislation to reduce the scope of midwifery practice, leading to the shift from birth in the home, to birth in the hospital. The women who were deemed as suitable for midwifery-led care and homebirth has changed throughout time. Once birth moved from the home to the hospital, the obstetric profession

⁸³⁹ Worrall, "In Depth Interview with Midwife."

⁸⁴⁰ Ritchie, "In Depth Interview with Midwife."

⁸⁴¹ Trungeon, "In Depth Interview with Doctor."

started to define who was, and who was not, suitable for midwifery led care and also defined the suitable place of birth.⁸⁴² Treating women as having different levels of risk status, rather than as individuals, may contribute to a distrust of birth. In addition, the corresponding definition of what is considered 'normal' is forever shrinking to the extent that there is now no such thing as 'normal' but only the categories of low to high risk. Mary Jane said:

I see most of my friends who are midwives are so scared of birth and they're looking for the abnormal all the time, whereas I'm looking for the normal and I see more as normal and then I can pick the things that aren't normal. Whereas everyone (in the system) is treated as high risk. it's all risk management and it all seems over the top. I think midwives need to see normal birth without medical intervention, and to normalise birth, not see all women as all risk.⁸⁴³

Vanessa described observing the impact of medicalised birth on women, and her frustration and disappointment in the midwifery profession:

I saw disempowerment...women didn't even realise or know that they have choice... The fear in the women of what was going to be done to them... Lack of knowledge, lack of support...working with the students and seeing the hospital environment... [seeing the hospital staff use] policies and guidelines that aren't evidence-based... Seeing how women were struggling to birth naturally really frustrated me... [made me] really disappointed with the profession, with the lack of support to the women, it's not women focussed and it's mainly protecting oneself with litigation.⁸⁴⁴

The experience of working with students in the hospital setting led Vanessa to continue with her private midwifery practice:

I was going to finish this year with private practice, but I got a job with ECU [Edith Cowan University] for facilitating students, and I got a sub-contractor job working with GP clinics with one of the midwives to see women and because I've been with homebirthing for so many years living in my own little world of homebirthing, it really opened my eyes to see what women were faced with outside of the homebirthing world and that made me go back into private practice.⁸⁴⁵

⁸⁴³ McNamara, "In Depth Interview with Midwife."

⁸⁴⁴ Butera, "In Depth Interview with Midwife."

⁸⁴⁵ Ibid.

Evidence clearly demonstrates the safety of planned homebirths attended by a registered midwife.⁸⁴⁶ There are however some statistics indicating that homebirth has increased mortality and morbidity, but these reports include all births at home, including unattended and unplanned homebirths and freebirths (planned births not attended by a registered midwife).⁸⁴⁷ Despite this increasing body of evidence to the contrary, many midwives and doctors do not seem to be aware of the research or choose to disregard it, therefore believing that home birth is dangerous and that midwives providing midwifery care at home were taking risks. Denise said that “a lot of hospital midwives believe the myths that homebirth is dangerous”.⁸⁴⁸ Margaret talked about how a lack of understanding around homebirth led many midwives and doctors to disregard the positive research around the safety of homebirth and focus on the statistics that suggested it was unsafe.⁸⁴⁹ She described babies that were not expected to survive and were born and died at home, thereby becoming statistics of a homebirth neonatal death:

I think this is one of the problems with the rest of the medical profession and homebirths is that they don't understand it and they don't know the people, so they don't have any trust. I mean you can prove anything with statistics, and they don't actually look at what the statistics mean. Like I had some stillbirths at home and most of those, or the absolute majority of them were women who knew that they had a chromosomal abnormality or some serious birth defect that was going to be fatal and they chose to birth at home and have their baby die at home. And I was happy to support them to do that but of course that looks bad on

⁸⁴⁶ Dahlen, Hannah et al., 2010. "Planned Home and Hospital Births in South Australia, 1991–2006: Differences in Outcomes," *Medical Journal of Australia* 192, (12): 726-727; Kennare et al., 2012. "Planned Home and Hospital Births in South Australia, 1991-2006: Differences in Outcomes"; Olsen, O. and J.A. Clausen. 2012. "Planned Hospital Birth Versus Planned Home Birth," in *Cochrane Database System*; Davis et al., 2011. "Planned Place of Birth in New Zealand: Does It Affect Mode of Birth and Intervention Rates among Low-Risk Women?," *Birth*, 38 (June): 111-119; Johnson, Kenneth C. and Betty-Ann Daviss. 2005. "Outcomes of Planned Home Births with Certified Professional Midwives: Large Prospective Study in North America." *British Medical Journal*, 330 (June): 1416-22; Birthplace in England Collaborative Group. 2011. "Perinatal and Maternal Outcomes by Planned Place of Birth for Healthy Women with Low Risk Pregnancies: The Birthplace in England National Prospective Cohort Study," *ibid.* 343 (d7400).

⁸⁴⁷ Bastian, Hilda, Marc J Keirse, and Paul Lancaster. 1998. "Perinatal Death Associated with Planned Home Birth in Australia: Population Based Study". *British Medical Journal* 317 (August): 384-88".317; Gyte et al., 2009. "Estimating Intrapartum-Related Perinatal Mortality Rates for Booked Home Births: When the 'Best' Available Data Are Not Good Enough," *British Journal of Obstetrics and Gynaecology* 116 (7): 933-942; McLachlan, Helen and Della Forster. 2009. "The Safety of Home Birth: Is the Evidence Good Enough?" *Canadian Medical Association Journal*, 181 (September): 359-60.

⁸⁴⁸ Hynd, "In Depth Interview with Midwife."

⁸⁴⁹ Trungeon, "In Depth Interview with Doctor."

the homebirth figures. I wasn't going to say to them 'well you can't do this because it's going to make the homebirth figures look bad'.⁸⁵⁰

Naomi spoke of how the lack of trust in women and birth and the medicalisation of birth based on risk perception, contributed to obstetricians and midwives in the mainstream hospital system using unnecessary medical or 'just in case' interventions:

I've seen them doing things that don't need to be done out of their fear and then it just spirals and then the next time they've already got that inbuilt trauma, they are reactive rather than reacting to what's actually happening. They have to get back to trusting birth, that birth is normal, support it, it works, don't interfere with it in case something might happen. But how do you get them to do that when they're working in a system that constantly tells them to pre-empt that risk, to do something in case something happens?⁸⁵¹

PPMs interviewed in this study did consider 'risks' in their practice, but they practiced individualised midwifery care. This enabled the midwife to treat the woman as an individual, so that rather than applying blanket policies relating to perceived risk factors, the midwives assessed the woman and provided her with evidence-based information relevant to her individual needs. This enabled the woman to make an informed decision about her care based on her individual circumstances. Naomi described the differences in assessing risks she found in working as a PPM:

In private practice you're a critical thinker. You have to critically think in private practice whereas in the system you get told "you've got a chart in front of you, it tells you what should be happening and if it's not happening what you should do, all written in a policy". It becomes conveyor maternity care, nobody gets individualised care. Whereas in private midwifery practice each woman is an individual and you're looking at the whole picture.⁸⁵²

The medicalisation of birth also contributes to the expectation that midwives must provide care in accordance with the medical ideology and medical model of maternity care. This assumption can present problems when risks factors are assessed and treated differently. Different perceptions of risk have led to the persecution and increasing surveillance of the PPM and the patriarchal institution having power and control over women and midwives who do not conform to the medical model's expectations. For example, persecuting and reporting midwives who continue to support women who decline

⁸⁵⁰ Truncheon, "In Depth Interview with Doctor."

⁸⁵¹ Newman, "In Depth Interview with Midwife."

⁸⁵² Ibid.

screening or who may have obstetrically identified risk factors to birth at home. This will be discussed further in the theme, 'Persecution and reporting of midwives' and its sub themes 'Power and control in the institution' and 'Legislation'.

Midwives' use of Intuition and the Concept of Authoritative Knowledge

The second sub theme 'Midwives' use of intuition and the concept of authoritative knowledge', under the theme 'Trusting women and birth is central to our midwifery philosophy' will now be presented. In today's society, some types of ideologies with their associated knowledge systems are more accepted than others. When a certain ideology is dominant, other ideologies are considered 'alternative' ideologies. The dominant ideology thus defines itself as the 'authoritative' knowledge. Authoritative knowledge is defined as the knowledge which forms the basis on which decisions are made and actions are taken.⁸⁵³ There are many different types of knowledge systems, for example; scientific, religious, spiritual, cultural, indigenous, embodied and intuition. Scientific knowledge, however, is considered to be the highest level of knowledge, and it is argued to be rational, neutral and definitive. In contrast, embodied knowledge or intuition is considered unscientific and therefore subordinate to scientific knowledge.⁸⁵⁴ Jordan states that the knowledge that becomes authoritative "explains the state of the world better for the purpose at hand (efficiency)" or is "associated with a stronger power base (structural superiority)".⁸⁵⁵ Davis Floyd argues that the Western maternity system is less grounded in science than in its wider cultural context and the biases and beliefs of the society that created it.⁸⁵⁶ Patriarchy and its associated ideology is the dominant power base in maternity care, therefore, it is this power that enables the medical ideology to manage and control birth, associated professions and the knowledge that is deemed superior. The core values of the patriarchal maternity system are the belief in science, technology, economic profit and large hierarchal and patriarchally governed institutions.

⁸⁵³ Jordan, Brigitte. 1997. "Authorative Knowledge and Its Construction," in *Childbirth and Authorative Knowledge: Cross Cultural Prospectives*, ed. Robbie Davis-Floyd and Carolyn F. Sargent, Berkeley: University of California Press.

⁸⁵⁴ Sackett et al., 1996. "Evidence-Based Medicine: What It Is and What It Is Not" *British Medical Journal*, 312: 71-72; Jordan, "Authorative Knowledge and Its Construction."

⁸⁵⁵ Jordan, "Authorative Knowledge and Its Construction."56.

⁸⁵⁶ Davis-Floyd, *Ways of Knowing About Birth: Mothers, Midwives, Medicine and Birth Activism*.4.

Midwives are expected to use 'evidence' in their decision making and use knowledge to inform their midwifery practice. In recent years the term 'evidence-based practice' has been used to define the expected level of practice. The modern-day concept of evidence-based practice originated in medicine and was heralded by Archie Cochrane in the 1970s.⁸⁵⁷ This led to the formation of the Cochrane Collaboration and the rise of midwifery practice informed by randomised controlled trials (RCTs) which were defined as the 'gold standard' in evidence. The original expectation of evidence-based practice was not purely the use of scientific research and although the terms 'research based' and 'evidence based' are not differentiated in the literature, they are different. Sackett et al define evidence-based practice as "the combination of integrating individual clinical experience with the best available external clinical evidence from systematic research. By individual clinical experience we mean the proficiency and judgment that individual clinicians acquire through clinical experience and clinical practice".⁸⁵⁸ They also state that there "are many types of evidence that can be used as evidence to inform practice". However, as evidence-based practice originated in medicine the focus is primarily on using scientific research evidence to inform practice. The patriarchal medical model of maternity care states that obstetricians are the most effective and safest providers of care. However, as described above, this medical model of care often shows a lack of awareness around birthing processes and fails to recognise the limitations of medical interventions. Therefore, rather than practice being evidence-based, in reality, obstetric practise is culture-based. In practice this means that the accepted patriarchal and medical ideologies and associated authoritative knowledge, enable the mainstream maternity care providers to continue to use many routine obstetric procedures, not because they make scientific sense, but because they make cultural sense.⁸⁵⁹

Medical ideology requires that doctors define themselves as rational, objective and scientific. The accepted authoritative knowledge in obstetrics is the knowledge provided by science and technology. Jordan states that the legitimacy of one type of knowing as authoritative is the devaluation, and often dismissal, of all other types of knowing.⁸⁶⁰ In many situations equally legitimate knowledge systems exist and are used concurrently; yet,

⁸⁵⁷ King, James Forrester. 2005. "A Short History of Evidence-Based Obstetric Care" *Best Practice and Research Clinical Obstetrics and Gynaecology*, 19 (1): 3-14.

⁸⁵⁸ Sackett et al., "Evidence-Based Medicine: What It Is and What It Is Not".

⁸⁵⁹ Davis-Floyd, *Ways of Knowing About Birth: Mothers, Midwives, Medicine and Birth Activism*.4.

⁸⁶⁰ Jordan, "Authorative Knowledge and Its Construction."58.

the use of the 'alternative' knowledge systems are seen as backward, ignorant and naïve.⁸⁶¹ In contrast to the use of scientific knowledge, intuition is described as emotional and unscientific, as it cannot be measured or quantified scientifically.

Historically, 'women's ways of knowing' — their embodied knowledge and intuition— were considered a genuine form of knowledge; nonetheless, with the rise of science and rational thought, this knowledge form has been dismissed. Theresa said, "if we listen to women and we listen to midwives ... midwives have intuition, but we know that they are not allowed to use that in the hospital, it's not recognised as a form of knowledge."⁸⁶² This dismissal of female intuition as a form of knowledge is patriarchal, as patriarchy does not value the knowledge of women.

All of the midwives interviewed in this study described women's embodied knowledge and intuition. Susanjane said "you have to value their intuition and the women's knowledge, that they carry because they know their body much better than I do".⁸⁶³ Because the midwives believed and listened to the woman, they also trusted the woman's knowledge of her own body, again reinforcing their trust in women and birth and woman-centred philosophy, Vanessa said "Midwives in private practice trust birth and they trust the woman's own instincts".⁸⁶⁴

The midwives interviewed described the intuition they themselves felt and used this 'knowing' as an authoritative knowledge within their clinical practice, often combined with other forms of knowledge. Midwives used what they described as their "gut feelings" and intuition in other situations too, such as assessing clients for suitability for homebirth and deciding whether to take the women on as clients. Carol said, "you have to learn to trust that gut"⁸⁶⁵ and Mary Jane said, "Sometimes you just have that gut feeling, that intuition about people"⁸⁶⁶ and Naomi said, "You got to go on your clinical skills, your critical thinking, looking at the whole picture but also what's your gut saying".⁸⁶⁷ Often this form of knowledge was increased because of the relationship the midwives had with the women. Naomi reflected, "It's interesting when you watch other midwives. I think midwives in private practice are a lot more in tune with the intuition, they are a lot more in tune

⁸⁶¹ Jordan, "Authorative Knowledge and Its Construction."

⁸⁶² Clifford, "In Depth Interview with Midwife."

⁸⁶³ Morison, "In Depth Interview with Midwife."

⁸⁶⁴ Butera, "In Depth Interview with Midwife."

⁸⁶⁵ Pinch, "In Depth Interview with Midwife."

⁸⁶⁶ McNamara, "In Depth Interview with Midwife."

⁸⁶⁷ Newman, "In Depth Interview with Midwife."

because it's really hard to have intuition on somebody you don't know. It's the relationship that makes it".⁸⁶⁸ All the midwives who were interviewed described how providing continuity of carer enabled them to form a strong relationship with the women they provided maternity care to. This enabled them to be confident in using their intuition and combining it with other forms of knowledge, including the woman's embodied knowledge and intuition and scientific knowledge combining the 'art and science' of midwifery to provide holistic care. The midwives talked about how the continuity of carer and strong relationship they formed with the woman also increased their intuition. The relationship enabled the midwives to really know the woman, which led to the midwives being able to interpret even the subtlest of cues. Susanjane said, "Sometimes I was so connected to the woman that I would be getting the mothers nesting instinct, I would be cleaning my house at 10 o'clock at night manically and then I'd get a call at 1am to say she was in labour". Mary Jane said her intuition often told her when the woman would have her baby, "Often I get a feeling about someone, and I think, you'll have your baby today"

PPMs were confident in being heard by their PPM colleagues when using their intuition as a form of knowledge, as they had it validated continually by the other midwives in private practice. This gave this form of knowledge credibility and increased the trust that the midwives had in their intuition. Naomi said, "You are supported to use your intuition, because I can call my colleagues in private practice and say, my guts wobbling but I don't know why, and they say if your gut's wobbling you need to listen. So, it's reinforcing rightly that it's a form of knowledge."⁸⁶⁹ In contrast, the midwives and doctors who conformed to the medical ideology did not recognise intuition as a form of knowledge and wanted physical proof before listening to the midwife or woman. Carol explained:

I work a lot on gut feeling with people, even if I'm interacting with people today. So, if you knew something wasn't quite right you could ask someone to check them for you and they wouldn't think you were stupid because you say you've got a feeling about it. They really understood that whereas the system doesn't trust women, or trust midwives to have that. If someone said, "oh, I've just got a gut feeling about it", they'd want something. They'd want her to show us something.⁸⁷⁰

⁸⁶⁸ Newman, "In Depth Interview with Midwife."

⁸⁶⁹ Ibid.

⁸⁷⁰ Pinch, "In Depth Interview with Midwife."

Naomi also described the lack of understanding or respect of intuition as a form of knowledge but stated that she still used her intuition regardless:

Midwives are treated like a nut job if they verbalise things like intuition and women's knowledge and empowerment and stuff, they just kinda roll their eyes. Whereas, when you work in private practice you see all the time. You walk in some days and you go 'yep, I know, it's all good, that woman can have her baby in water, it's all fine' and then other days you go 'I just can't see it, something not right'. There's nothing to actually say that she shouldn't have a normal beautiful birth in water, but sometimes you just can't see that and that's my little why, why? And then I'm more aware, I still don't change my practice, I still practice the same way anyhow.⁸⁷¹

The validity of this form of knowledge and the use of intuition as useful and relevant was confirmed by the midwives reflecting on their experiences. The more the midwives were 'proven right' the more confident they became in using their intuition as a form of authoritative knowledge, as this knowledge formed the basis on which their decisions were made and actions are taken.⁸⁷² Susanjane described this, "Because I listened to my intuition, I really, really value that intuition. Sometimes I'd be carrying bizarre things in my car and be going like I don't really know why I need to take this to the birth but then it would be proven later why I needed it".⁸⁷³ Theresa said "You learn more with each journey, and every time you had a gut feeling you reflect and evaluate",⁸⁷⁴ and Sam said "looking back at what happened when your intuition told you something was going to happen, that reinforces your inner sense of knowing, that you were right, that your gut was right and you did what you needed to do".⁸⁷⁵ The women themselves also felt confident in talking about their instincts, intuition and embodied knowledge. The women's knowledge was validated by the midwives as valued knowledge, demonstrated the midwives trust and belief in women as the experts in their bodies and their trust in birth. The patriarchal institution and its medical ideology does not give credence to women's own knowledge and this is demonstrated in its continued attempts to control midwives, women and birth. The impact of the power and control exerted on women and midwives by the medical ideology will be

⁸⁷¹ Newman, "In Depth Interview with Midwife."

⁸⁷² Jordan, "Authorative Knowledge and Its Construction"; Davis-Floyd, *Ways of Knowing About Birth: Mothers, Midwives, Medicine and Birth Activism*.

⁸⁷³ Morison, "In Depth Interview with Midwife."

⁸⁷⁴ Clifford, "In Depth Interview with Midwife."

⁸⁷⁵ Mansfield, "In Depth Interview with Midwife."

discussed further in the theme 'Power of the institutions' and its related subthemes in the following chapter.

Chapter Summary

To conclude, this chapter has presented the second major theme 'Trusting women and birth is central to midwifery philosophy' and its subthemes 'Medicalisation of birth' and 'Midwives use of intuition and the concept of authoritative knowledge'. The next chapter will present the third major theme, 'Power and control of the institutions' and its subthemes: 'Persecution and reporting of midwives' and 'Legislation'.

Chapter Eight - Power and Control of the Institution

As previously outlined in Chapter Six, there are four themes identified in this current study of Privately Practising Midwives (PPMs) in Western Australia (see Table 1 in Chapter Six) This chapter will describe and explain the third theme, 'Power and control of the institutions' and its subthemes: 'Persecution and reporting of midwives' and 'Legislation' (see Table 7 below).

Table 7: Findings part three themes and sub themes

Theme	Power and control of the institution	
Sub themes	Persecution and reporting of midwives	Legislation: Jumping through the hoops and all the red tape

Power and Control of the Institutions

Agar defines an institution as “a socially legitimated expertise together with those persons authorised to implement it”.⁸⁷⁶ Using this definition, the term institution is not restricted to physical buildings such as hospitals, but can refer to any powerful group, including the government, the media, and in the context of this thesis, the health professionals' governing and regulatory bodies, professional colleges and other organisations.⁸⁷⁷ Agar's definition also includes “the conception of institutions as involving asymmetrical roles between institutional representatives or 'experts' and 'non-experts' or 'clients', who must comply with institutional norms and objectives”.⁸⁷⁸ Institutions are also seen as inextricably linked to power, serving the interests of certain powerful groups, and the institutions' power and politics are frequently exercised through the discourse and behaviour of their members.⁸⁷⁹ The 'institutional culture' is an important dimension of the institution, which comprises the informal attitudes, values, norms, and the ethos or 'spirit' which pervades an

⁸⁷⁶ Agar, Michael. 1985. "Institutional Discourse." *Interdisciplinary Journal for the Study of Discourse* 5 (3): 147-168.

⁸⁷⁷ Ibid.; Mayr, Andrea. 2008. "Introduction: Power, Discourse and Institutions." In *Language and Power: An Introduction to Institutional Discourse*, ed. Andrea Mayr. London: Continuum International Publishing Group.

⁸⁷⁸ Agar, "Institutional Discourse."; Mayr, "Introduction: Power, Discourse and Institutions."

⁸⁷⁹ Mayr, "Introduction: Power, Discourse and Institutions."

institution and determines the behaviours of the members.⁸⁸⁰ The institutions' value systems legitimise the world view of the individuals and the organisations they represent,⁸⁸¹ therefore in the institutions referred to in this theme — 'power and control of the institutions'—the medical model of birth is the world view that is valued.

As discussed in Chapter Four, medical ideology is a key feature in the production, social structure and organisation of health care in Australia today.⁸⁸² Medical ideology and the medical model of maternity care dominates the practice of hospital-based doctors and midwives and is also present in the midwifery regulatory and governing bodies. Historically medicine was able to define the conditions under which it recognised and legitimised midwifery; and although midwifery now has its own regulatory bodies, the medical model's view of pregnancy and childbirth is apparent in the risk based approach to independent midwifery practice and homebirth.⁸⁸³ The midwives and doctors employed by the institutions are part of the hierarchical system and the medicalised approach to pregnancy and birth discussed in the previous themes. This medical philosophy is demonstrated in the institutions' policies and guidelines and these govern the clinical practice of the midwives and doctors employed within it.⁸⁸⁴ Many individual doctors and midwives working within the institutions may have personal philosophies that align with the midwifery model of care, however, working within the medical model makes this difficult to express and makes it appear that those working within these institutions subscribe to the medical ideology.

American psychologist Irvin Janis coined the term 'Groupthink', which described the way in which the 'thinking' or decisions made as a group, results in people 'going along'

⁸⁸⁰ Miller, Seumas. 2010. *The Moral Foundations of Social Institutions: A Philosophical Study*, New York: Cambridge University Press.

⁸⁸¹ Mayr, "Introduction: Power, Discourse and Institutions."

⁸⁸² Willis, *Medical Dominance*; Willis, "Introduction: Taking Stock of Medical Dominance."

⁸⁸³ Australian College of Midwives. 2017 "COAG Asks NMBA for Audit of All PPMs Providing Homebirth Services in 2017"; Australian College of Midwives Inc. *National Midwifery Guidelines for Consultation and Referral*; Nursing and Midwifery Board of Australia. 2016. "Safety and Quality Guidelines for Privately Practising Midwives."

⁸⁸⁴ Davis-Floyd, *Ways of Knowing About Birth: Mothers, Midwives, Medicine and Birth Activism*; Dahlen et al., "Planned Home and Hospital Births in South Australia, 1991–2006: Differences in Outcomes,"; Government of Western Australia, "Family Birth Centre Application Form Version 5"; Government of Western Australia, "Community Midwifery Program Application Form"; Nursing and Midwifery Board of Australia, "Safety and Quality Guidelines for Privately Practising Midwives"; Australian College of Midwives. "COAG Asks NMBA for Audit of All PPMs Providing Homebirth Services in 2017"; Australian College of Midwives Inc. *National Midwifery Guidelines for Consultation and Referral*.

with decisions that they do not agree with, rather than challenge the group.⁸⁸⁵ Janis described a dominant characteristic of 'Groupthink' as being when people remain "loyal to the group, sticking with the decisions to which the group has committed itself, even when the policy is working badly and has unintended consequences that disturb the conscience of the members."⁸⁸⁶ According to Janis, members of institutions may consider loyalty to the institution (the group) as the highest form of morality. To keep this loyalty to the group each member is required to avoid raising controversial issues or to question the group's decisions.⁸⁸⁷ For the group to maintain control, the members may be hostile to non-members of the group, non-members do not have the same loyalty and may therefore question or challenge their policies or decisions.⁸⁸⁸

The midwives and doctors interviewed in this study all discussed the mainstream maternity system in Western Australia, which they defined as a 'patriarchal' institution which sought to control women and midwives.⁸⁸⁹ GP obstetrician Margaret said, "the doctors want to be in control, and they know that they're in control with the hospital midwives".⁸⁹⁰ As described above, the Groupthink mentality allows the dominant group to treat the 'others' with hostility, and therefore the negative treatment of the PPMs is a result of the underlying patriarchal culture of the institution and the medical ideology. As previously discussed, the medicalisation of birth defines women as a combination of risk factors and childbirth as pathological and only ever normal in retrospect. The medical model therefore defines what 'type' of women midwives can provide midwifery care to in the community. This medicalisation of birth, within the medical model, enables the institutions to gain 'power and control' over the midwives who do not subscribe to their ideology, contributing to the midwives feeling that they are being bullied to conform.

Specialist obstetrician Liza was shocked by the treatment of the midwives in private practice in WA, not only from individual hospital midwives and doctors, but from the whole maternity system. Liza felt that the disrespect shown to PPMs was not just because they

⁸⁸⁵ Janis, Irving L. 1982. *Groupthink: Psychological Studies of Policy Decisions and Fiascoes*, 2nd ed, Boston: Houghton Mifflin Company.7.

⁸⁸⁶ *Ibid.*11.

⁸⁸⁷ *Ibid.*12.

⁸⁸⁸ *Ibid.*257.

⁸⁸⁹ Trungeon, "In Depth Interview with Doctor"; Smith, "In Depth Interview with Midwife"; Hynd, "In Depth Interview with Midwife"; Clifford, "In Depth Interview with Midwife"; Vervest, "In Depth Interview with Midwife"; Ritchie, "In Depth Interview with Midwife"; Pinch, "In Depth Interview with Midwife"; Butera, "In Depth Interview with Midwife"; Newman, "In Depth Interview with Midwife"; McNamara. "In Depth Interview with Midwife."

⁸⁹⁰ Trungeon, "In Depth Interview with Doctor."

were providing care at home, but because the PPMs were not controlled by the mainstream maternity system and did not conform to the medical model of care with its risk aversion approach:

The disrespect towards the private midwives was terrible. I have been in circumstances where I've been really shocked about the disrespect from a specialist to a midwife. From specific people and just the whole system. People were used to a system that worked in a certain way and to change anything, even slightly from their normal is very hard. I would say we, we had quite a few GP obstetricians working, and I would say some of them would even see private midwives as competition. So that was definitely a barrier. And most specialists were definitely of the opinion that it's [homebirth] high litigation risk and just wanted to avoid it completely.⁸⁹¹

The doctors interviewed in this study felt that power and control were incentives to subjugate PPMs, financial considerations were also a factor. Obstetrician Ralph believed the doctors were frightened of losing their clients to midwives. Ralph said, "Well they're afraid that, frightened that, they're going to lose a lot of money".⁸⁹² Emma believed that power and control by the patriarchal medical institution was a gendered issue, "I know that there's a lot of money to be made from normal birth from the medical side but I think it was more a power thing and an ego and a battle of feminist issues, you know, an underlying feminist issue and an underlying women's issue".⁸⁹³

Naomi felt that institutional patriarchy was the main challenge:

I think we just need to smash the patriarchy actually (laughs) get rid of the hierarchy and get men out of control of women's vaginas and babies and we will be fine. Although in saying that there are a lot of midwives in there that are part of the patriarchy as well. It's not man vs. woman, it's patriarchy that is the problem.⁸⁹⁴

Liza also felt that the roles and responsibilities of midwives were not understood. She believed that PPMs were autonomous practitioners; however, she felt that there was a lack of understanding of the scope of practice of the PPM from Australian doctors:

it's a mistrust in the capabilities of private midwives...not having insight into the training and the abilities and the responsibility that midwives have and I found that doctors that trained in

⁸⁹¹ Fowler, "In Depth Interview with Doctor."

⁸⁹² Hickling, "In Depth Interview with Doctor."

⁸⁹³ Ritchie, "In Depth Interview with Midwife."

⁸⁹⁴ Newman, "In Depth Interview with Midwife."

the UK were better because they had a bit of experience with midwives being responsible and taking responsibility at a high level, where the other people that trained in WA and also other countries that it's not common. The whole hierarchical training system where the doctor's always right. They see midwives as nurses and that's the same level of responsibility that they're attributing.⁸⁹⁵

The institutions have the power and controls who has access to the institutions and all the benefits that can bring. The PPMs were not considered part of the institutions, therefore they felt they experienced many barriers to accessing support. This was partly due to the differences in ideology, the lack of support for homebirth and the assumption that the PPMs were dangerous. Mary had tried to obtain admitting rights to the hospitals in the 1980s so that she could admit women under her name, not the doctors', if hospital admittance was required:

I formally applied [to the hospitals for admitting rights] and I included all of my certificates, all of my up to date education and of course I was a bit of an education nut and if there was a lecture on, I would go...I always did my obstetric emergencies and you know anything else that came up that I thought would benefit me. Even if I didn't use it, it might benefit me in my background knowledge. So, I sent them all my up to date CV and made a formal request which got a formal letter back, about 3 lines, to say no. I did have a lot of letters of rejection from all of the hospitals who had maternity units around the metropolitan area. Not because I didn't have insurance or the right qualifications, I did, but because they didn't want me. They didn't want any private midwives there. The doctors were unhappy, and they didn't want us there. They were really even unhappy [about] us transferring in from home. They wanted to be in control, of us and the women.⁸⁹⁶

Although some private hospitals in WA can choose whether to provide maternity care to women, public hospitals must provide maternity care to women in an emergency. However, many barriers such as the lack of admitting rights, the differences in ideology and hierarchy of the professions made accessing the hospitals very stressful for the midwives and women they cared for, and in some cases the midwives stopped going to particular hospitals. Enid recalled the power imbalance caused by the hospitals not accepting clients and midwives.⁸⁹⁷ Not accepting PPMs and their clients into the hospitals is extremely problematic, particularly if a woman needs to be transferred from a planned homebirth to

⁸⁹⁵ Fowler, "In Depth Interview with Doctor."

⁸⁹⁶ Murphy, "In Depth Interview with Midwife."

⁸⁹⁷ Facer, "In Depth Interview with Midwife."

hospital, either during her pregnancy, labour and birth or postnatally. By the time Enid retired in the early 2000s, she felt that the pressure and politics were becoming too much for the midwives:

We had so much aggro [aggravation]. There were hospitals that said you can't come here, we couldn't even take them in even just as a support person. We had to go because we weren't family, so we stopped going to those places...I didn't like the changes that were coming, it became more political, King Edward's [hospital] trying to get more involved. We couldn't get insurance, and I remember Theresa saying, 'I envy you being retired, it's really not happy time to be a midwife'. She said, 'you got out in time'.⁸⁹⁸

PPMs in WA have been unable to obtain admitting rights to hospitals, although Theresa did have visiting 'privileges' at Woodside hospital in Fremantle from the late 1970s until the late 1990s, which enabled her to provide clinical care for the women she transferred into hospital.⁸⁹⁹ Theresa was, however, unable to admit the women to hospital under her name. Therefore, although she was able to administer clinical midwifery care, the women would be admitted under the care of the medical team. This restricted the role of Theresa and other PPMs (who were granted visiting privileges) as the woman's primary care provider, as the power to determine what care should or should not be implemented rested with the institution. Although the situation was not ideal, at least the midwife could provide clinical care to the woman; however, these visiting privileges were revoked in 1997 when the midwives were informed that the *Health Act of 1927* clauses 18 (1a) and 31 (1) stated that only medical practitioners were eligible to have admitting rights to hospital.⁹⁰⁰ However, during a 1999 interview undertaken by Carol Thorogood, Theresa stated that she felt these privileges were revoked as a punishment for the PPMs' criticism of the hospital. The midwives had never actually had admitting rights to the hospital, they only had visiting privileges, therefore the legislation should not have had any relevance to the agreement. Just prior to the removal of their hospital privileges, the midwives had submitted a letter of concern regarding the lack of access to anaesthetic services during a homebirth transfer.⁹⁰¹ In this example the state apparatus is being used (via the *Health Act of 1927*) to support the power imbalances in the institution. The institution is the vehicle through which medical control is exerted and the state is complicit in this.

⁸⁹⁸ Facer, "In Depth Interview with Midwife."

⁸⁹⁹ Clifford, "In Depth Interview with Midwife."

⁹⁰⁰ Thorogood, "Politics and the Professions: Homebirth in Western Australia." 250.

⁹⁰¹ Ibid. 250.

For the PPMs the lack of visiting privileges in hospitals meant that during a transfer they were not allowed to provide clinical care to the woman; their role was relegated to a 'support' person rather than a 'midwife', potentially leading to further conflict and power imbalances. Some of the PPMs talked about the fine line they felt they had to walk between accepting the power and control of the institution and supporting the women. The midwives talked about how they felt they were bullied into complying with the institution's rules and regulations, even if they felt that sometimes it was not in the best interest of the woman. Vanessa said:

it can get quite... brutal, but it's more like the bullying tactics. It's putting the woman first and going ok what's best for this woman and you know sometimes you do have to draw that line and go well you know it's not what should be happening but it's the best that we can do.⁹⁰²

Some midwives preferred to be in the support role as they did not feel comfortable with the hospital midwives. Nicky said the hospital midwives did not treat her professionally and were often rude and disrespectful towards her and her homebirth clients.⁹⁰³ The negative attitudes and unprofessional behaviours that the PPMs experienced are the result of the medical ideology and institutional culture which strongly resists anything that appears a 'threat' to the institution's way of doing things. As such, these bullying tactics are a way to maintain control and power over PPMs – the aim is to silence them and to isolate them. Nicky said, "the hospital midwives were not particularly friendly and that was another reason why I just sort of thought "I don't want to get this accreditation" because why would you want to work with a bunch of women who see you as an alien trying to kill babies".⁹⁰⁴ Emma talked about witnessing the way the midwifery manager spoke about her PPM, Sally, when Emma was a midwifery student and pregnant with her second daughter, "the midwifery manager was very scathing of Sally [Emma's PPM]. The way Sally looked, the way Sally practiced, the amount of trust that Sally put in me and in birth, she was scathing of all that."⁹⁰⁵ Susanjane also talked about how she had been described unprofessionally by another health professional who said "'you're the odd, you're the feral, you're the maverick', [this] was one of the statements I got from a DON [Director of Nursing]."⁹⁰⁶

⁹⁰² Butera, "In Depth Interview with Midwife."

⁹⁰³ Vervest, "In Depth Interview with Midwife."

⁹⁰⁴ Ibid.

⁹⁰⁵ Ritchie, "In Depth Interview with Midwife."

⁹⁰⁶ Morison, "In Depth Interview with Midwife."

The midwives also talked about how they had witnessed their clients being bullied, and knew they had to submit to the medical power and control to try to stop this. Jane stated, "I've seen doctors take it out on the woman not me",⁹⁰⁷ and Vanessa said:

I'm very much aware that we need to be aware of that one that just keeps right there in your face, that you have to draw that line of sometimes backing off because they can retaliate and take it out on the woman. So, it's a fine line of finding that balance.⁹⁰⁸

The midwives talked about how they were forced to practice like the institutions. Denise believed that "you have to practice like they do and if you don't you'll have a hard time".⁹⁰⁹ She described how she tried to stand up to the institution but in doing so drew attention to herself:

"The obstetricians used to stand over the woman with their hands on their hips saying 'that baby is not going to fit through that pelvis' and I used to quietly suggest that maybe we could wait until labour started, and that went down like a lead balloon didn't it, yes, I was questioning things and it wasn't appropriate, so my card was marked".⁹¹⁰

Bronwyn talked about how the expectation that midwives needed to work in a hospital prior to becoming a PPM was a way of controlling the midwives, she said, "Go and work in the hospital for 6 months and then you can come back into the community. It's almost like go and get brainwashed into total fear and then we'll let you come back, and you won't cross the guidelines again or misbehave, it's a bit sad".⁹¹¹

The AMA and RANZCOG consistently maintain the medical ideology that birth is pathological, therefore the care of women during pregnancy, labour and birth is only safe if a doctor is involved, and the birth is safest in a hospital.⁹¹² Furthermore, even if midwives are providing midwifery care, they must only do so if they report to the supervising obstetrician. This rhetoric continues the wide held belief that if midwives choose to work independently, they must therefore be dangerous, and it is the responsibility of the

⁹⁰⁷ Smith, "In Depth Interview with Midwife."

⁹⁰⁸ Butera, "In Depth Interview with Midwife."

⁹⁰⁹ Hynd, "In Depth Interview with Midwife."

⁹¹⁰ Ibid.

⁹¹¹ Key, "In Depth Interview with Midwife."

⁹¹² Roome et al., 2015. "Why Such Differing Stances? A Review of Position Statements on Home Birth from Professional Colleges," *British Journal of Obstetrics and Gynaecology*, 123 (3): 376-382; Royal Australian and New Zealand College of Obstetricians and Gynaecologists. 2011. "Home Birth," *O&G Magazine*, (13): 58-59; Royal Australian and New Zealand College of Obstetricians and Gynaecologists, "Homebirth Statement."

patriarchal maternity system to keep the public safe by attempting to control the midwives and women who do not comply with the expected norm. The perceived need to keep the public safe by controlling the midwives has led to the persecution of many PPMs and this will be discussed in the next section in the sub theme, Persecution and reporting of midwives.

Persecution and Reporting of Midwives

The persecution of midwives has been a recurring concept that has been apparent throughout the history of midwifery in Western Australia. Nineteenth century WA midwives were held responsible for the colony's high levels of maternal and foetal mortality. The medical profession called for them to be controlled. A 1911 newspaper article discussed the "much needed measure" of the registration of midwives and the *Health Act of 1911*, noting that prior to the new legislation:

The control, or rather want of control, was simply scandalous...Sairey Gamps ruled supreme and the elderly lady who had a predelection to Old Tom or Plymouth gin, usually presided at the arrival of our grandparents and parents. According to their lights they, maybe, did excellent service, but it is safe to say thousands of children and thousands of mothers died at or through birth troubles...[If] the cradle may be kept full, it is necessary that the mothers, should be assured, that the risk they run in child birth is infinitesimal. This can only be assured by the provision of some method by which those who are allowed to attend maternity cases are competent, trained to the nursing service and of good repute.⁹¹³

The reputations of WA midwives were also damaged by criticisms from male medical doctors. This is demonstrated by a letter to the editor of the *The Perth Gazette* written in 1871 by Mr Henry Wood, the husband of a satisfied customer of 'Mrs McNee', which defended her reputation against an untruth spread by "a certain medical gentleman having spread reports reflecting on the ability of Mrs McNee as a midwife".⁹¹⁴

We can see links between these past experiences of midwives like McNee and her modern counterpart, despite PPMs now being highly trained. In 1999 when Mary was attempting to obtain admitting rights at KEMH, obstetrician Dr Graham Smith wrote a letter

⁹¹³ "Registration of Midwives," *Pingelly Leader*, December 11, 1911.

⁹¹⁴ *The Perth Gazette*. 1871. "Letter to Editor; Henry Wood." September 29, 1871.3.

to the medical director, Dr Brian Robertson, to attempt to discredit Mary.⁹¹⁵ The letter dated 22nd April 1999 stated:

Homebirthing is not an option that I can support in a rational and informed society.

When a person is admitted to this hospital and becomes a medical responsibility of the hospital staff and there should be a clear-cut delineation of ongoing responsibility and care and recognition of medico-legal implications for the consultant clinician on call.

I believe this hospital should not be seen to be giving support or credence to a practitioner who is providing substandard and dangerous services to the community. To do this will inevitably lead to false assumptions by the public that their pregnancies are safe and adequately provided for.⁹¹⁶

Mary decided to fight back, employing a lawyer to sue the doctor for defamation of character and an apology. She was successful in her case and received a letter of apology that stated:

In a letter to Dr Brian Robertson dated 22 aril 1999 I alleged that Ms Murphy, a practising Homebirth Midwife provided substandard and dangerous services to the community.

I now recognise that there was no foundation to this allegation and that the allegation was false.

I apologise to Ms Murphy and regret the allegation was ever made.

Further, I undertake to Ms Murphy not to publish such allegations of her in the future.⁹¹⁷

The midwives interviewed for this study spoke at length about the politics of birth and the persecution and reporting of midwives. Either they had experience of this themselves or had witnessed the persecution of other PPMs. Theresa said, "I think it was and always has been the climate that they've always been out to get us. They've always been like 'let's hope something goes wrong and we can get her, and we can get her struck off' ".⁹¹⁸ Denise said being a private midwife meant being political whether you wanted to be or not, "other midwives said to me 'it's alright for you Denise you're political' and I said 'everybody's political it's just about whether you put your head above the parapet or not

⁹¹⁵ Smith, Dr Graham. 1999. Letter, April 22, 1999.

⁹¹⁶ Ibid.

⁹¹⁷ undated 1999.

⁹¹⁸ Clifford, "In Depth Interview with Midwife."

and when you do you get it shot off' ".⁹¹⁹ Emma spoke about the midwives she had seen persecuted by the dominant maternity system and the affect it had on her and the midwives:

it was heart-breaking to me, to see incredible midwives who have made such amazing differences to people's lives, be crushed and spat out and some angry, some broken, some relationships and family life affected...I've seen midwives who were so experienced and still had like 20 and 30 years, of incredible care and incredible facilitation of births be just bullied and degraded and post-traumatic stress, depression, relationship breakdown.⁹²⁰

From witnessing this persecution Emma felt relieved when she became pregnant with her third child as it gave her an excuse to leave private practice midwifery:

I was really happy to be pregnant for the third time, but it was also a relief for me because it was almost like my way out of private practice midwifery. I knew from that time [2011], that what had been in the past was a gift and that I had a lot of gratitude that I'd actually experienced that style of positive community midwifery without pressure and that someone wasn't ready to just hang me by a noose because the midwives were being attacked. There was a massive power struggle in Perth between GPs, obstetricians and the hospital doctors mainly but also hospital midwives and the private community midwives. Like it had gotten personal all of a sudden.⁹²¹

Autonomous PPMs have not only suffered bullying and disrespect from medical practitioners and hospital midwives, they also had complaints and allegations made against them to their governing bodies, the Nurses and Midwifery Board of Australia (NMBA) and the Australian Health Practitioners Regulation Agency (AHPRA).⁹²² These complaints were often vexatious and can be interpreted as an attempt to eliminate homebirth and the midwives who provided homebirth care. Jane said, "I needed to understand it [why they were reporting the midwives] because it doesn't make sense, really good passionate women doing a really good job....they don't want them, they want foot soldiers they can control".⁹²³ Specialist obstetrician Liza, was told by obstetric colleagues that all women

⁹¹⁹ Hynd, "In Depth Interview with Midwife."

⁹²⁰ Ritchie, "In Depth Interview with Midwife."

⁹²¹ Ibid.

⁹²² Clifford, "In Depth Interview with Midwife"; Fowler, "In Depth Interview with Doctor"; Smith, "In Depth Interview with Midwife"; Murphy, "In Depth Interview with Midwife"; Morison, "In Depth Interview with Midwife."

⁹²³ Smith, "In Depth Interview with Midwife."

would birth in hospital if they could not find a midwife to support them to birth at home, she said:

So, it was kind of, 'get rid of the private midwives and we won't have a problem with people wanting to birth at home'. So, they [obstetricians] were anti-home birthing and anti-midwife and instead of supporting midwives, they [obstetricians] would have that attitude that almost the harder you make their [PPMs] life the easier their [obstetricians] lives would get because then they wouldn't have to deal with them at all.⁹²⁴

From the late 2000s, the midwives interviewed in this study identified an increase in PPMs being reported. Emma described feeling shocked at the persecution of midwives, when she first relocated to Perth in the late 2000s from Broome:

...it was a real shock and that's I remember ... the first time I'd ever felt fear to be a homebirth midwife. I remember the fear came up. I could be crucified, I could lose this midwifery, everything that I've loved, and I think I want to do for 40 and 50 and 60 years. By being a homebirth midwife, you are wearing your heart on your sleeve but you're also...at risk from losing everything. Actually, every midwife I've worked with in that period...older women who were really wise, went through disciplinary action and I knew one day it would probably be me and that made me feel really scared, just from the conflict side of it and from the pressure of it.⁹²⁵

Naomi described how she felt "lucky"⁹²⁶ not to have been reported but then described an incident with an obstetrician, which occurred when a woman she was caring for made an informed decision to decline induction and antibiotics after her membranes ruptured before labour started.⁹²⁷ Naomi said:

I've been lucky and I haven't had too much conflict, but there was this one time when the obstetrician wrote that I had been advising the woman to refuse treatment which wasn't true at all, the woman had made an informed choice to decline induction and antibiotics. But when I read the hospital file, the obstetrician had written "private midwife Naomi Newman advised her to decline induction, private midwife Naomi Newman has advised her to refuse antibiotics" so every single decision that woman had made he had written that I had told her to do it and then basically he was threatening to report me and I said "great let's go because I have actually done nothing wrong, my documentation is here, this is the referral collaboration

⁹²⁴ Fowler, "In Depth Interview with Doctor."

⁹²⁵ Ritchie, "In Depth Interview with Midwife."

⁹²⁶ Newman, "In Depth Interview with Midwife."

⁹²⁷ Ibid.

guidelines, I'm sure you got a copy of them and I know that we follow them and pretty sure you do. So, I'd really like to have this case reviewed about the way you've treated this woman" because the bullying and the coercion, because she wasn't being a good girl and doing as she was told, was absolutely disgusting.⁹²⁸

Many of the PPMs described how from the late 2000s it seemed that any time they put a foot inside a hospital they were threatened with being reported. Theresa said, "You take anybody in, and you get reported. I don't know why they do it, but you know I wouldn't encourage anybody to be a midwife these days".⁹²⁹ One of the effects of this climate was that many midwives became frightened, some, like Emma, gave up being a PPM altogether⁹³⁰ and others, such as Naomi and Vanessa, took a break from private practice midwifery due to the stress.⁹³¹ Vanessa was worried about getting reported for supporting women to birth at home. She said, "I just thought it's just getting harder and harder for midwives who support women at home to not get reported and I didn't want to have to go through all of that stress".⁹³² Emma said, "there were just people there who felt that private midwives were incredibly dangerous and risking women and babies lives and they were making it their ethical business to report them, there was a massive amount of vexatious reporting going on and it was scary, I hated it".⁹³³ Naomi said:

Seeing other midwives getting reported definitely made me get out of private midwifery for a while, because everywhere where I was looking there were midwives being vexatiously reported and being put through the ringer, and their mental health and their family's mental health was affected. And we've known people who've gone through the coroner's court when we know that looking at the midwifery care there was nothing that they had done, there was nothing that would change the outcome and yet they're still made to feel terrible...that it was their fault.⁹³⁴

Theresa was the midwife involved in a case that was referred to the coroner's court, when a baby died at a birth she had attended.⁹³⁵ Interestingly, the coroner's case involved three babies that had died at separate and unrelated births, however, all the babies had died at home which made it seem that the coroner's court was investigating homebirth

⁹²⁸ Newman, "In Depth Interview with Midwife."

⁹²⁹ Clifford, "In Depth Interview with Midwife."

⁹³⁰ Ritchie, "In Depth Interview with Midwife."

⁹³¹ Butera, "In Depth Interview with Midwife"; Newman, "In Depth Interview with Midwife."

⁹³² Butera, "In Depth Interview with Midwife."

⁹³³ Ritchie, "In Depth Interview with Midwife."

⁹³⁴ Newman, "In Depth Interview with Midwife."

⁹³⁵ Clifford, "In Depth Interview with Midwife."

rather than the individual cases.⁹³⁶ Theresa described how after the stillbirth everyone involved in the birth was treated as a criminal:

And so, this woman, her husband was taken away from her, her midwife was taken away from her..., her husband was put in a separate room [at the hospital], the midwife was put in a separate room, they were each interviewed for an hour by the police and then the police came to the woman's home. I met her at her home, the police they'd gone, they went through all of her garbage, they took everything out of her rubbish bin. They went to her house, they confiscated you know her essential oils, her lavender, everything that was there that had anything to do with the birth they took away and her baby was taken away from her as well⁹³⁷

Theresa and the other independent midwives in WA had declined to take the woman on as a client for a planned homebirth as she was expecting twins.⁹³⁸ However, it became clear that the woman had no intention of attending hospital for the birth— as when she was unable to find a midwife to support her in WA, the woman had employed an unregistered midwife from another state— Theresa had attended the birth as a reluctant 'back up' midwife and stated she had initially only agreed to provide post-natal care but felt she had no choice but to attend the birth when the unregistered midwife called her during the labour:

I couldn't support her as a midwife. The only way I could support her as a midwife would be to pick up the postnatal care because her midwife would have to go back over east, so I would do the postnatal work. The unregistered midwife said she didn't usually have a doula or a midwife at the birth, she preferred to work on her own. Well you know, if I get called to attend a birth, according to my registration requirements and guidelines and stuff I have to come if I get called. I did get called, that put me in an awkward position because the woman had chosen the unregistered midwife as her lead carer but then I get there and I'm a registered midwife who it can be seen that I'm delegating my duty of care to an unregistered midwife, even though it was very clear who the woman wanted.

I've never delivered a stillborn baby, I've never been at a birth with a fresh stillborn baby. I've been at a birth with a baby that I know has died in utero and supported that woman at home and stayed at home with women whose babies have been diagnosed as having died in utero

⁹³⁶ SBS News. 2014. "Home Birth in Spotlight at Perth Inquest" September 30, 2014.

⁹³⁷ Clifford, "In Depth Interview with Midwife."

⁹³⁸ Ibid.

and they've still chosen to have a homebirth. But this one, that's the first time I've ever seen a fresh stillborn baby.⁹³⁹

Following the birth Theresa was reported:

I was reported to the Nurses Board [Australian Health Practitioner Regulation Agency] I was reported as being the midwife at the birth and even though it was very clear that I was the backup midwife who was there to do the postnatal care, as the registered midwife, I was the midwife who was responsible and so somebody had sent a complaint, I don't know who sent the complaint, I still never found out.⁹⁴⁰

Following the complaint APRHA wrote to Theresa stating they would be putting restrictions on her registration that would restrict her practice to the hospital setting until an investigation had been undertaken.⁹⁴¹ Theresa had not worked in the hospital setting for over 40 years, so she made the decision to give up midwifery:

because it was a coronial enquiry, they wouldn't be following up this investigation until after the coronial enquiry. In the meantime, there were restrictions on my practice, so I could only work under supervision in a tertiary hospital as a midwife. I haven't worked in a tertiary hospital since I was 21 and I was 64 then. I just thought I'm 64, I'm winding down my practice, I haven't got the time or the energy to fight, to say what I did was the right thing, so I just waited until I finished her postnatal care because the [unregistered] midwife went back over east. I stayed registered until the 10 days of postnatal care, so I could do all the PKU [newborn screening test] and stuff that needed to be done. If I'd been 44 it would have been a different story because I'm giving up my passion. But it still makes me really sad that I gave it up... It's just a horrible way to end your career.⁹⁴²

Emma described the contrast between poor outcomes within the institution and the homebirth setting and how this was portrayed in the media:

if something happened in hospital which they did of course, poor outcomes happen, it would get no media coverage, if something happened in community it would get days and weeks of community coverage...if it was related to a homebirth. So, homebirth almost had like a vendetta against it and the midwives that were supporting women to have homebirths had a huge vendetta against them. It was nasty and there was only going to be one winner although midwives fought hard. It was just a battle of you know David versus Goliath, that's the way I

⁹³⁹ Clifford, "In Depth Interview with Midwife."

⁹⁴⁰ Ibid.

⁹⁴¹ Ibid.

⁹⁴² Ibid.

look at it in hindsight and although the effort was absolutely huge from midwives and mothers and people who were supporting mother's choices in birth, they were never going to win that particular battle during that particular time because we just were well, under-armed.⁹⁴³

The media also reported on the coroner's case which took place in 2015. PPMs and women choosing to birth at home are vilified in the media, in July 2015, an article titled *Homebirths a 'selfish' choice* appeared in the West Australian.⁹⁴⁴ The article stated:

Couples who insist on a homebirth despite the risks are selfish and putting the birthing experience ahead of their baby's safety, according to a prominent Perth obstetrician... Dr Gannon said a small minority of women and their partners insisted on having a homebirth in the face of increased risks, and were instead preoccupied with the few hours of the birth rather than the bigger picture of their child's long-term welfare.

"Women will usually do anything to protect their babies in terms of what they eat and the medication they take, yet a minority seem to be willing to take on extra risks because they feel it part of their experience of womanhood," he said.

"They are often strongly supported in this way by their husband or partner, but the outcomes can be tragic."

He said the nature of the public hospital system meant it was difficult for women giving birth "to feel special", so some turned to unorthodox practices.

"Unfortunately, there's a small number of women who continue to defy the advice of obstetricians and midwives," Dr Gannon said.⁹⁴⁵

Dr Michael Gannon is a prominent Perth Specialist Obstetrician and was head of the WA Medical Association during the time of the coronial enquiry. He was quoted in a Sydney newspaper in 2016 as saying:

'there are still a small number of women who refuse to follow advice and engage the service of private midwives who are not covered by insurance. They need to be aware that they are placing their life and the life of their unborn child in the hands of someone who doesn't have

⁹⁴³ Ritchie, "In Depth Interview with Midwife."

⁹⁴⁴ O'Leary, Cathy. 2015. "Homebirths a 'Selfish' Risk," *The West Australian*, July 7, 2015.

⁹⁴⁵ Ibid.

the skill, training and adheres simply to their own ideology which is very, very dangerous' said Dr Gannon.⁹⁴⁶

Another example of a midwife being made to feel responsible for a baby's death is illustrated by Sam's recent experience. Sam had a tragic outcome with one of her clients in 2017, when a woman suffered a ruptured uterus in early labour and the baby died. Sam was very emotional when she described what happened:

I had a really tragic outcome last year, when a woman did rupture her uterus in really early labour and the baby passed away after 5 days. It is still affecting me, but it hasn't stopped me from supporting women and it's not over yet. It's everybody's worse nightmare. Working in birth there are always some bad outcomes but this one really affected me because you have that relationship with the woman and the family. You are really heartbroken for them and you have spent all that time with them in their pregnancy and done your absolute best to make it as good as it can be and for it to turn out like that was really heart-breaking.⁹⁴⁷

During the woman's transfer to hospital in early labour the hospital staff were supportive; however, Sam was told by the hospital staff to expect that her conduct would be investigated:

I had only been with her for 15 minutes when I picked it up and then we transferred in and everything was really quick from there. No one blamed me, everyone was really supportive, you know they said, "you did your best. You couldn't have done anything different". But they said to prepare yourself because you know there will be an investigation. I mean, I do feel like they are going to blame me. It's like they are looking to make an example out of me and my profession, that's how I feel sometimes. But I have to just keep trying to reassure myself that I did nothing wrong and hopefully that's what they will find. But it is a shame because it is such a stressful process.⁹⁴⁸

Naomi reflected on the different way deaths at home and deaths in hospital were treated; she believed that the only reason she was not persecuted or reported after a baby died that she had cared for was because the baby had a genetic condition:

we just don't as a society want to acknowledge that sometimes babies die. And yes, it's sad and no family wants to go through that. But you just know that at some point in private

⁹⁴⁶ Katsambanis, Karalee. 2016. "Karalee Katsambanis: Home Birth Will Always Be a Game of Russian Roulette." *The Sydney Herald*, April 3, 2016. An email and letter were sent to Dr Gannon requesting to interview him as part of this study, but no reply was received.

⁹⁴⁷ Mansfield, "In Depth Interview with Midwife."

⁹⁴⁸ Ibid.

practice you can have a baby that passes away or doesn't stay, that's just life. I'm just lucky that my baby that died had a reason, that she had something wrong and needed palliative care. Because if we hadn't had the genetic screening, can you imagine the scrutiny that I would have had? It would have been 'that baby died, what did you do, what didn't you do properly? What didn't you find, what didn't you pick up.' It's absolutely different in hospital, in hospital babies die, and it's not a coroners' case. If a baby dies at home even if it's a shoulder dystocia and they did everything, even if it's on FDIU [foetal death in utero] before labour, the midwives are still hauled over the coals and are made to be responsible.⁹⁴⁹

Emma too reflected on how the medical ideology and power of the institutions impacts on the way that homebirth and PPMs are viewed:

So people who didn't even have an interest in homebirth or private midwives i.e. like your normal GP, things were in the media, things were on the radio and they were starting to take interest and starting to, the turf battle was well and truly on about you know, the turf battle between almost like who owns birth. Do women, do midwives, do doctors and how does that all work?⁹⁵⁰

With the increased surveillance and the vexatious reporting of PPMs, the midwives in this study felt it was getting harder to practice autonomously and to provide true holistic midwifery care to the women they supported. Since the introduction of the *Health Act of 1911* and the requirement that all midwives are registered health practitioners,⁹⁵¹ legislation has continued to attempt to control midwifery practice and this will now be discussed in the next subtheme.

Legislation: Jumping through the Hoops and all the Red Tape

As discussed in Chapter Five the *Health Act of 1911* was the first legislation aimed at controlling and regulating midwives' practice in Western Australia.⁹⁵² Legislation to control midwifery has continued over the last hundred years. As discussed in the previous section, the increased scrutiny and reporting that the PPMs in this study have experienced has led to increased pressure and stress. One of the other concerns the midwives in this study spoke about, was the increasing restrictions on their scope of practice and certain

⁹⁴⁹ Newman, "In Depth Interview with Midwife."

⁹⁵⁰ Ritchie, "In Depth Interview with Midwife."

⁹⁵¹ *Health Act of 1911* (WA).

⁹⁵² *Ibid.*

requirements that they had to fulfil to be able to continue to provide private midwifery care to women in the community and attend births at home.⁹⁵³ Discourses in maternity care are affected by the ideologies and philosophies of the maternity care provider. In Australia, obstetricians are the lead professionals, so their philosophies and ideologies are the ones that dictate how policies and services are provided. As previously discussed, although some individual obstetricians have woman centred philosophies, the mainstream philosophy is the medical model. Although there have been some recent advances to support private midwives there have also been some concerns, in particular the perceived need for medical dominance in maternity care. Legislation and policies focus on 'risk', as previously discussed in Chapter Seven the medical model perceives childbirth as inherently dangerous, with women assessed and categorised according to their perceived risk level. Medicalisation of birth involves control, manipulation and intervention being justified through 'risks' defined by the medical model, therefore care mainly focuses on the physical status of the woman and the pathology of pregnancy and birth. The increasing reliance on technology and medically dominated birth contributes to the belief that midwives who provide care in the community and attend births at home cannot be competent.⁹⁵⁴ Therefore, to assess their competence they must be closely monitored and controlled.

All the midwives interviewed in this study talked about the "hoops" they have had to jump through just to be able to practise private midwifery. They also described the "red tape" that has surrounded them. From having to notify the Department of Health of their intention to provide private midwifery services, to the recent audit in 2017 of PPMs providing homebirth services,⁹⁵⁵ the midwives stated that they felt excessive red tape was there to try to restrict their practice not to enhance it.

Theresa talked about how the expectations, which she called "the hoops" were constantly changing. She said "we jump through the hoops, we keep jumping through the hoops they put out for us. Then they make them smaller and we still jump and then they lift

⁹⁵³ Australian College of Midwives Inc. *National Midwifery Guidelines for Consultation and Referral*; Australian College of Midwives. 2017 "COAG Asks NMBA for Audit of All PPMs Providing Homebirth Services in 2017"; Nursing and Midwifery Board of Australia. "Safety and Quality Guidelines for Privately Practising Midwives"; Nursing and Midwifery Board of Australia. 2017. "Fact Sheet: Safety and Quality Guidelines for Privately Practising Midwives Audit."

⁹⁵⁴ Nursing and Midwifery Board of Australia, "Fact Sheet: Safety and Quality Guidelines for Privately Practising Midwives Audit."; Davis-Floyd, *Ways of Knowing About Birth: Mothers, Midwives, Medicine and Birth Activism*.

⁹⁵⁵ Nursing and Midwifery Board of Australia, "Fact Sheet: Safety and Quality Guidelines for Privately Practising Midwives Audit."; Australian College of Midwives. 2017 "COAG Asks NMBA for Audit of All PPMs Providing Homebirth Services in 2017."

them higher and set them on fire and we still jump".⁹⁵⁶ Theresa also described how, in order to meet the legislative requirements, she was being forced to try and make women comply with hospital policies and guidelines:

I felt we were expected to coerce the women into doing things that women didn't want to do like routine ultrasounds, routine testing that the women didn't want and once you'd given them the information they would say, 'well I don't want to do that' and you were a bad midwife if your women didn't comply because they said, 'you couldn't have given the information adequately', and I kept saying, 'well do you expect me to coerce them into complying'.⁹⁵⁷

As discussed in Chapter Five from 2010, all registered midwives have been required to have private indemnity insurance (PII).⁹⁵⁸ Employed midwives receive PII through their employer.⁹⁵⁹ PPMs providing private midwifery care can access PII for antenatal and postnatal care, however, there is no insurance available for PPMs providing midwifery care at a homebirth.⁹⁶⁰ As previously discussed, PPMs have been exempted from this requirement, currently this exemption is in place until 31st December 2019.⁹⁶¹ Following this continuing exemption, the Council of Australian Governments (COAG) Health Council requested the NMBA to audit all PPMs who provide homebirth services against the new *NMBA Safety and Quality Guidelines*, which had come into effect on the 1st January 2017.⁹⁶² These guidelines were introduced to:

protect the public through a robust regulatory framework for Privately Practising Midwives (PPMs). The guidelines provide PPMs with clarity and support to practise their role with safety and quality, while facilitating workforce flexibility and access to services. PPMs practise in a range of settings that can include providing midwifery services in the woman's home. This practice is outside the routine clinical governance arrangements of a health service provider. These guidelines describe the regulatory requirements with which a PPM is expected to comply in order to be eligible for an exemption from requiring professional indemnity

⁹⁵⁶ Clifford, "In Depth Interview with Midwife."

⁹⁵⁷ Ibid.

⁹⁵⁸ Nursing and Midwifery Board of Australia, "Fact Sheet: Professional Indemnity Insurance Arrangements."

⁹⁵⁹ Ibid.

⁹⁶⁰ Ibid.

⁹⁶¹ Nursing and Midwifery Board of Australia "Fact Sheet: Safety and Quality Guidelines for Privately Practising Midwives Audit."

⁹⁶² Australian College of Midwives. 2017 "COAG Asks NMBA for Audit of All PPMs Providing Homebirth Services in 2017."

insurance (PII) for providing intrapartum care for homebirths (under section 284 of the National Law).⁹⁶³

The midwives who were still practising as PPMs at the time of this study, talked about the negative effects of the *Safety and Quality Guidelines* and the subsequent audit had on them.⁹⁶⁴ The audit was undertaken in two phases; phase one commenced in August 2017 and phase two in October 2017. PPMs providing intrapartum care in the home were required to respond with the documented evidence within 28 days of receiving the audit, which was sent by post.⁹⁶⁵ Vanessa talked about how exhausting it was keeping up with the requirements:

I just thought that [the audit] was very discriminative and one-sided and I just went, 'where does it stop'. Like once they start doing this, what's next and I didn't know how far they were going to push it and then I started thinking I'm tired of fighting the fight and I sort of thought enough is enough.⁹⁶⁶

Loralee felt that the audit was discriminatory to homebirth PPMs:

The audit was to identify if there were any risk factors, to see if there was any midwives that were unsafe out there in the community and I just felt like that's just discriminatory to homebirth midwives, because there's a lot of midwives working everywhere, that may be doing unsafe practices in all different sorts of work places and areas.⁹⁶⁷

Finally, Naomi shared how she had stopped working as a PPM for a while because she felt it was becoming too challenging:

I'm glad I've had some time out because it was all getting too hard with all the red tape, the new insurance and the vindictive auditing of midwives providing homebirth. How is it that we have to be audited? They don't audit the hospital midwives. They don't get the scrutiny that we get.⁹⁶⁸

Vanessa also felt that the audit was a way of persecuting the PPMs and that it was not useful, she said, "A lot of what they were asking for was quite pointless, a lot of it was

⁹⁶³ Nursing and Midwifery Board of Australia, "Safety and Quality Guidelines for Privately Practising Midwives."

⁹⁶⁴ Nursing and Midwifery Board of Australia, "Fact Sheet: Safety and Quality Guidelines for Privately Practising Midwives Audit."

⁹⁶⁵ Ibid.

⁹⁶⁶ Butera, "In Depth Interview with Midwife."

⁹⁶⁷ Worrall, "In Depth Interview with Midwife."

⁹⁶⁸ Newman, "In Depth Interview with Midwife."

irrelevant...I was so annoyed that we had to prove ourselves when we've all been registered, we've all had to do the same things as everyone else with our registration and regulations".⁹⁶⁹

Naomi felt that rather than auditing the midwives the government and NMBA should have been working with the midwives:

The audit was time-consuming and vindictive, and what actually came out of it? Have we actually seen anything, any feedback from the audit? Have any changes been made to make it more accessible for midwives to get collaboration? Has it made any extra choices for women? No, it just made a whole heap of private midwives really, really stressed, providing paperwork to justify what they do. If they just looked at the outcomes and looked at the stats. If you just said to the private midwife let me look at the stats, show me how many vaginal births, how many Caesareans, how many transfers? If you just looked at that data that should validate that they are actually all doing the right thing.⁹⁷⁰

The purpose of the audit was to demonstrate that PPMs were safe practitioners and therefore able to be insured for homebirth, however, no insurance policy has eventuated. Insurance has been a contentious point since 2010 when personal indemnity insurance (PII) became a requirement for registration.⁹⁷¹ The midwives interviewed in this study felt that the insurance was another way to add "red tape" and that it was "compulsory but useless" and "worthless".⁹⁷² Naomi felt the insurance, "wasn't worth the paper it is written on".⁹⁷³ As there was no insurance for intrapartum care and home birth, and because of the increased reporting of PPMs, Emma felt that she was vulnerable to persecution:

I felt not only was I not insured, I've never been insured, but there were people out there who would make it their business to bring me down and I'd seen that and it got personal and Perth's so small I could just see, if we had to use the insurance they would find a way to say we did something wrong and we weren't covered.⁹⁷⁴

⁹⁶⁹ Butera, "In Depth Interview with Midwife."

⁹⁷⁰ Newman, "In Depth Interview with Midwife."

⁹⁷¹ Nursing and Midwifery Board of Australia, "Fact Sheet: Professional Indemnity Insurance Arrangements"; "Vero Cuts Midwives' Insurance Scheme," 2015. News release. May 11, 2015.

⁹⁷² Worrall, "In Depth Interview with Midwife"; Clifford, "In Depth Interview with Midwife"; Ritchie, "In Depth Interview with Midwife"; Butera, "In Depth Interview with Midwife"; Newman, "In Depth Interview with Midwife"; Mansfield, "In Depth Interview with Midwife"; McNamara, "In Depth Interview with Midwife."

⁹⁷³ Newman, "In Depth Interview with Midwife."

⁹⁷⁴ Ritchie, "In Depth Interview with Midwife."

Sam attempted to get support from her insurance company after the adverse outcome in her practice in 2017, however, she was told she was not covered.⁹⁷⁵ According to Sam the woman was transferred to hospital prior to labour commencing, therefore her insurance, which covered antenatal care, should have provided cover.⁹⁷⁶ Sam said:

It's also such a big financial cost to me because my insurance is now saying that they are not going to cover me because they are saying it was intrapartum. I thought it [insurance] was compulsory but useless before it happened and now this just confirms it. It took the insurers 10 months to decide and then they have only just got back to me to say no we can't cover it, the reason they gave me was that she was intrapartum but I'm going to contest that because she was 2 cm when I got there in the afternoon. I am going to try and appeal it.⁹⁷⁷

The midwives talked about how alone they felt at times as a PPM and felt unsupported by organisations such as the Australian College of Midwives (ACM). Carol said, "So to me the ACM was the thing that should have been changing the boundaries, but they've got no balls really".⁹⁷⁸ Naomi felt that the ACM, rather than supporting the midwives were trying to control them, she said "the ACM keep adding more and more restrictions [to] what we can and can't do. The referral guidelines are getting much more restrictive. There are hardly any 'category A' women anymore".⁹⁷⁹ Theresa attempted to get help and support from the ACM when she was reported but she said "they [ACM] weren't interested, it was like 'you shouldn't have been there, it's your own fault'. No recognition of my duty of care to the woman, no recognition that I did what I thought was the best I could do".⁹⁸⁰ The PPMs interviewed in this study felt that in recent years there had been an ever-growing divide between the ACM and the PPMs and that the increasing legislation and red tape had made it more difficult to support women. Vanessa said, "The politics of it was just hitting my head against the brick wall and it was just making it harder for midwives to support women who choose to birth their way and birth the way that they wanted to".⁹⁸¹

Many PPMs were giving up their practices in a combination of fear, stress and the inability to meet the increasing requirements. Following the introduction of the *Quality and*

⁹⁷⁵ Mansfield, "In Depth Interview with Midwife."

⁹⁷⁶ Ibid.

⁹⁷⁷ Ibid.

⁹⁷⁸ Pinch, "In Depth Interview with Midwife."

⁹⁷⁹ Newman, "In Depth Interview with Midwife."

⁹⁸⁰ Clifford, "In Depth Interview with Midwife."

⁹⁸¹ Butera, "In Depth Interview with Midwife."

Safety Framework, midwives attending homebirths were legally required to have two health professionals present at the time of birth.⁹⁸² The framework stated, “There should be two registered health professionals, educated to provide maternal and newborn care and skilled and current in maternity emergency management and maternal/neonatal resuscitation, one of whom is a midwife, present at a homebirth”.⁹⁸³ There were fewer midwives able to attend births, therefore, the same few midwives were constantly on call, which contributed to more stress and burn out. Vanessa said, “I was getting burnt out, also there was a lot of midwives stopping, so, I was running out of back up midwives and with the law that says we have to have two midwives at the birth put heaps more pressure on me”.⁹⁸⁴ Theresa reflected and felt that all the restrictions and red tape were a way of trying to get rid of the autonomous midwives and attempting to make the midwives and women using their services more compliant, “I could see that they were picking off, not just the older midwives, but the more experienced private midwives in homebirth practice. I could see that they were trying to get rid of us to get hospital centred midwives who could conform and comply and work for the organisation rather than the women”.⁹⁸⁵

Even with the increased surveillance, vexatious reporting and the other “hoops and red tape” the midwives past and present continued to believe that being a PPM was worth the effort. As discussed in Chapter Five PPMs had made some advances with the ability to access Medicare rebates for their clients, although as previously discussed, there is no rebate for homebirth. These advances also came with their own red tape, such as the need to provide evidence of collaboration with a named medical practitioner or health service.⁹⁸⁶ This will be discussed further in the next chapter.

Chapter Summary

To conclude, this chapter has presented the third major theme, ‘Power and control of the institutions’ and its subthemes: ‘Persecution and reporting of midwives’ and ‘Legislation’. The next chapter will present the final theme in this current study ‘Moving forward: continuing to support women and each other’ and its sub themes; ‘Feel the fear but do it anyway’, and ‘Collaboration’.

⁹⁸² Australia, "Safety and Quality Guidelines for Privately Practising Midwives."

⁹⁸³ *Ibid.*4.

⁹⁸⁴ Butera, "In Depth Interview with Midwife."

⁹⁸⁵ Clifford, "In Depth Interview with Midwife."

⁹⁸⁶ Australia, "Safety and Quality Guidelines for Privately Practising Midwives."

Chapter Nine – Breaking Through the Fear: Continuing to Support Women and Each Other

This chapter will describe the final theme in this study of Privately Practicing Midwives (PPMs) in Western Australia (WA): ‘Breaking through the fear: continuing to support women and each other’ and its two sub themes, ‘Collaboration’ and ‘Getting educated and gaining power’.

Table 8: Findings part four theme and sub themes

Theme	Breaking through the fear: continuing to support women and each other	
Sub themes	Collaboration	Getting educated and gaining power

Breaking through the Fear: Continuing to Support Women and Each Other

In WA, even after the medicalisation of birth made hospital the more accepted place of birth, there has consistently been a small number of women who have chosen to receive maternity care from a PPM, with many of them choosing to birth at home. The midwives and doctors interviewed in this study were at times persecuted, faced vexatious reporting and were often marginalised. Some had ceased practice altogether due to the stress and increasing legislation. However, despite these challenges they were adamant that they would continue to support women and each other to enable current PPMs to provide midwifery care that aligned with their philosophy. Their faith and belief in women and birth contributed to their decision to support each other, as they shared the same passion for supporting and empowering women. Participants interviewed also shared a belief and trust in women’s ability to have a normal physiological birth. Their rejection of the medicalisation of birth assisted them to form a cohesive group; to be able to continue to work in this climate they needed the support of each other.

The midwives and doctors described how they felt fear in providing midwifery care in the community as doing so was not in keeping with the dominantly held medical ideology of birth. They still chose, however, to continue to provide care to women, including

supporting them to birth at home. The midwives shared how they felt able to work within this model of care because of the support they received from the other midwives and the doctors they worked with. Bronwyn shared her passion around supporting women to birth at home as her philosophy, “it was ‘oh you’re going to do it’, ‘we’ll support you in any way we can if you are willing to be there to support the women in her wishes, we will support you’ that was the philosophy and trusting each other’s professional judgement”.⁹⁸⁷

PPMs in Western Australia have consistently found ways to support women and each other. As described in the Chapter Five if a midwife was not available, women would support each other throughout their births. As previously mentioned, in the 1950s Henny Ligtermoet established the Midwives Resource Centre in East Fremantle.⁹⁸⁸ This support centre has continued to provide support for women and midwives for the last 60 years and continues to do so today, with midwives and women using the centre to provide education sessions, support and resources.⁹⁸⁹ In the 1970s, GP Obstetrician Margaret, found her midwife while attending childbirth education classes there. “Henny, she was very, very good as an antenatal teacher and she was running the midwifery contact centre, so she put people in touch with the midwives. And so that’s when I met Theresa”.⁹⁹⁰ In the 1980s, Nicky was supported by Theresa to pursue her love of midwifery and started to teach childbirth classes at the Midwives Resource Centre. Nicky reflected “I started teaching natural childbirth classes and they were very, very popular, I was quite surprised. But you know within a very short time all the midwives were referring their mums to me and I was getting lots of positive feedback for that and lots of support to continue”.⁹⁹¹ Mary Jane also met her midwife and other midwives at the resource centre. “I went to childbirth education classes with Henny, she played Grant Dickley Read records, old 78s, there were five couples there. But I learnt relaxation and it was good. I got the details for my midwife from Henny”.⁹⁹² Obstetrician Ralph also attended the centre with Henny in the 1980s, he reflected:

I mean she sort of led a movement and didn’t employ midwives to do homebirth but she had ways of attracting midwives to do homebirths, at least part time, and I sat in on a meeting,

⁹⁸⁷ Key, "In Depth Interview with Midwife."

⁹⁸⁸ Ligtermoet, "Correspondence, Documents and Submissions by Henny Ligtermoet".

⁹⁸⁹ Ibid.; Clifford, "In Depth Interview with Midwife"; Newman, "In Depth Interview with Midwife."

⁹⁹⁰ Trungeon, "In Depth Interview with Doctor."

⁹⁹¹ Vervest, "In Depth Interview with Midwife."

⁹⁹² McNamara. "In Depth Interview with Midwife."

where she had a group of about 7 or 8 midwives there and she had her list of people who wanted homebirths and sort of allocated them out. She wasn't a midwife herself of course but she was very good with studies, she held classes and always supported the women and midwives.⁹⁹³

Theresa too talked about how the resource centre provided support to women and midwives:

There was no resource centre at King Edward, so you'd get referrals from King Edward coming down to borrow books. People and women were told in the clinic at King Edward, oh no go to East Fremantle, there's information there. So, it was a really busy, busy place and we gave support to the midwives and women. So, we've still got the resource centre and hopefully it'll always be there as a resource centre for women. But there's no funding for it and I mean I'm really sad about that, the midwives have to fund it themselves.⁹⁹⁴

The midwives interviewed in this study reflected on how the work of being a PPM was challenging but manageable because of the support they received from each other and the knowledge that they made a difference to women. Jane felt she had made a big difference to women's lives by supporting midwives and women in birth, she said, "I thought, I'm happy that even after all the fear and bullying, we supported each other, and I think that I've made a positive difference to a lot of women and babies".⁹⁹⁵ Vanessa reiterated that she would continue to support women:

My attitude is I'll do what I need to do for the women because it doesn't really matter what you do, you're damned if you do, you're damned if you don't. So there's not point worrying about it. I'll just keep doing what I'm doing until someone tells me not to.

Naomi stated, "So much of my journey was because of the midwives that supported me to support that woman, that made it good, made it okay".⁹⁹⁶ Vanessa praised the PPMs. "The private midwives that I work with are really amazing women, they go off on these amazing journeys with women and they change lives".⁹⁹⁷ Even when midwives were isolated due to location, such as Mary Jane working in Broome in the North West of WA, they found support from other PPMs. Mary Jane said, "being able to do an apprenticeship with someone would have been fantastic and to have a mentor, because for me there was

⁹⁹³ Hickling, "In Depth Interview with Doctor."

⁹⁹⁴ Clifford, "In Depth Interview with Midwife."

⁹⁹⁵ Smith, "In Depth Interview with Midwife."

⁹⁹⁶ Newman, "In Depth Interview with Midwife."

⁹⁹⁷ Butera, "In Depth Interview with Midwife."

no one [in the NW] but I had my sister who was a midwife, so I used to ring her".⁹⁹⁸

However, Naomi reflected on how the system was not set up to support midwives in private practice:

we need to get some supported grad positions with the private midwives because at the moment the mentorship is altruistic by the midwives who take the time to support these midwives because we know that there is nothing else out there, so if we don't mentor and support them, then they're never going to get out there.⁹⁹⁹

Some women's lack of trust in the mainstream maternity system could make providing care in the community challenging for the PPMs without support, particularly if the woman required transfer or medical care. The doctors interviewed in this study talked about the need to keep supporting the PPMs and each other to be able to provide safe and ethical care.¹⁰⁰⁰ Obstetrician Liza described how she felt, by supporting the PPMs, she made the mainstream maternity system more accessible, thereby enabling safer care for women:

So, what I tried to do, was just to try to get to know the private midwives, to try and pull their patients into the system rather than push them out, by giving the midwives support. I got to support them, the midwives got the support, which they needed because a lot of the patients are really complex and emotionally complex and scarred and demanding. It's a very hard thing to look after a patient like that on your own anyway. And also engaging the patients and making the relationships better between the patients and the doctor helps support everyone. A lot of times the reason women choose to have a private midwife is because they don't trust the system and they don't trust the doctor.¹⁰⁰¹

Liza, now working as a private obstetrician, still supports the PPMs and their clients, and stated:

I still feel the same as I felt when I worked in the public system, obviously. I love to support them. I just think it's a win-win situation. The better I know the midwife, the better I can communicate, the better I can support the patient, the more they can reassure the patient that they can trust me, the more we can be safe with what the patient wants to do.¹⁰⁰²

⁹⁹⁸ McNamara, "In Depth Interview with Midwife."

⁹⁹⁹ Newman, "In Depth Interview with Midwife."

¹⁰⁰⁰ Trungeon, "In Depth Interview with Doctor"; Fowler, "In Depth Interview with Doctor."; Hickling, "In Depth Interview with Doctor."

¹⁰⁰¹ Fowler, "In Depth Interview with Doctor."

¹⁰⁰² Ibid.

The midwives interviewed in this study also felt working with supportive doctors and midwives made caring for women in the community much safer, physically and emotionally, for the women and the midwives. Naomi said, "working with supportive doctors just makes it so much smoother, you can call them and discuss the woman's situation without the bullying or the worry that they are going to report you if she chooses not to do what we advise".¹⁰⁰³

Finding supportive doctors has been challenging for the PPMs at times. Theresa described how in the 1980s, it was difficult for the doctors to support the women and midwives, but doctors still did:

Margaret was at Woodside and because she was a woman as well, then she got a really, really hard time from the rest of the doctors there. I know John who was an obstetrician, he got a really hard time at Woodside from the rest of the doctors for supporting homebirths and I'm sure Frank did as well, Frank's just much more laid back and wouldn't buy in to the fight, he'd just you know cruise, cruise around and whatever whereas you know I think Margaret had got a really, really hard time there and the same with Anne [not real name]. I think she got a hard time from the other doctors, so it wasn't easy for them supporting the women and us, but they did it.¹⁰⁰⁴

Loralee and Sam found supportive doctors in the South West of WA. Loralee described how doctors' support and trust enabled her to offer women the option of waterbirth in hospital:

I called him and just let him know what was happening and he said. 'Well if she's your client you just do what you need to do and just call me if there's a problem'. He's not really keen on water birth but I said to him. 'you know she's not totally committed to the idea of water birth but how do you feel', and he said, 'you know I don't like doing water births but I know that you do them all the time so if you want to do a water birth go ahead', and usually the GPs would come in for the birth, we would call them around the time of the birth and I said 'do you want to be called when she's fully dilated or when there's head on view', and he said 'oh no, just call me if there's a problem otherwise you don't need to'. That was actually really lovely, he was there if I needed him but absolutely didn't have to come in for anything and we were able to go home a few hours later.¹⁰⁰⁵

¹⁰⁰³ Newman, "In Depth Interview with Midwife."

¹⁰⁰⁴ Clifford, "In Depth Interview with Midwife." Obstetrician's names have been changed

¹⁰⁰⁵ Worrall, "In Depth Interview with Midwife."

Sam also talked about the support she received from the doctors in the South West:

I don't hesitate to just give the doctor a call or a text and just say 'I've seen so and so and I'm a little bit concerned about this or everything's going ok'. They trust that we're going to talk to them if we're worried about anything.¹⁰⁰⁶

Naomi said she never felt alone working as a PPM because of the support she received from the midwives she worked with, particularly when she first came to work as a private community midwifery, "If I hadn't met my mentor midwives I don't know where I would be".¹⁰⁰⁷ Naomi had previously worked as a midwife in a private hospital:

The biggest piece of advice that I would want to give to anybody who was going to go into private midwifery is to find your tribe, find people who have the same philosophy that will support you, because even though you're out in private practice, and you are working autonomously, you never work truly alone, you need those people to bounce off, you need people to reflect and debrief and support you. The good private midwives are confident in their decisions, they are confident in their practice and if they don't know, they ask, and they find out the information. They're not afraid to ask or get extra support. I found mentors who were happy to work with me and support me, while I worked out how it all worked and got my confidence, because I came from an obstetric model.¹⁰⁰⁸

In summary, the theme, 'Breaking through the fear: continuing to support women and each other', demonstrates that the PPMs interviewed in this study have always worked collaboratively. The PPMs remained passionate about supporting midwives and women, they were willing to provide help and advice to other midwives, especially as all the midwives interviewed had always received support themselves from other PPMs. PPMs formed collaborative groups, and with other health professional including doctors. However, this collaboration has generally been an informal arrangement and only with doctors who have the same woman-centred philosophy as the midwives. This concept will be discussed further in the next section under the first sub theme 'Collaboration'.

Collaboration

The midwives interviewed in this study recognised that, although they believed that most women were able to achieve a normal physiological birth with minimal intervention, there

¹⁰⁰⁶ Mansfield, "In Depth Interview with Midwife."

¹⁰⁰⁷ Newman, "In Depth Interview with Midwife."

¹⁰⁰⁸ Ibid.

were some situations where the woman would need to access medical care. As explored in Chapter Four, midwives throughout history have sought assistance if complications have arisen during birth.¹⁰⁰⁹ In the previous chapter, it was mentioned that PPMs had clinical privileges at Woodside Hospital in Fremantle in the late 1970s. Theresa explained how this began; she initially formed a collaborative relationship with Woodside hospital when a woman whom she was providing midwifery care to, asked her to support her to give birth in hospital:

she wanted to have her baby in Woodside, but she wanted continuity of midwifery care, she didn't want what happened last time which was just lots of midwives in and out and she felt very disempowered and she didn't want to have a homebirth...she wanted her baby in Woodside but she wanted her own midwife. So I had several meetings at the hospital with the matron and then there was a meeting with the midwives who were on duty, so I was introduced to the midwives as 'this is Theresa and she's a private midwife and she's actually going to come into our hospital and deliver a baby in here and when she comes in you've all got to smile at her and be nice to her, whether we feel like it or not and help her as much as she wants, and Theresa I expect you to do the same. You have to smile at them, be nice to them whether you want to be or not, you know we've got to work together'. And there was a bit of 'why does she want a midwife, like we're midwives, why does she want a private midwife. What's she doing that we're not doing'.

This option enabled Theresa to provide midwifery care within the midwifery model and woman-centred philosophy so that the woman continued to receive care from her chosen care provider. Theresa described this first birth at Woodside Hospital:

this woman had, oh just an amazing birth and she was on her hands and knees and they'd never seen that before and they were all talking about it, and from then on I had an arrangement at Woodside that I could take women in there who wanted to have babies in the hospital.¹⁰¹⁰

If Theresa had clients that may have potentially needed medical support during pregnancy or labour and birth, she felt confident offering them the option of a hospital birth with her providing clinical midwifery care at Woodside Hospital. Theresa felt having this option made women less likely to request homebirth with more complicated

¹⁰⁰⁹ Towler and Bramall, *Midwives in History and Society*.

¹⁰¹⁰ Clifford, "In Depth Interview with Midwife."

pregnancies, as they knew the midwife caring for them had the same philosophy and ideology as them and would be with them throughout the journey:

it was just me saying, no I'll do the twins in hospital. So all the twins, the breeches and the VBACs, again I never used to say to them well would you like to stay home, they never asked to stay home, it was just like 'you've had a previous Caesarean section, ok what I do with previous caesarean sections is I come to your house, we have a bit of labour at home, when you're ready we go in, we have a baby, whichever way we have a baby. If you have a vaginal birth that's great, if you have another Caesar [caesarean sections] I'll come into the theatre with you and you come home when you're ready'. So, breeches, twins, VBACs all happened in Woodside [hospital] with me as the lead midwife and one of their staff coming in and calling the doctor for the birth usually, but the doctors would just stand back and watch it happen.¹⁰¹¹

Following the success of Theresa's collaboration, Bronwyn, Enid, and Mary too formed collaborative arrangements with Woodside hospital and this enabled them to continue to support women during planned births in hospital and during transfers from planned home births. The support that the PPMs encountered from the hospital midwives and collaborating doctors made a big difference to the midwives and women as they felt confident that women and midwives would be treated with respect. Enid said, "we made friends with Woodside [hospital] so all the women had to go there no matter where they lived".¹⁰¹² Mary too described how she had positive experiences at Woodside hospital in Fremantle:

Woodside used to be very midwifery friendly and I helped a woman with a pair of twins there and two sets of twins there with the help of Ralph [Hickling, obstetrician] and his pediatrician who didn't interfere. They sat quietly outside and only came in when the babies were born...That was a lovely experience being able to take women to Woodside to birth or being able to stay with them and be their midwife in the proper sense if we needed to transfer them.¹⁰¹³

Mary attempted to have similar arrangements with the other hospitals in the Perth metropolitan area, but was only able to make a similar collaborative arrangement with the Family Birth Centre in Perth "The Family Birth Centre at King Edwards [hospital] was the

¹⁰¹¹ Clifford, "In Depth Interview with Midwife."

¹⁰¹² Facer, "In Depth Interview with Midwife."

¹⁰¹³ Murphy, "In Depth Interview with Midwife."

only hospital that allowed me access, with the exception of Woodside down at Fremantle. I took on the occasional woman who wanted to birth at the Birth Centre".¹⁰¹⁴

The midwives and doctors interviewed as part of this study all believed that respectful collaboration between midwives and doctors made birth much safer. Recognising that midwifery led continuity of carer was the most appropriate type of care for pregnant women, Ralph said:

I confess to being a poacher turned gamekeeper because I got a great deal of my money from conducting normal birth, it was just the accepted way. Birth as I said in all sorts of places is, pregnancy is, regarded as a disease and childbirth is a way of relieving the disease and it's therefore it's all a doctor's business. It's absolutely wrong ...because of this lack of understanding now and this closing the door and not wanting to know about homebirths or midwives.....I think it causes a delay and problems with collaboration because people are still going to do it [birth at home]whether you accept it or not.¹⁰¹⁵

Margaret provided collaboration and support for the PPMs at Woodside Hospital where she also provided maternity care for women.¹⁰¹⁶ She found that changes in the medical team had an impact on the support she received, both as a doctor providing care herself to women, and as a backup doctor for women receiving care from PPMs.¹⁰¹⁷ She also felt that working in a patriarchal institution was a contributing factor to the lack of support:

I admitted people under myself and, and when I first started working there, I had exceptional backup from [specialist obstetrician]. He was an old school obstetrician, his view was that he couldn't be bothered with all the normal stuff and he was very happy for the GP or PPMs to look after the normal obstetrics and he'd do the backup, which worked really well...he was good and very supportive really. What I found over the years, after he retired, I had a series of backup obstetricians who were not nearly as flexible or supportive about it. I found as time went on that the younger obstetricians started coming through and they were very anti-homebirth, not very nice to the patients, treated me like a first year resident. Just treated me as though I knew nothing, and I had several runs ins with them which is really why I got out....

¹⁰¹⁴ Murphy, "In Depth Interview with Midwife."

¹⁰¹⁵ Hickling, "In Depth Interview with Doctor."

¹⁰¹⁶ Trungeon, "In Depth Interview with Doctor."

¹⁰¹⁷ Ibid.

because I was involved in homebirth and alternative birthing, and of course because I was a woman in a patriarchal institution.¹⁰¹⁸

Collaboration in maternity care can only work if all parties are willing to work together. Unfortunately, as explored in the previous chapters, differences in ideology, hierarchy of the professions and power imbalances can all contribute to difficult situations and negative experiences. Jane who practiced as a PPM from 1995-2008 reiterated that supportive collaborative care was not universal stating “there was only a handful of doctors that supported us anyway and a handful of obstetricians that would back up homebirth”.¹⁰¹⁹ Margaret remembered how the midwives started to receive less support and collaborative relationships deteriorated following the changes at Woodside Hospital in the late 1990s, “I think because midwives had got an experience of ringing up doctors and being abused over the phone and they’d rather not have that happen and I can understand that”.¹⁰²⁰ Denise attempted to collaborate with a hospital in the Perth metropolitan area in the early 2000s. The woman’s GP was supportive of the woman’s plan to birth at home, but once Denise attempted to book the woman into the hospital for back-up, she received a negative response:

I’d talked to the woman’s GP and he was fine about her having a homebirth and I said I will book her into the hospital for back up. I got the woman to go to the clinic at the hospital. And then apparently this set off a lot of trouble with the obstetricians saying that if I came in with her in labour they would ‘ship her off to King Edwards [hospital] because no way was she allowed to come here’. And I remember having this conversation with Mary [Mary Murphy PPM] who said ‘they can’t do that she’s got the right to birth to any public hospital she chooses’. Luckily, she didn’t need to go in, she birthed her baby beautifully.¹⁰²¹

Naomi believed that developing relationships led to better care: “One of the keys to being a private midwife is being able to walk between the systems and have rapport with everybody, the better rapport you get with people providing the next level of care the better the outcomes”.¹⁰²² Obstetrician Liza described how she attempted to develop relationships with the PPMs when she arrived in Australia in 2010, but felt the midwives were wary of her efforts to collaborate in the beginning:

¹⁰¹⁸ Trungeon, "In Depth Interview with Doctor."

¹⁰¹⁹ Smith, "In Depth Interview with Midwife."

¹⁰²⁰ Trungeon, "In Depth Interview with Doctor."

¹⁰²¹ Hynd, "In Depth Interview with Midwife."

¹⁰²² Newman, "In Depth Interview with Midwife."

I got to know the midwives over time and it took quite a while to build up a relationship because I think they were so used to being judged and criticised and getting really bad attitude when they actually do come into hospital that it took a while for them to trust me. But once that happened it was really good.¹⁰²³

Theresa spoke about how she never had an issue working collaboratively with doctors with whom she had developed a relationship:

There was that trust, there was certainly trust. I mean they thought you were doing something different and once you could actually say to them, 'look I don't have to agree with what this woman's doing to support her in her choice. You know it's not an unsafe choice, I wouldn't do it, it wouldn't be my choice but it's her choice and I'll support her in her choice'. And I guess when you're upfront like that and you're just telling them who you are and what you're doing and you're not asking them. I've never, never ever felt like I worked for a doctor I've always worked with them. It's always been absolutely a two way street.¹⁰²⁴

Recently introduced legislation has somewhat unsuccessfully attempted to formalise collaboration between the medical institutions and PPMs. In 2009, in an attempt to "improve access and choice for Australian women enabling them to access Government-subsidised services and medicines through the Medicare Benefits Scheme (MBS) and Pharmaceutical Benefits Scheme (PBS)",¹⁰²⁵ the Senate referred the Health Legislation Amendment (Midwives and Nurse Practitioners) Bill 2009 and two related Bills to the Community Affairs Legislation committee for inquiry and report. The Senate asked the committee to consider:

- whether the consequences of the Government's amendments for professional regulation of midwifery will give doctors medical veto over midwives' ability to renew their licence to practise;
- whether the Government's amendments' influence on the health care market will be anti-competitive;
- whether the Government's amendments will create difficulties in delivering intended access and choice for Australian women;

¹⁰²³ Fowler, "In Depth Interview with Doctor."

¹⁰²⁴ Clifford, "In Depth Interview with Midwife."

¹⁰²⁵ *Health Legislation Amendment (Midwives and Nurse Practitioner) Bill 2009 and Two Related Bills*. 2010. Parliament of Australia.

- why the Government's amendments require 'collaborative arrangements' that do not specifically include maternity service providers including hospitals;
- whether the Government's amendments will have a negative impact on safety and continuity of care for Australian mothers; and
- any other related matter.¹⁰²⁶

The inquiry received 933 submissions related to the Bills and amendments, 430 comment letters and 900 form letters from midwifery, medical and consumer organisations and individuals.¹⁰²⁷ One of the concerns highlighted in these submissions was the legislation's position on collaboration between midwives and doctors. The proposed legislation would specify that eligible midwives were to have official collaborative arrangements with medical practitioners to enable them to access MBS and PBS. In the submissions received it was argued that the requirement for midwives to have collaborative arrangements with medical practitioners to access the MBS and PBS would mean that medical practitioners would ultimately control women's access to Medicare funded midwifery care.¹⁰²⁸ Collaborative arrangements could also mean that a medical practitioner could have veto over the ability of a midwife to practice.¹⁰²⁹ Midwives argued that they were happy to collaborate and work in a collaborative practice but that the amendments would restrict their practice and create power imbalances. They argued for "collaborative practice not collaborative arrangements".¹⁰³⁰ They argued the amendment was "one professional body being given authority to limit the ability of another profession to practise is totally unprecedented and unacceptable, particularly so in this case when there is no guarantee that the generic professional given dominance has relevant knowledge or skill to do so".¹⁰³¹ The committee concluded that:

effective collaborative arrangements amongst health professionals ensures the delivery of safe and high quality care. Collaborative arrangements are at the heart of the midwives and

¹⁰²⁶ *Health Legislation Amendment (Midwives and Nurse Practitioner) Bill 2009 and Two Related Bills.*

¹⁰²⁷ Ibid.33.

¹⁰²⁸ Ibid.

¹⁰²⁹ Ibid.

¹⁰³⁰ Ibid.

¹⁰³¹ Ibid.

nurse practitioner reforms introduced by the government and thus the government supports the principles of collaborative arrangements in legislation.¹⁰³²

Following the committee's approval, the two Bills were passed and in April 2010 legislation was added to the *National Health Act 1953* and the *Health Insurance Act 1973* which enabled "authorised" midwives to access the MBS and the PBS.¹⁰³³ The authorised midwife must be "eligible". To be eligible the midwife must fulfil criteria laid out by the Nursing and Midwifery Board of Australia demonstrating:

- current unrestricted registration
- the equivalent of three years fulltime post initial registration experience as a midwife
- Evidence of current competence to provide pregnancy, labour, birth and postnatal care, through professional practice review
- an approved qualification to prescribe scheduled medicines required for practice across the continuum, of midwifery care in accordance with relevant State and Territory legislation.¹⁰³⁴

The National Health (Collaborative arrangements for midwives) Determination 2010 stated that the authorised midwife must have collaborative arrangements in place.¹⁰³⁵ The legislation defined collaborative arrangements as:

- (a) an arrangement under which the midwife:
 - (i) is employed or engaged by one or more obstetric specified medical practitioners, or by an entity that employs or engages one or more obstetric specified medical practitioners; or

¹⁰³² *Health Legislation Amendment (Midwives and Nurse Practitioner) Bill 2009 and Two Related Bills.*

¹⁰³³ *Health Legislation Amendment (Midwives and Nurse Practitioners) Act 2010* No. 29 (WA).

¹⁰³⁴ Nursing and Midwifery Board of Australia. 2010. "Eligible Midwife Registration Standard."

¹⁰³⁵ National Health (Collaborative Arrangements for Midwives) Determination 2010. Amendment made under Subsection 84(1) of the National Health Act 1953.

- (ii) has an agreement, in writing, with an entity, other than a hospital, that employs or engages one or more obstetric specified medical practitioners;
- (b) a patient is referred, in writing, to the midwife for midwifery treatment by a specified medical practitioner.¹⁰³⁶

The requirement for collaborative arrangements caused difficulties for the midwives. Many midwives found it hard to get written collaborative arrangements in place. The midwives who were practising at this time reported sending many emails and posting written requests to individual medical practitioners and hospitals with no responses. Women also reported GPs refusing to write them referrals to the midwives, in fact the only doctor in the Perth metropolitan area who was willing to collaborate was Dr Liza Fowler.¹⁰³⁷ Naomi said "Women are trying to get referrals to the private midwives and been told that they can't refer them because they don't believe in homebirths. It's actually none of their business where they have their baby".¹⁰³⁸ In 2013, another amendment was added to the National Health Act 1953; National Health (Collaborative arrangements for midwives) Amendment Determination 2013.¹⁰³⁹ The explanatory report that accompanied the legislation states:

since the measure was introduced on 1 November 2010, midwives have reported ongoing difficulties in establishing collaborative arrangements. This has hindered their ability to participate in the Medicare and PBS arrangement which is lower than the expected uptake of the measure.¹⁰⁴⁰

The 2013 amendment added a new type of collaborative arrangement for an eligible midwife who had been credentialled to a hospital.¹⁰⁴¹ The explanatory statement explains that to be credentialled the midwife had to undergo:

¹⁰³⁶ National Health (Collaborative Arrangements for Midwives) Determination 2010. Amendment made under Subsection 84(1) of the National Health Act 1953.

¹⁰³⁷ Fowler, "In Depth Interview with Doctor."

¹⁰³⁸ Newman, "In Depth Interview with Midwife."

¹⁰³⁹ Plibersek, Tanya. 2013. "National Health (Collaborative Arrangements for Midwives) Amendment Determination 2013, under Subsection 84 (1) of the National Health Act 1953."

¹⁰⁴⁰ National Health (Collaborative Arrangements for Midwives) Determination 2013. Amendment made under Subsection 84(1) of the National Health Act 1953. "Explanatory Statement".

¹⁰⁴¹ "National Health (Collaborative Arrangements for Midwives) Amendment Determination 2013, under Subsection 84 (1) of the National Health Act 1953."

a formal assessment of his or her qualifications, skills, experiences and professional standing. It is expected that appropriately qualified medical practitioners would be involved in the assessment. The midwife is also required to have a defined scope of clinical practice at the hospital and be eligible to treat his or her own patients at the hospital.¹⁰⁴²

In Western Australia at the time of this study no PPM had been credentialled at any hospital, however, a process for credentialling had been established by the state government. PPMs had attempted to become credentialled, completing the lengthy process and providing evidence to support their skills and experiences but the hospitals had to invite the midwives to participate. In 2018 a letter was received by the PPMs who were still practising in the Perth Metropolitan area. The letter dated 17th July stated that:

- King Edward Memorial Hospital has recently endorsed the new policy for endorsed Privately Practicing Midwives.
- Under this policy, you are now able to bring your women into KEMH for care and birth under your own admitting rights.
- To complete the process, you will need to register with CredWA [government credentialing database] and you will receive confirmation of this process being complete and acceptance of your application in due course.¹⁰⁴³

Although the midwives registered with CredWA as advised, at the time of writing (April 2019) there is still no process for the PPMs to be credentialled at King Edward Memorial Hospital (KEMH). Apart from meeting the requirement to have collaborative arrangements, PPMs wished to be credentialled so that women choosing to birth in hospital could access Medicare rebates. Following the changes in the legislation women accessing care from PPMs were able to access Medicare rebates for antenatal and postnatal care and birth, but only if the birth took place in hospital. Therefore, the women and midwives in WA were not able to access Medicare rebates for any care relating to labour and birth. Naomi felt that this was unfair and again demonstrated the lack of support for women's choice relating to place of birth:

¹⁰⁴² National Health (Collaborative Arrangements for Midwives) Determination 2013. Amendment made under Subsection 84(1) of the National Health Act 1953. "Explanatory Statement."

¹⁰⁴³ King Edward Memorial Hospital. 2018. July 17, 2018.

The whole system's fucked, even the Medicare system is pushing people into the system, if you got a private midwife that has got admitting rights to a hospital then you get \$600 back from Medicare for your birth but if you have your baby at home with the same midwife you get nothing. How does that actually work? How is that equitable and fair?¹⁰⁴⁴

Collaboration was less challenging in the South West of WA. Sam and Lorelee both felt supported and had developed collaborative arrangements with GPs and Obstetricians.¹⁰⁴⁵ Lorelee stated "The doctors don't always agree with what I'm doing but they're respectful". Sam and Lorelee also felt that being endorsed helped these relationships. Sam said:

the barriers have improved, since we became endorsed and eligible just from a logistics point of view being able to order our own blood tests and ultrasound some things and getting the results sent straight to us saved us so much time because they don't have to chase doctors up for results and things.¹⁰⁴⁶

Collaboration is an essential part of safe care for women and babies, but for effective collaboration, equality, respect and support to all parties must be maintained. Acceptance of diversity in opinions, beliefs, values and philosophies must be a core feature. However, as demonstrated in this study, differences in ideology, hierarchy of the professions and the related power balances can contribute to less than optimal situations for women, midwives and doctors.

Getting Educated and Gaining Power

This final sub theme 'getting educated and gaining power' completes the qualitative findings of this study of PPMS in WA. The interviewed participants had always been involved in education, both officially and unofficially. They felt that it was an essential part of their roles as health professionals. The midwives and doctors felt that it was important that they educate the community and other health professionals to the impact of the medicalisation of birth on women. They also wanted to influence the next generation of health professionals in an attempt to change practice and promote woman-centred care and the midwifery model of philosophy.

¹⁰⁴⁴ Newman, "In Depth Interview with Midwife."

¹⁰⁴⁵ Worrall, "In Depth Interview with Midwife"; Mansfield, "In Depth Interview with Midwife."

¹⁰⁴⁶ "In Depth Interview with Midwife."

As mentioned earlier in this chapter, the Resource Centre in East Fremantle was a hub for supporting the women and midwives and facilitating homebirth. The centre was also a place where knowledge and education were shared. The centre's founder, Henny Ligtermoet, gave many education sessions to women and their families, including health professionals. Education also enabled Henny to gain support from doctors such as Margaret and Ralph interviewed in this study. As discussed previously, Henny spent her life fighting for homebirth, midwifery led care and the promotion of physiological birth. In the 1950s Henny started her campaign to educate and develop support for midwives and homebirth; she wrote letters to all the doctors in Perth asking them if they supported homebirth and physiological birth. Henny wrote over eighty letters and only received three replies. Following this poor response Henny visited doctors in the metropolitan area, providing information and education in relation to the role of the midwife and homebirth.¹⁰⁴⁷ Henny's antenatal classes continued for over 30 years and were based on the natural childbirth teachings of Grantly Dick-Read.¹⁰⁴⁸

In 1977, Henny became a founding member of Homebirth Australia (HBA). Homebirth Australia's aim was to provide an alliance of national groups that supported homebirth and to lobby the government for support and funding for midwives and homebirth. Another important aim of HBA was to increase public awareness of the role of the midwife and homebirth, to gather national statistics to substantiate the claim that homebirth was safe, and to refute the argument that Australian women did not want to give birth at home with a midwife. Throughout her life Henny attempted to provide education to the WA community, her radio shows interviewed women and midwives and she shared evidence and research to promote physiological birth at home with a midwife.¹⁰⁴⁹ In 1978 Henny co-wrote a book with Margaret Ireland, a PPM from Sydney, Australia. The book *Responsible Homebirth* provided a two-sided view of homebirth from both the woman's and the midwife's views. Her incentive to write the book was "to work

¹⁰⁴⁷ Ligtermoet, "Correspondence, Documents and Submissions by Henny Ligtermoet"; Ligtermoet, "My Thoughts in the Mid 1950s."

¹⁰⁴⁸ Read, Grantly Dick. 1933 *Natural Childbirth*, London: Heinemann; Read, Grantly Dick. 1943. *Revelation of Childbirth*, London: Heinemann; Read, Grantly Dick. 1944. *Childbirth without Fear*, New York: Harper.

¹⁰⁴⁹ Ligtermoet, "Radio 101 FM Transcribes."

toward preventing unnecessary medical interference in the birth process after seeing the effect it was having on mother and child".¹⁰⁵⁰

Obstetrician Ralph was also compelled to try and educate and increase support of physiological birth, midwifery care and homebirth:

I was always ready to provide education, to promote midwifery care and homebirth, to provide the evidence and back it up with research. In 1985, I was invited to give a talk. In those days at King Edward [hospital] every Friday at lunch time they had a teaching hour and I was invited to give my talk then about homebirth and that was a very interesting experience and I shared these things and it was given a reasonable reception.

Ralph published many articles over the years. In 1999 he wrote an article for the journal of the Royal Australian and New Zealand College of Obstetricians and Gynaecologists discussing and promoting "Alternatives in Maternity Care".¹⁰⁵¹ In 2004 he wrote another article for the journal in support of midwifery care and homebirth. At this time RANZCOG's position statement declared it did not support homebirth, but in the article Ralph declared his support for homebirth and stated, "medical funding systems should recognise homebirth under the care of a suitably qualified midwife as a genuine alternative to hospital care".¹⁰⁵² In 2011 Ralph attended the Regional Scientific meeting of the West Australian Branch of RANZCOG. He presented a counter cultural speech, "Proposing the motion that homebirth be accepted by RANZCOG as a Model of Maternity Care".¹⁰⁵³ In this speech Ralph presented evidence and research in support of maternity care provided by midwives and homebirth. This controversial and political speech stated:

We have to accept that this is all about control. We want to maintain control of childbirth, and if it is normal and might be thought to be outside our remit, we contrive to make the normal abnormal so that it is...it is the fault of the entire culture, which treats pregnancy as a disease and puts it into the hands of doctors who do their job as doctors and treat it as a disease that already has a cure in the form of an operation.¹⁰⁵⁴

¹⁰⁵⁰ Ligtermoet, Henny and Margaret Ireland. 1978. *Responsible Childbirth* (Victoria Park, Western Australia: Midwifery Contact Centre.

¹⁰⁵¹ Hickling, Ralph. 1999. "Alternatives in Maternity Care," *O&G Magazine*, 1 (2).

¹⁰⁵² Hickling, Ralph. 2004. "Childbirth in Our Time: An Obstetrician's Perspective on Home Births." *O&G Magazine*. 6 (3): 206-207.

¹⁰⁵³ Hickling, Ralph. 2011. "Speech Proposing the Motion That Homebirth Be Accepted by RANZCOG as a Model of Maternity Care." June 7, 2011.

¹⁰⁵⁴ Ibid.

Ralph lobbied for support from RANZCOG. "But", he argued, "RANZCOG has dialogue with the politicians who control the legislative authorities and judiciary through the Attorney General. Our protests against this situation should be loud and robust".¹⁰⁵⁵

Midwife Carol, who practised as a PPM from 1978 to 2012, also felt that the only way to influence practise was to change the education of midwives. Carol became a midwifery lecturer in 2007:

I went into ECU [Edith Cowan University] and I thought there's got to be some way we can change the system. We've got to be able to educate midwives differently here if we want to change, actually make a change in our system because even though they're doing case load midwifery and have midwives in the birth centre they've put so many rules around it that midwives can't practice autonomously. They still have to do all these crazy rules.¹⁰⁵⁶

When Carol started working as a lecturer, she was challenged by the education that midwifery students were receiving:

that drove me a bit nuts because they were actually teaching what the hospitals were already doing and I thought this can't be right. Surely, we have to do it some other way, we should be starting from the premise that everything's normal before we actually start teaching them the abnormal and make it that a percentage, that 20% of it's going to be abnormal and the rest's going to be normal.¹⁰⁵⁷

Carol believed that the midwives of the future needed to be taught the right philosophy and

it's actually the philosophy that makes the students realise what you're trying to teach them, trying to get that midwifery philosophy was probably a hard ask in the first few years but we managed and got there. So we had this group of students that we could actually mould into what I thought was normal midwifery and people that were going to actually keep that philosophy through their career.¹⁰⁵⁸

Educating the next generation of midwives with the right philosophy was seen as a way to influence and evoke change in clinical practice through questioning and consumer advocacy. The PPMS believed that if it was achieved, there might be a chance of changing

¹⁰⁵⁵ Hickling, "Speech Proposing the Motion That Homebirth Be Accepted by RANZCOG as a Model of Maternity Care."

¹⁰⁵⁶ Pinch, "In Depth Interview with Midwife."

¹⁰⁵⁷ Ibid.

¹⁰⁵⁸ Ibid.

the institutions, challenging the dominance of the interventionist medical model and redressing the power imbalances. Carol said “we’re not teaching them to fit into this system, we want them to actually go out and change the system you know. There’s no point in being educated if you can’t actually make a difference”.¹⁰⁵⁹ Naomi too got involved in teaching the next generation of midwives:

I had to get out and change it, get educated be involved in the education of new midwives. I couldn’t be complicit, I couldn’t work in the system that lies to women and disrespects women. And as a midwife in that particular system I was powerless, I had no voice, even when you try to use your voice for the women it didn’t work. You got in trouble with the nurse manager because you’d argued with the obstetrician or you hadn’t followed his orders.¹⁰⁶⁰

The PPMs interviewed in this study talked not only about sharing knowledge with others, but also about furthering their own education. They discussed how they felt that having more research and evidence related to midwifery and not obstetrics, helped to strengthen their power and credibility. Carol stated, “you’ve got to have the credibility, people have got to respect you and know you’re not going to actually be a bullshitter, you actually mean what you say, and you’ve got to just keep going”. The midwives spoke about how this would help them to ‘fight back’ as without it they felt that they would not be taken seriously. Emma said:

We felt like we had no credibility so now we have to get all the letters next to our name to even enter into a conversation about birth and power and women now because all of a sudden midwives’ experiences counted for nothing and that all the policy makers were politicians, obstetricians, masters students, PhD students, all these people who have got a lot of qualifications and are incredibly left brain smart, they had all the power now and all the sisterhood, the women, the midwives and right brain, it was completely now secondary.¹⁰⁶¹

As discussed in the previous chapter, the accepted authoritative knowledge in maternity care is the knowledge provided by science and technology. Midwifery research focusing on qualitative research enables midwifery to build evidence to support their philosophy and supports other ways of knowing. Qualitative approaches by their nature prioritise the personal experience of individuals and this is particularly important for an

¹⁰⁵⁹ Pinch, "In Depth Interview with Midwife."

¹⁰⁶⁰ Newman, "In Depth Interview with Midwife."

¹⁰⁶¹ Ritchie, "In Depth Interview with Midwife."

industry that deals with women – thus qualitative approaches are often feminist and support alternative approaches to research. Susanjane said, “I did my masters because I was interested in qualitative research, because I’m not a numbers person I think people are rich in their information, that was my way of learning always listening to people”.¹⁰⁶² Embracing and celebrating different ways of gaining knowledge, particularly from narrative, strengthens the knowledge base of midwifery. Challenging the knowledge system of pure scientific knowledge by using evidence gained from women and midwives’ experiences also supports other ways of knowing as described in the previous chapters. MaryJane stated her reason for participating in this research, “I hope I can contribute to the future knowledge”.¹⁰⁶³

The participants of this study suggested that birth was much more than a healthy mother and baby, they believed that the experience of pregnancy and birth had long reaching consequences. Therefore, by building their own knowledge, sharing experiences and conducting qualitative research they could support this growing evidence base. Susanjane described her research:

I did my research looking at couples’ experience of homebirth using phenomenology, because I was reading lots of stats, I thought there’s something missing, there’s a gap of information and I was more interested in what people were feeling and thinking and experiencing.¹⁰⁶⁴

The midwives felt that by conducting research themselves they could make a difference by gaining more power to influence change at a higher level. Emma stated:

I feel like I’ll come back a much wiser midwife into community midwifery and yes with a few titles beside my name now because I think that’s important to do if you can, to do a bit of study because if you don’t have credentials in the medical model, you’re nothing. And not that we want to be a medical model but they’re our biggest enemies and to be allies or at least partners we need to be on the same page, talking the same lingo and we need to be on the panels and with the policy makers and the decision makers.¹⁰⁶⁵

This history and discussion of PPMs in WA demonstrates the resilience and passion of these women and men who continued to work hard to support and care for women and

¹⁰⁶² Morison, "In Depth Interview with Midwife."

¹⁰⁶³ McNamara, "In Depth Interview with Midwife."

¹⁰⁶⁴ Morison, "In Depth Interview with Midwife."

¹⁰⁶⁵ Ritchie, "In Depth Interview with Midwife."

each other regardless of the obstacles. This final quote from Carol is an excellent illustration of this commitment:

I guess the thing that I've learnt from my career is never give up. You know there's more ways to skin a cat, so you know if I have changed my career and done it differently it's because that door's been too hard, you know you're fighting the battle and it's just not going to win that way. So, change tact and do it some way. So, for midwives of the future don't accept people bullying you, don't accept that that's normal, it's not normal. You know we're colleagues and we're women and we should actually be supporting each other and caring for each other. Just don't give up, get educated, just keep putting one foot forward. And we're a good example of that, anyway, if you get your head beaten this way, you move it around. Just keep pushing boundaries for the greater good of midwifery.¹⁰⁶⁶

This chapter concludes the findings of this thesis. Chapter Five presented the historical context for this study and Chapters Six to Nine have presented the themes and sub themes documenting and discussing this study of the history of PPMs in WA. The qualitative data presented in these findings chapters was taken from the in-depth interviews with fifteen midwives and three doctors and supplemented with historical, archival and contemporary documents providing new knowledge that is relevant and useful to midwifery today and adds to the growing number of post-revisionist accounts of women's history. The following chapter will discuss the findings of the study in relation to the relevant literature.

¹⁰⁶⁶ Pinch, "In Depth Interview with Midwife."

Chapter Ten – Discussion Chapter

Chapter Overview

In the previous five chapters, the findings related to the study of Privately Practising Midwives (PPMs) in Western Australia (WA) were presented. The purpose of this discussion chapter is to provide a brief overview of the study's findings, situate the findings within the existing literature and to highlight the unique contribution of this study.

Study Aim and Objectives

This study adopted a post revisionist, feminist and interdisciplinary approach to researching midwifery history in Western Australia and aimed to fill one of the gaps that exists within the history of women and midwifery in WA. This research follows on from McKenzie's historical analysis of WA's maternity services from 1829-1950, which gave an initial voice to women, "both midwives as service providers and mothers as recipients of that service".¹⁰⁶⁷ Current findings from this study support McKenzie's assertion that in studying the previously untold history of women and midwives "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".¹⁰⁶⁸

The overall aim of this interdisciplinary feminist research was to contribute to midwifery knowledge by documenting and discussing the history of WA midwives in private practice. The qualitative analysis drew upon data predominantly from in-depth interviews with living PPMs who practiced in WA between 1978 and 2018. This data was also supplemented by interviews with medical practitioners, and where relevant, media reports, archival documents, and National and State maternity health policies and guidelines.

Following extensive analysis of the historical and contemporary data, themes were discovered throughout the history of PPMs in WA providing rich descriptions of the experiences of these midwives. Four main interrelated themes and subthemes emerged from the interviews and archival data which described the history and experiences of PPMs in WA. The first major theme 'Midwives in the community: the journey of the Privately

¹⁰⁶⁷ McKenzie, "Place and Power: A History of Maternity Service Provision in Western Australia, 1829-1950".190.

¹⁰⁶⁸ Ibid.190.

Practising Midwife (PPM)' and its sub themes 'Birth within the home' and 'Building a relationship and providing continuity of carer' described how the journey of the PPM resulted in her working within the community, supporting women to birth at home and the value placed on building a relationship based on mutual respect. The second major theme that emerged from the qualitative analysis was 'Trusting women and birth is central to midwifery philosophy' and its subthemes 'Medicalisation of birth' and 'Midwives' use of intuition and the concept of authoritative knowledge'. A component of the midwifery philosophy shared by midwives and doctors in this study, was the belief that birth was a normal physiological process. This theme also described how the PPMs rejection of the technocratic medical model of birth resulted in their decision to work in the community. PPMs also described their belief in other forms of knowledge such as intuition and the woman's innate knowledge of her body. The third major theme 'Power and control of the institutions' and its subthemes 'Persecution and reporting of midwives' and 'Legislation, red tape and jumping through the hoops' described how the medicalisation of birth, within the medical model, enabled the institutions to gain 'power and control' over the midwives and the women who did not subscribe to the medical ideology. The midwives described being persecuted and reported to their governing bodies as they did not 'fit' into this system. This theme also described how the midwives felt new legislation led to increasing restrictions on their scope of practice. The final theme 'Moving forward: continuing to support women and each other' and its sub themes, 'Feel the fear but do it anyway', and 'Collaboration' illustrated how throughout this 40-year period midwives had supported each other and women, and would continue to do so regardless of their fear of persecution and other forms of intimidation and legislative requirements.

The findings of this study will be explored within the context of the current and relevant literature and will be provided in three sections, with notable relevance to the study findings. As discussed in Chapter Four and Five, historically, the medical profession's demarcation strategies in relation to midwives describes their interventions in the affairs of midwives and the desire to define and control the inter-occupational boundaries between medical men and midwifery practice¹⁰⁶⁹. By the mid nineteenth century the occupational boundaries between midwifery and medical practice had been constructed. These boundaries created the division between the process of 'normal' labour, defined as a natural process and therefore within the sphere of the midwife, and intervention in the

¹⁰⁶⁹ Willis, *Medical Dominance*; Witz A. 1990. "Patriarchy and Professions: The Gendered Politics of Occupational Closure". *Sociology*. 24 (4): 675–690.

process of 'abnormal labour' (as defined by the medical profession) which was the exclusive prerogative of medicine¹⁰⁷⁰. However, this remained problematic for the medical profession, as the midwife was the one to make the decision of what determined an 'abnormal' labour and decide when to call for the assistance of the doctor. One solution advocated by the medical profession was to abolish the independent midwife and to establish an exclusive medical prerogative over the provision of all midwifery services¹⁰⁷¹. Rather than abolish the independent midwife, a deskilling strategy of demarcation preserved the independent midwifery practitioner, however, limited the midwife to a narrowly and rigidly prescribed sphere of competence determined by the medical profession of what constitutes normal and abnormal¹⁰⁷². The findings of this current study demonstrate the demarcation strategies described above. The first two discussion points will be discussed under the following headings that reflect their key message: The suppression of autonomous midwifery and the reduction of women's autonomy in childbirth. The final discussion point 'other ways of knowing, trust and relationship-based care' brings discussion to the type of care the midwives within this study described and the challenges they faced in using other forms of knowledge.

The Suppression of Autonomous Midwifery

From the early 20th century, when birth moved into the hospital, midwives in WA have been incorporated into the hierarchy of the professions with obstetrics as the lead profession and midwifery considered a speciality of nursing.¹⁰⁷³ This study has highlighted how the role of the midwife has been subordinated, initially controlled by medicine and then incorporated into the institutions and nursing. The midwives and doctors in this study believed that although nursing and midwifery could complement each other, they were separate professions. The PPMs also believed that they were autonomous practitioners, who, despite their willingness to collaborate as appropriate with other health professionals, did not feel that it was necessary to have formal requirements and legislation to collaborate.

The experiences of midwives identified by post-revisionist histories are similar to the experiences of the PPMs identified in this current study. As previously discussed in Chapter

¹⁰⁷⁰ Witz, "Patriarchy and Professions: The Gendered Politics of Occupational Closure".

¹⁰⁷¹ Ibid.

¹⁰⁷² Ibid.

¹⁰⁷³ Fahy, "An Australian History of the Subordination of Midwifery,"; McKenzie, "Place and Power: A History of Maternity Service Provision in Western Australia, 1829-1950."

Five, historically in Australia, the introduction of midwifery registration and training provided for the standardisation of midwifery services and education to some midwives who were eligible and able to access it.¹⁰⁷⁴ However, it also had the impact of dividing midwifery instead of improving the status of all midwives.¹⁰⁷⁵ McKenzie states that the introduction of the Health Act of 1911 in WA:

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.¹⁰⁷⁶

The increase in legislative and training requirements for midwives throughout Australia and the move from home to the hospital, gradually led to the decrease in midwives working within the community, impacting women's choice of birth attendant and place of birth.¹⁰⁷⁷ Davies explored the factors that underpinned the regulation of midwifery practice in Queensland in the early 20th century and found that the power of the 'institutions', in this case the medical profession and the state, were the main influences on the regulation of midwives. Historically, midwives were not formally trained, but empirically trained (trained through experience). These midwives were able to be controlled due to their class and gender, as they were usually poor, older and working-class women.¹⁰⁷⁸ The historical suppression of midwifery in Australia has impacted the understanding of the role of the midwife in the contemporary setting.

In the modern context, one of the issues identified in this current study, was the lack of understanding of the scope of the midwife by the public and other health professionals and barriers created by the dominance of the medical model. These findings are supported by Australian research. In 2009, Homer and associates explored the role of the midwife in Australia.¹⁰⁷⁹ The authors concluded that there was some confusion from the public as to

¹⁰⁷⁴ McKenzie, "Place and Power: A History of Maternity Service Provision in Western Australia, 1829-1950."

¹⁰⁷⁵ Ibid.198.

¹⁰⁷⁶ Ibid.130.

¹⁰⁷⁷ Summers, ""For I Have Ever So Much More Faith in Her Ability as a Nurse": The Eclipse of The. Community Midwife in South Australia 1836-1942""; Selby, "Motherhood in Labour's Queensland 1915-1957"; Davies, "She Did What She Could: A History of the Regulation of Midwifery Practice in Queensland 1859-1912."

¹⁰⁷⁸ Davies, "She Did What She Could: A History of the Regulation of Midwifery Practice in Queensland 1859-1912."

¹⁰⁷⁹ Homer et al., 2009. "The Role of the Midwife in Australia: Views of Women and Midwives." *Midwifery*, 25 (6): 673-681.

what the midwife actually did. The study identified two main categories related to the role of a midwife: professional capacities and professional qualities. The professional capacities included being a skilled and expert practitioner, who provided safe, competent and up to date care, and was able to facilitate a normal physiological birth. As highlighted in this current study of PPMs, Homer et al's 2009 study also identified barriers to midwives practising to the full role of the midwife; these barriers included, the dominance of the risk adverse medical model in maternity care and the institutional system of maternity care.¹⁰⁸⁰

A particular issue raised by the study findings has been how the concept of risk has come to dominate all aspects of maternity care, with women assessed and categorised according to their perceived risk level during their first contact with the maternity care providers. This risk label attributed to a woman then defines the level and type of care she should, in the broader maternity care system's view, receive. Risk can also be used to dictate what is the 'acceptable' place of birth.¹⁰⁸¹ Risk is an ambiguous term that is defined in accordance with multiple factors, including past experiences, knowledge and individual attitudes.¹⁰⁸²

The PPMs in this study talked about the differences in how health professionals and women perceive risk, and the findings demonstrated in this thesis demonstrate how the perception of what is considered 'normal' in obstetric terms has changed over time, with an ever-shrinking definition of 'normal'. Risk means different things to different people and is defined in different ways depending on the ideological underpinning of health professionals and childbearing women and is affected by an individual's own personal experiences. When women are classified according to risk status, they are always seen as sick patients, and while women who are defined as high risk are unlikely to decrease their risk status, women who are defined as low risk can always increase their risk status.¹⁰⁸³

¹⁰⁸⁰ Ibid.

¹⁰⁸¹ Smith, Valerie, Declan Devane, and Jo Murphy-Lawless. 2012. "Risk in Maternity Care: A Concept Analysis." *International Journal of Childbirth*, 2 (2): 126-35; Government of Western Australia, "Community Midwifery Program Application Form"; Dahlen et al., "Planned Home and Hospital Births in South Australia, 1991–2006: Differences in Outcomes."

¹⁰⁸² Smith, Devane, and Murphy-Lawless, "Risk in Maternity Care: A Concept Analysis"; Plested, Mariamni, and Mavis Kirkham. 2016. "Risk and Fear in the Lived Experience of Birth without a Midwife." *Midwifery* 38 (July): 29-34.

¹⁰⁸³ Hausman, Bernice. 2005. "Risky Business: Framing Childbirth in Hospital Settings," *Journal of Medical Humanities*, 26 (1): 23-38; Smith, Devane, and Murphy-Lawless, "Risk in Maternity Care: A Concept Analysis."

Historically, in the Australian context, the link between the concept of 'risk' and institutionalisation of maternity care can be seen. The increasing medicalisation of childbirth has led, not to more choices for women but to the continued restriction of those choices through the normalisation of institutionalised birthing.¹⁰⁸⁴ The concern highlighted within this current study and supported by other recent studies is that increasing legislation reduces women's access to PPMs, which in turn decreases women's choices and access to their preferred model of midwifery. PPMs in this study described how they are increasingly unable to support women who may choose care outside of recommended guidelines, for example, women with pre-existing medical or obstetric history which may label them high-risk within medically defined risk categories.¹⁰⁸⁵ The principle underlying regulation of midwifery practice is one of protecting the safety of the public, however in the case of PPMs regulation has had the opposite effect. Rather than protecting the public and providing them with access to a variety of safe maternity models including midwifery-led care, regulation has reduced options for women. This is supported by recent research in Australia that suggests women who are denied the option they prefer will seek alternate options as reflected in the increase in unassisted 'freebirth' and unregulated birth worker attended births.¹⁰⁸⁶ Freebirth, is a planned homebirth without the aid of medical assistance,¹⁰⁸⁷ these concerns will be discussed in more detail later in this chapter.

The PPMs in this study described a culture of fear where they were persecuted and reported to their governing body by health professionals working within the institutions. The PPMs recalled how differences in ideologies led individuals within maternity care institutions to believe that they were providing inadequate or unsafe care, particularly if women choosing PPMs services were deemed unsuitable for midwifery-led care according

¹⁰⁸⁴ McKenzie, "Place and Power: A History of Maternity Service Provision in Western Australia, 1829-1950."206.

¹⁰⁸⁵ Australian College of Midwives Inc. *National Midwifery Guidelines for Consultation and Referral*; Keedle et al., 2019. "A Narrative Analysis of Women's Experiences of Planning a Vaginal Birth after Caesarean (VBAC) in Australia Using Critical Feminist Theory," *BMC Pregnancy and Childbirth*, 19 (142).

¹⁰⁸⁶ Dahlen, H, M Jackson, and J Stevens. 2011. "Homebirth, Freebirth and Doulas: Casualty and Consequences of a Broken Maternity System," *Women and Birth* 24 (1): 47-50; Jackson, Melanie, Hannah Dahlen, and Virginia Schmied. 2012. "Birthing Outside the System: Perceptions of Risk Amongst Australian Women Who Have Freebirths and High-Risk Homebirths." *Midwifery* 28 (5): 561-67; McWhirter, Rebekah. 2018. "Regulation of Unregistered Birth Workers in Australia: Homebirth and Public Safety," *Women and Birth* 31 (2): 134-42; E Rigg et al., 2017. "Why Do Women Choose an Unregulated Birth Worker to Birth at Home in Australia: A Qualitative Study," *BMC Pregnancy and Childbirth* 17 (99); Rigg et. al. 2019. "The Role, Practice and Training of Unregulated Birth Workers in Australia: A Mixed Methods Study," *Women and Birth* 32 (1): e77-e87.

¹⁰⁸⁷ Plested and Kirkham, "Risk and Fear in the Lived Experience of Birth without a Midwife."

to the medical model and medically defined risks. There are very few midwives in Australia who provide private midwifery care.¹⁰⁸⁸ Furthermore, the numbers of PPMs attending homebirths have decreased in recent years. The Australian Institute of Health and Welfare (AIHW) recorded 241 registered midwives attending homebirths in 2015, these numbers included both PPMs and government employed midwives.¹⁰⁸⁹ In 2012, the number of PPMs attending homebirths was 271, therefore the latest data demonstrates a reduction in the numbers of PPMs attending homebirths.¹⁰⁹⁰ This reduction in PPMs coincided with the Australian government's introduction of the midwifery reforms and the need for midwives to be insured to be registered.¹⁰⁹¹ The PPMs in this study spoke about the stresses and anxiety they felt in relation to legislative requirements and the fear of being persecuted and reported for supporting women. This concern applied to not just those who chose care outside of recommended accepted guidelines, but any woman who chose a PPM as her primary carer and was planning on birthing at home. Since 2010, there has been an increase in Privately Practising Midwives throughout Australia being reported to APHRA for supporting women with medically-defined risk factors to birth at home.¹⁰⁹² Toose believes that the overregulation and persecution of PPMs in Australia will eventually lead to the end of homebirth with a PPM.¹⁰⁹³ Toose describes a "cycle of death by regulation" (Figure 3) and believes that access to PPMs has been steadily reducing due to the over-regulation of these midwives through the application of additional professional standards and the use of inappropriate disciplinary action to manage performance issues (see Figure 3 below for Toose's cycle of death by regulation).¹⁰⁹⁴ Toose believes that if the cycle continues then it will result in a significant reduction of the availability of PPMs for women who choose to

¹⁰⁸⁸ Hunter, J. 2018. "The Experiences of Privately Practising Midwives in Australia Who Have Been Reported to the Australian Health Practitioner Regulation Agency: A Qualitative Study," Bachelor of Nursing (Honours), Western Sydney University.

¹⁰⁸⁹ Australian Institute of Health and Welfare. 2015a. "Australia's Mothers and Babies 2015."

¹⁰⁹⁰ Ibid.

¹⁰⁹¹ Dahlen, Jackson, and Stevens, "Homebirth, Freebirth and Doulas: Casualty and Consequences of a Broken Maternity System."

¹⁰⁹² Hunter, "The Experiences of Privately Practising Midwives in Australia Who Have Been Reported to the Australian Health Practitioner Regulation Agency: A Qualitative Study"; Hunter, J. 2014. Hunter, J. 2014. "Vexatious Reporting of Midwives." in *Homebirth Australia Conference*. Brisbane, Queensland, Australia; Sassine, H. 2017. "The Needs and Experiences of Women Who Choose Homebirth in Australia: A National Survey" Bachelor of Nursing (Honours), University of Western Sydney.

¹⁰⁹³ Toose, L. 2016. "Privately Practising Midwives in a Cycle of Death by Regulation-How the Medical Model and Unfounded Perception of Risk is Leading to the Removal of Choice for Women in Australia."

¹⁰⁹⁴ Ibid.

birth at home.¹⁰⁹⁵ It will also result in a reduction of the number of women whom midwives can care for due to medically defined risk factors, regardless of whether the woman will default to a hospital birth if no midwife is available. It will also create financial barriers for women choosing to birth at home and become an unviable business model for the self-employed PPMs.¹⁰⁹⁶ These concerns are supported by the experiences of the PPMs in this study.

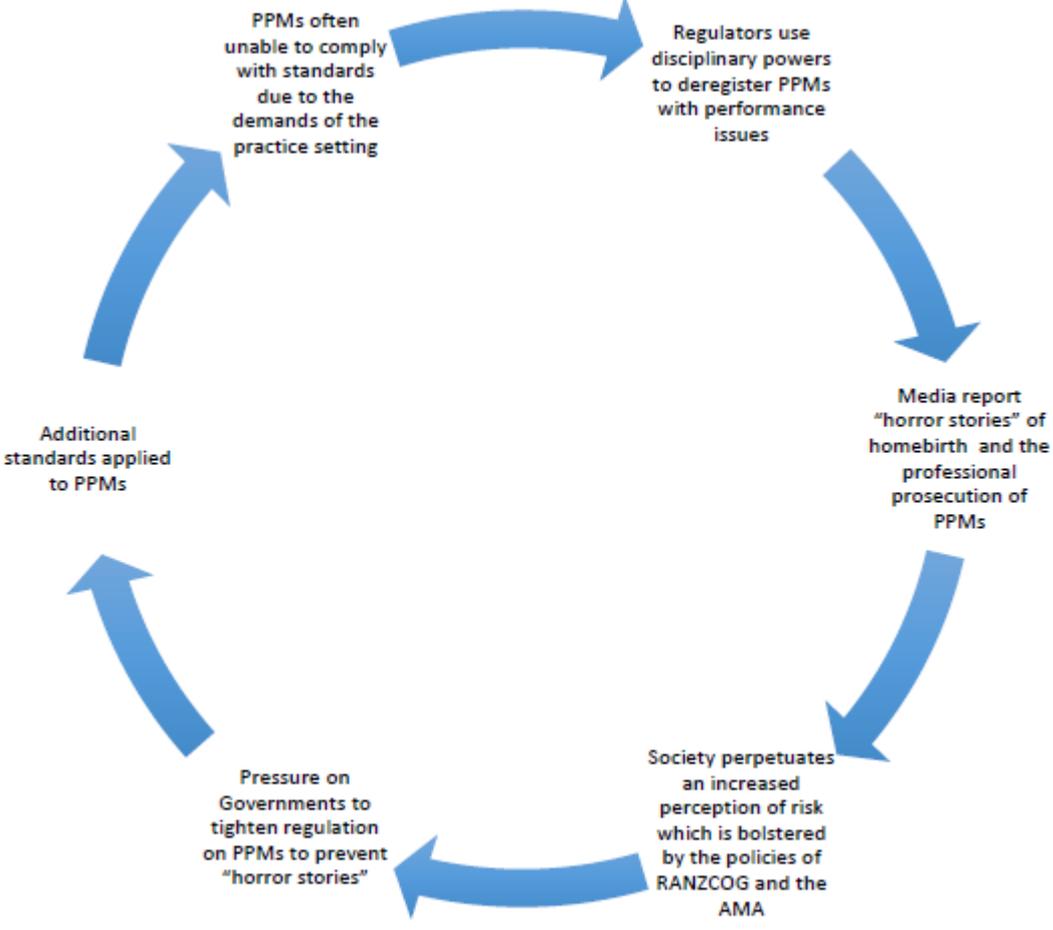


Figure 3: The Cycle of Death by Regulation by L. Toose. 2016

¹⁰⁹⁵ Toose, L. 2016. "Privately Practising Midwives in a Cycle of Death by Regulation-How the Medical Model and Unfounded Perception of Risk is Leading to the Removal of Choice for Women in Australia."

¹⁰⁹⁶ Ibid.

As previously mentioned in this thesis, throughout history, midwives have been persecuted.¹⁰⁹⁷ In Australia, during the late 19th and early 20th century empirically-trained midwives were portrayed in medical journals and newspapers as meddlesome and ignorant, with some medical doctors calling for midwives to be completely removed from the provision of maternity services.¹⁰⁹⁸ As revealed in the findings of this WA study, midwives whose practise does not conform to the dominant medical model of maternity care and who thus choose to challenge this system, are at risk of persecution. The conflict between perceived institutional interests and the autonomy of the midwife has resulted in a climate of silencing and bullying leading to the suppression of autonomous midwifery practice, which ultimately affects the provision of woman-centred care.¹⁰⁹⁹ The midwives and doctors in this study spoke of their own personal experiences of persecution and being reported to their governing bodies; they also described the distressing experiences of watching how their colleagues were affected by this.

In 2014, Jo Hunter, a PPM based in New South Wales (NSW) on the East Coast of Australia, highlighted an increase in vexatious reporting of midwives in Australia.¹¹⁰⁰ Hunter's study collated the data from twenty-one cases of vexatious reporting, from midwives in five Australian states. She also reported having personal knowledge of at least twenty additional reports.¹¹⁰¹ A more recent 2018 study from Jo Hunter, explored the experiences of PPMs in Australia who had been reported to APHRA.¹¹⁰² Hunter conducted in-depth interviews with eight Australian PPMS who had been reported to APHRA. All the PPMs who were interviewed in Hunter's study were reported following a transfer from home to hospital. Hunter's thesis described the medical domination of midwifery and defined the PPMs experiences of being reported, and similar themes that emerged from the data support the findings of this study. Hunter identified six themes, with the overarching theme 'caught between women and the system'. In her study, PPMs described how midwifery only existed with the permission of the medical establishment that

¹⁰⁹⁷ Ehrenreich and English, *Witches, Midwives and Nurses: A History of Women Healers*; Katz Rothman, *Recreating Motherhood: Ideology and Technology in a Patriarchal Society*.

¹⁰⁹⁸ McKenzie, "Place and Power: A History of Maternity Service Provision in Western Australia, 1829-1950." 77-89.

¹⁰⁹⁹ Wagner, *Born in the USA: How a Broken Maternity System Must Be Fixed to Put Women and Children First*; Edwards, et al., 2011. "Attacks on Midwives, Attacks on Women's Choices," *AIMS Journal* 23 (3): 3-7.

¹¹⁰⁰ Hunter, "Vexatious Reporting of Midwives."

¹¹⁰¹ *Ibid.*

¹¹⁰² Hunter, "The Experiences of Privately Practising Midwives in Australia Who Have Been Reported to the Australian Health Practitioner Regulation Agency: A Qualitative Study."

dominates and holds the power over maternity care and midwifery, leading to the suppression of midwifery.¹¹⁰³ PPMs described the attack against midwives' which they called a "witch hunt" and they believed they were regarded as being "guilty until proven innocent".¹¹⁰⁴ The PPMs reported feeling bullied, threatened and in one case suicidal, leading to several of them ceasing practice as Privately Practising Midwives.¹¹⁰⁵ In both of Hunter's studies the midwives had also been reported for supporting women choosing to birth at home with medically defined risk factors. The PPMs also described having first-hand knowledge of women deciding to freebirth due to their PPM being unable to attend them during labour and birth. This will be explored in more depth later in this chapter.¹¹⁰⁶

The suppression of midwifery due to medical control— with its corresponding impact on women's autonomy— is not a new phenomenon. Historically, women's choices during childbirth were restricted by their socioeconomic and geographic status, as well as by the impact of the combined actions of the medical profession and the state.¹¹⁰⁷ 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,¹¹⁰⁸ leading to the autonomy and independence of midwives becoming severely limited. The PPMs in this current study described how the power and the control of institutions negatively affected them, particularly when they had to transfer a labouring woman into hospital. This theme was apparent throughout the qualitative data, covering a time span of over 40 years. The midwives spoke about feeling bullied and described how some hospitals even told them not to bring women into their facility.

These findings are supported by other recent Australian research. Ball and colleagues conducted a study of midwives' experience of intrapartum transfer from home to hospital within the context of a planned homebirth in WA.¹¹⁰⁹ The overarching theme from their

¹¹⁰³ Hunter, "The Experiences of Privately Practising Midwives in Australia Who Have Been Reported to the Australian Health Practitioner Regulation Agency: A Qualitative Study."

¹¹⁰⁴ Ibid.

¹¹⁰⁵ Hunter, "Vexatious Reporting of Midwives."; Hunter, "The Experiences of Privately Practising Midwives in Australia Who Have Been Reported to the Australian Health Practitioner Regulation Agency: A Qualitative Study."

¹¹⁰⁶ Ibid.

¹¹⁰⁷ McKenzie, "Place and Power: A History of Maternity Service Provision in Western Australia, 1829-1950."101.

¹¹⁰⁸ Ibid.; *Health Act of 1911 (WA)*.

¹¹⁰⁹ Ball, C et al., 2016 "Under Scrutiny: Midwives' Experience of Intrapartum Transfer from Home to Hospital within the Context of a Planned Homebirth in Western Australia," *Sexual/ Reproductive Healthcare* 8 (June): 88-93.

study 'under scrutiny' captured the midwives' experience from the decision to transfer, through to the reception at the hospital and the ongoing care.¹¹¹⁰ The midwives in this 2016 study described how they felt this scrutiny was pervasive and above and beyond what midwives working within the hospitals experienced. The midwives also talked about the "them and us" attitude they experienced.¹¹¹¹ The difference in the ideologies between the transferring midwives and the hospital staff were apparent with the perception that homebirth and the midwives providing care in that setting were unsafe, and with some hospitals' environments being described as hostile, judgemental and passive aggressive.¹¹¹² The midwives in Ball et al's study, described how they felt mistrusted and disrespected, with the childbearing women also being aware of this treatment, which raised further concerns.¹¹¹³

Another Australian study, published in 2018, researched the processes and interactions between midwives, doctors and women during the intrapartum transfer of women from planned homebirth to hospital.¹¹¹⁴ The study by Fox and colleagues included in-depth interviews with 36 midwives (including PPMs), as well as women and obstetricians from four states in Australia, all of whom had experienced a homebirth transfer within three years of the interview taking place. Three categories were taken from the study data, 'transferring out of the comfort zone', 'encountering us and them' and 'celebrating a successful transfer'.¹¹¹⁵ The women, midwives and doctors in this study felt out of their 'comfort zone' following the transfer into the hospital. Participants in this study often had competing ideologies with different paradigms of risk and safety, which could make collaboration challenging.¹¹¹⁶ The behaviours which gave rise to the 'us and them' dynamic included stereotyping, resisting, blaming and taking over; there was also the assumption that the women who had planned a homebirth were more burdensome to care for than women planning hospital births.¹¹¹⁷ The blame was often directed towards the transferring homebirth midwife, who was perceived to have caused the complications. 'Us and them'

¹¹¹⁰ Ball, et al., "Under Scrutiny: Midwives' Experience of Intrapartum Transfer from Home to Hospital within the Context of a Planned Homebirth in Western Australia."

¹¹¹¹ Ibid.

¹¹¹² Ibid.

¹¹¹³ Ibid.

¹¹¹⁴ Fox, D, A Sheehan, and C Homer. 2018 "Birthplace in Australia: Processes and Interactions during the Intrapartum Transfer of Women from Planned Homebirth to Hospital," *Midwifery* 57 (February): 18-25.

¹¹¹⁵ Ibid.

¹¹¹⁶ Ibid.

¹¹¹⁷ Ibid.

dynamics were heightened by the hospital policies that did not support or recognise the role of the homebirth midwife as a registered midwife.¹¹¹⁸ Even when the homebirth midwife accepted that she was no longer recognised as a registered midwife providing clinical care, the 'us and them' dynamics continued due to the strong relationship the homebirth midwife had with the child-bearing woman. This was reported to cause at best, discomfort, and at worst, conflict and animosity.¹¹¹⁹ A successful transfer however, featured a smooth process with acceptance and respect of the relationship between the woman and her homebirth midwife. This was demonstrated by mutual respect for the expertise of care givers, a willingness to listen and skills in clarifying roles and goals. A positive transfer also required respecting a woman's informed decision even if it was in opposition of one's own beliefs.¹¹²⁰

As previously described the use of the term 'institution' in this thesis is not restricted to physical buildings such as hospitals, but refers to any powerful group, including the government, the media, and in the context of this thesis, the health professionals' governing and regulatory bodies, professional colleges and other organisations . The 'institutional culture' is an important dimension of the institution, which comprises the informal attitudes, values, norms, and the ethos or 'spirit' which pervades an institution and determines the behaviours of the members. The two Australian studies discussed above support the experiences of the PPMs in this study. They show that the misuse of power dynamics between the culture of the institutions, women and their midwives has had negative impacts, as the imbalance in power has led to very stressful situations. The PPMs in this WA study described how the stress of this scrutiny, persecution, fear of being reported and the 'them and us' attitude of the institutions led them to cease or take a break from providing private midwifery.

The suppression of midwifery can also be linked to the rise of freebirths. The actual numbers of freebirths in Australia cannot be verified due to the births taking place away from the mainstream maternity system, however an increase in unassisted childbirth or freebirth has been reported in recent years.¹¹²¹ Numbers of women birthing at home with

¹¹¹⁸ Fox, Sheehan and Homer, "Birthplace in Australia: Processes and Interactions during the Intrapartum Transfer of Women from Planned Homebirth to Hospital."

¹¹¹⁹ Ibid.

¹¹²⁰ Ibid.

¹¹²¹ Dahlen, Jackson, and Stevens, "Homebirth, Freebirth and Doulas: Casualty and Consequences of a Broken Maternity System."; Jackson, Dahlen, and Schmied, "Birthing Outside the

the support of an unregistered birth worker also appear to have increased,¹¹²² with some associated adverse outcomes which will be discussed later in this chapter. An unregistered birth worker (UBW) can be anyone who provides support to women during pregnancy, labour and birth and during the postnatal period.¹¹²³ As they are unregulated there are no requirements for formal supervised training that would lead to registration, however, they may have some informal training, and knowledge and experience of childbirth.¹¹²⁴ Unregulated birth workers include doulas, lay midwives, childbirth educators and previously registered midwives who do not hold registration in Australia; these include midwives who may have been registered in other countries and midwives who previously held registration in Australia.¹¹²⁵

A 2014 study of women's reasons and experiences of choosing a PPM to provide maternity care in WA, found that if the opportunity to have individualised care with a PPM had not been available, the women would not have considered acceptance of the medicalised and technocratic maternity care on offer in the mainstream system.¹¹²⁶ For these women, maternity care within the institution with its associated increased risk of intervention, lack of support and multiple carers presented a higher and unacceptable risk than birthing with no assistance.¹¹²⁷ An earlier Australian study in 2012 explored how women who make the decision to birth outside of the mainstream birthing system perceive the risks associated with childbirth and the place of birth.¹¹²⁸ Twenty women were interviewed from four Australian states; of these women, nine chose to freebirth and eleven chose homebirth despite the presence of medically defined risk factors.¹¹²⁹ Jackson and associates found three main themes in their qualitative study: 'birth always has an

System: Perceptions of Risk Amongst Australian Women Who Have Freebirths and High-Risk Homebirths."

¹¹²² Rigg et al., "Why Do Women Choose an Unregulated Birth Worker to Birth at Home in Australia: A Qualitative Study."

¹¹²³ McWhirter, "Regulation of Unregistered Birth Workers in Australia: Homebirth and Public Safety"; Rigg et al., "The Role, Practice and Training of Unregulated Birth Workers in Australia: A Mixed Methods Study," *ibid.*32.

¹¹²⁴ Rigg, et. al. "The Role, Practice and Training of Unregulated Birth Workers in Australia: A Mixed Methods Study."

¹¹²⁵ *Ibid.*; Rigg, et. al. "Why Do Women Choose an Unregulated Birth Worker to Birth at Home in Australia: A Qualitative Study"; McWhirter, "Regulation of Unregistered Birth Workers in Australia: Homebirth and Public Safety."

¹¹²⁶ Davison, "The Relationship is Everything: Women's Reasons for, and Experience of Maternity Care with a Privately Practising Midwife in Western Australia."

¹¹²⁷ *Ibid.*

¹¹²⁸ Jackson, Dahlen, and Schmied, "Birthing Outside the System: Perceptions of Risk Amongst Australian Women Who Have Freebirths and High-Risk Homebirths."

¹¹²⁹ *Ibid.*

element of risk'; 'the hospital is not the safest place to have a baby'; and 'interference is a risk'.¹¹³⁰ The women in this 2012 Australian study perceived the risk of birthing in mainstream care as more significant when compared to having a homebirth with or without a registered midwife or doctors present.¹¹³¹ The women discussed how staying away from the hospital would minimise the risk of intervention and increase their control of external factors in relation to their births.¹¹³² International research is also demonstrating an increase in freebirth. Joanna Joy conducted an informal survey of two hundred and twenty freebirthing UK women who belonged to a freebirth group on social media.¹¹³³ Joy found that many women chose to freebirth due to the increasing medicalisation of birth within the mainstream maternity care options.¹¹³⁴ The women in her study believed in relationship-based midwifery and continuity of care throughout the childbirth continuum, however they felt this was not an option within the free UK maternity care options. Many of the women thought that the care provided by a PPM may have been a more suitable option, but it was unobtainable for them due to the associated costs and lack of accessibility.¹¹³⁵

This current study and other recent Australian and international studies confirm PPMs rising concerns over the increasing numbers of women choosing to freebirth. Women do not default to birthing in the institutions if they cannot get a PPM to support them. Increasing legislation and restrictions on PPMs practice does not make birth safer, as for some women the risk associated with birthing in the institutions is deemed too high and they would choose to freebirth or give birth with the support of an UBW rather than go into mainstream care. The rise in women choosing intentionally to birth at home unassisted by a registered midwife suggests that health systems are not meeting the needs of women who want continuity of care and a non-medicalised birth.

A recent study conducted by Australian researchers involved two phases to investigate the role of the UBW.¹¹³⁶ The first phase used qualitative methods to interview four UBWs about their training and experience of supporting women to birth at home

¹¹³⁰ Jackson, Dahlen, and Schmied, "Birthing Outside the System: Perceptions of Risk Amongst Australian Women Who Have Freebirths and High-Risk Homebirths."

¹¹³¹ Ibid.

¹¹³² Ibid.

¹¹³³ Joy, J. 2013. "Free to Birth," *AIMS Journal*, 25 (4): 6-7.

¹¹³⁴ Ibid.

¹¹³⁵ Ibid.

¹¹³⁶ Rigg et al., "The Role, Practice and Training of Unregulated Birth Workers in Australia: A Mixed Methods Study."

without a registered midwife present. Findings from the first phase informed the development of a survey that was used to collect quantitative data in the second phase of the study.¹¹³⁷ Findings demonstrated that although the thirty-eight UBWs who completed the study claimed they did not provide midwifery care to women, the findings showed that they practised skills and provided care that resembled midwifery practice.¹¹³⁸ The UBWs provided care that included social and emotional support, to the full range of midwifery care practices, similar to what a registered midwife would offer.¹¹³⁹ Care provided by the UBW included conducting assessment of foetal growth during pregnancy, assessing maternal and foetal wellbeing during labour and birth (including performing vaginal examinations and providing hands on assistance during the actual birth) and assessing maternal and neonatal wellbeing in the early postnatal period.¹¹⁴⁰

In recent years, high profile cases of UBWs have been reported in the media, highlighting the fact that UBWs previously registered as midwives continue to provide care to women and attend births at home.¹¹⁴¹ The most 'infamous' of these is Lisa Barrett who was educated as a midwife in the UK and worked as a registered midwife in the UK and in Australia, providing care to women in both the hospital and community settings.¹¹⁴² Lisa Barrett worked as a PPM in Australia before voluntarily surrendering her Australian midwifery registration at the beginning of 2011 due to the increasing legislative requirements as described in the previous chapters. Between 2007 and 2011 Lisa Barrett attended three planned homebirths in South Australia and another in Western Australia where four babies died. While the first two deaths under Lisa Barrett's care took place when she was a registered midwife the subsequent deaths took place when she attended the births as a UBW. Lisa defined her role as a birth advocate and argued that this differed from a midwife as she did not perform any clinical duties and acted only as an advocate to

¹¹³⁷ Rigg et al., "The Role, Practice and Training of Unregulated Birth Workers in Australia: A Mixed Methods Study."

¹¹³⁸ Ibid.

¹¹³⁹ Ibid.

¹¹⁴⁰ Ibid.

¹¹⁴¹ Dillon, Meagan. 2019. "Former Adelaide Midwife Lisa Barrett Goes on Trial over Two Home Birth Deaths."; McWhirter, "Regulation of Unregistered Birth Workers in Australia: Homebirth and Public Safety"; Thompson, Angus. 2016. "Coroner Recommends Criminal Action be Considered against Home Birth Death Midwife Gaye Demanuele," *Geelong Advertiser*, 24th March 2016.

¹¹⁴² Schapel, Anthony. 2012. "Coroner's Report: Home Birthing - Spencer-Koch Tate and Hobbs Jahli Jean and Kavanagh Tully Oliver"; McWhirter, "Regulation of Unregistered Birth Workers in Australia: Homebirth and Public Safety"; Dillon, "Former Adelaide Midwife Lisa Barrett Goes on Trial over Two Home Birth Deaths".

provide education, information and help as needed.¹¹⁴³ All four women's pregnancies had medically defined risk factors and were classed as not suitable for government funded homebirth.

Following the inquest into the South Australian deaths, the Deputy Coroner, Dr Anthony Schapel handed down his findings stating that the deaths could have been avoided had the babies been born by caesarean section.¹¹⁴⁴ He recommended that homebirths should only be attended by registered health care professionals and unregistered birth workers attending homebirths should be criminalised.¹¹⁴⁵ Demonstrating a paternalistic view and lack of understanding of informed choice and risk perception, he argued that women who chose to homebirth with high risk pregnancies do so without full knowledge and understanding of the consequences.¹¹⁴⁶ Schapel also suggested that health professionals should be duty bound to report the intention to birth at home with risk factors to the local health department. Then, a senior obstetrician could counsel the woman, and an education program should be implemented to highlight the risks of high-risk homebirths and encourage women to accept mainstream care.¹¹⁴⁷

Anthony Schapel dismissed the contention that in implementing the strict regulation of Privately Practising Midwives providing homebirth, women would not necessarily default to mainstream care and that some women may choose to freebirth. Following the 2012 South Australian inquest, the Health Practitioner Regulation National Law (South Australia) Act 2010, was amended to include "section 123a: Restricted Birthing Practices".¹¹⁴⁸ This legislation restricts attendance and the provision of care during labour and birth in South Australia to a registered midwife or midwifery student acting under the appropriate supervision of a registered midwife.¹¹⁴⁹ This legislation makes it illegal for anyone other than a registered health practitioner to attend a woman in labour and birth in South Australia and carries a penalty of \$30,000 or imprisonment for 12 months.¹¹⁵⁰

¹¹⁴³ Schapel, "Coroner's Report: Home Birthing - Spencer-Koch Tate and Hobbs Jahli Jean and Kavanagh Tully Oliver."

¹¹⁴⁴ Ibid.

¹¹⁴⁵ Schapel, "Coroner's Report: Home Birthing - Spencer-Koch Tate and Hobbs Jahli Jean and Kavanagh Tully Oliver."

¹¹⁴⁶ Ibid.

¹¹⁴⁷ Ibid.

¹¹⁴⁸ *Health Practitioner Regulation National Law (South Australia) Act 2010*. Section 123a: Restricted Birthing Practices. 2014 (SA).137-138.

¹¹⁴⁹ Ibid.137.

¹¹⁵⁰ Ibid.137.

Similar legislation has also been introduced into WA following the inquest into Baby P's death. Baby P was the second twin at the 2011 WA homebirth attended by Lisa Barrett. The Health Practitioner Regulation National Law (WA) clause 38, section 123A provides new legislation to restrict care during labour and birth to registered practitioners. This amendment states:

This amendment will restrict the care of a woman during the three stages of labour to a registered midwife or registered medical practitioner. The three stages of labour are generally accepted as the first stage: the start of regular contractions up until the cervix is fully dilated; second stage is the time when the cervix is fully dilated up until the birth; third stage is after the birth ending with the delivery of the placenta. Students who are undertaking an approved programme of study in the medical or midwifery profession may also undertake the restricted birthing practice. In the case of an emergency a person who assists a woman until such time as a medical practitioner or midwife arrives would not be penalised. However, if neither practitioner arrives in time for the restricted birthing practice there is no penalty. If a medical practitioner or midwife undertakes further training or upskilling under the supervision of a medical practitioner or midwife from the relevant health profession, the restricted birthing practice can be performed. For example, if an overseas midwife requires upskilling for registration purposes. A penalty of \$30,000 is prescribed.¹¹⁵¹

The inquest took place four years later in 2015 and found that the baby died from "natural causes", Coroner Sarah Linton stated:

Relying upon the expert opinions noted above and taking into account the evidence of the midwives of an acceptable foetal heart rate approximately five minutes before the birth, and then the clear evidence of the placental abruption, I am satisfied the cause of death was intrapartum hypoxia due to placental abruption. Given my conclusion as to the cause of death, it follows that I find that the death occurred by way of natural causes.¹¹⁵²

Theresa Clifford attended this birth as a reluctant registered midwife and spoke about the experience in her interview. As described in the findings chapters, Theresa did not want to attend this birth, and had agreed to provide postnatal care, however, she attended when called by Lisa Barrett during the woman's labour. At the time of the inquest there were differences of opinions on whether Theresa should have attended the birth. The

¹¹⁵¹ Government of Western Australia 2017. "Health Practitioner Regulation National Law (WA) Amendment Bill 2017 Explanatory Memorandum."21.

¹¹⁵² Linton, Sarah. 2015. "Coroner's Report: Inquest into the Death of Baby P."52.

medical expert, Dr Griffin, declared that Theresa should have withdrawn care and not attended the birth:

In Dr Griffin's view, the alternative choice for Ms Clifford, when she became aware that the primary carer was not a currently registered midwife, was to decline to continue her role as the support person and "walk", as Dr Griffin put it. He did not accept the proposition put to him that best practice would be to continue her role, in those circumstances.¹¹⁵³

However, midwifery expert, Dr Catling, believed it was the registered midwife's duty to attend in this situation. Coroner Linton stated:

I must assume that Dr Catling's response that Ms Clifford should stay included if she had a period of time to withdraw, I note that Dr Catling's evidence was that there was a difficult choice faced by both Ms Barrett and Ms Clifford, given Baby P's mother may have decided to free birth if she couldn't find someone to assist her. It is obviously better, from a safety perspective, to have experienced and qualified people at the birth than for a woman to be on her own, and that seemed to be a significant factor Dr Catling took into account. I accept that is the case. Ms Clifford's counsel emphasised that this was a primary factor in Ms Clifford's willingness to remain involved, and I accept that. Unlike Ms Barrett, Ms Clifford was not in the habit of facilitating the birth at home of twins...Ms Clifford's counsel, Mr Cuomo, submitted that Ms Clifford, on the other hand, was faced with a determined mother who had made decisions that were unlikely to be changed by advice from Ms Clifford. In those circumstances, Ms Clifford provided support out of the "best of motives", wanting to help and, in effect, to ensure that the birth that had been chosen took place in as safe an environment as was possible in the circumstances. I am prepared to accept that Ms Clifford did provide her support in those circumstances.¹¹⁵⁴

Theresa stated that she did what she thought was the right thing to do under the circumstances. However, as previously discussed, if PPMs are being reported for supporting women who choose care outside of recommended guidelines and the number of PPMs continues to decrease and it becomes illegal for UBWs to support women, this in fact leaves women with very few options, leading some to believe their only option is to freebirth. The assertion that women make uninformed decisions because they have not been given the 'right' information is in complete contrast to the findings of the studies discussed earlier in

¹¹⁵³ Linton, "Coroner's Report: Inquest into the Death of Baby P."66.

¹¹⁵⁴ Ibid.68.

this chapter which clearly demonstrate that women consider and are fully aware of all the risks in their decision making around place of birth and caregiver.

These high profile cases are isolated incidents and rather than identifying individual practitioners that may be providing sub-standard care, the reaction of the media and the coroners is to tighten control on the practice of all PPMs and increase legislation to reduce access to UBWs.¹¹⁵⁵ Another example of this is the recommendations resulting from the inquest into the tragic death of Caroline Lovell, who died in hospital in 2012, following the homebirth of her second child. Her death was caused by a post-partum haemorrhage. The coroner's inquest found her midwife, Gaye Demanuele, to have provided substandard care. The coroner, Peter White, recommended that:

The Department of Health and Human Services, in conjunction with the Australian Health Practitioner Regulatory Agency, examines the adequacy of the regulatory system currently in place and develops a specific regulatory framework for privately contracted midwives, working in the setting of a home.¹¹⁵⁶

Midwives being persecuted for supporting women who make choices outside recommended guidelines is an international trend that has an impact on child-bearing women's autonomy. In 2013, legal action against three Dutch midwives spurred discussion about women's autonomy during childbirth and what to do for a woman who chooses to birth 'outside the system'. The legal action concerned homebirth of high-risk pregnancies with the women all expressing the desire to birth at home against medical advice. Following the legal action, the midwives involved in the care were reprimanded by their governing body, with one losing her licence (although this was modified to temporary suspension following an appeal). The common theme in these lawsuits was that the wishes of the women did not correspond to what the health professionals, according to policy and guidelines, could offer, therefore when the midwives supported the women in their autonomous decisions they were reprimanded by the governing body of the profession. It can be shown therefore that the suppression of midwifery practice leads to a reduction in child-bearing women's autonomy and control during childbirth. This can make women

¹¹⁵⁵ Thompson, "Coroner Recommends Criminal Action be Considered against Home Birth Death Midwife Gaye Demanuele."

¹¹⁵⁶ White, Peter. 2016. "Coroner's Report: Inquest into the Death of Caroline Emily Lovell."86.

reject mainstream care options and choose to birth outside of the accepted birth system and this concept will be explored in more detail in the next section in this chapter.

The Reduction of Women's Autonomy in Childbirth

The PPMs and doctors interviewed in this study believed that the only way to provide woman-centred care was to work outside the institutions. They believe that the medical and technocratic model of birth does not respect women as autonomous beings who are able to make informed decisions. The medicalisation of birth within the medical ideology, controls and vilifies women and midwives who do not conform to the practices accepted in the institutions, leading to conflict between women, midwives and the institutions. In 2004, Billie Hunter explored how a range of UK midwives experienced and managed emotion in their work. Her results found that the key source of emotion work for the midwives in her study were the conflicting ideologies of midwifery practice, with some midwives adhering to the midwifery model of care and others to the medical model of care.¹¹⁵⁷ These were also linked to the context of the midwives' work. Hospital based midwifery was driven by the needs of the institution, with minimal attention given to the needs of the individual, therefore the midwives' ideology was described as "with institution". In contrast, community-based midwives were described as having a "with woman" approach characterised by an individualised midwifery philosophy, informed by a belief in the normal physiology of childbirth that placed the woman at the centre of care.¹¹⁵⁸

The idea of 'woman-centred care' can be traced back to the women's health movement during the second wave of feminism in the 1960s and 1970s.¹¹⁵⁹ A feminist definition of woman-centred care is offered by Leap:

Woman centred care is a concept. It implies that midwifery:

- Focuses on the woman's individual needs, aspirations and expectations, rather than the needs of the institution or professional,

¹¹⁵⁷ Hunter, Billie. 2004. "Conflicting Ideologies as a Source of Emotion Work in Midwifery," *Midwifery*, 20 (3): 261-272.

¹¹⁵⁸ Ibid.

¹¹⁵⁹ Leap, Nicky. 2009. "Woman-Centred or Women-Centred Care: Does It Matter?," *British Journal of Midwifery*, 17 (1): 12-16.

- Recognises the need for women to have choice, control and continuity from a known caregiver or caregivers,
- Encompasses the needs of the baby, the woman’s family and other people important to the woman, as defined and negotiated by the woman herself,
- Follows the woman across the interface of community and acute settings,
- Addresses social, emotional, physical, psychological, spiritual and cultural needs and expectations and
- Recognises the woman’s expertise in decision making.¹¹⁶⁰

Woman-centred care principles underpin the midwifery professional colleges in Australia, New Zealand, Canada and the UK.¹¹⁶¹ In 1995, the development of Guiland and Pairman’s book *The Midwifery partnership: a model for practice*, the authors brought these feminist and woman-centred principles together to outline a relationship-based model for midwifery practice. Leap states: “Woman-centred care is now an internationally recognised concept that acknowledges that when care concentrates on the individual woman, there is the potential to create situations where the woman can become more powerful, and in turn, strengthen her family, community and society”.¹¹⁶²

The concept of being ‘with woman’ is described as the foundation of midwifery and is embedded in professional philosophy, standards of practice and relationship based care with women.¹¹⁶³ Bradfield, Kelly, Hauck and Duggan recently explored what it meant to be ‘with woman’ for midwives working in Australia.¹¹⁶⁴ Exploring three different models of maternity care provisions, Bradfield and colleagues conducted in-depth interviews with midwives working in the private obstetric model (where care is provided by an unknown

¹¹⁶⁰Leap, "Woman-Centred or Women-Centred Care: Does It Matter?"; Leap, N. 2000. "The Less We Do, the More We Give," in *The Midwife Mother Relationship*, ed. M Kirkham, Basingstoke: Macmillan Press.

¹¹⁶¹ Leap, "Woman-Centred or Women-Centred Care: Does It Matter?"

¹¹⁶² Ibid.14.

¹¹⁶³ Bradfield et al., "Midwives Being 'with Woman': An Integrative Review," *Women and Birth*.

¹¹⁶⁴ Bradfield et al., 2019. "Midwives 'with Woman' in the Private Obstetric Model: Where Divergent Philosophies Meet." *Women and Birth* 32 (2): 157-167 *ibid*.32; Bradfield et al., 2019b. "Urgency to Build a Connection: Midwives' Experiences of Being 'with Woman' in a Model Where Midwives Are Unknown," *Midwifery* 69 (February): 150-157; Bradfield et al., ""It's What Midwifery Is All About"; Western Australian Midwives' Experiences of Being 'with Woman' During Labour and Birth in the Known Midwife Model.

midwife during labour with a known private obstetrician attending the birth), the 'known midwife' model (where care is provided by a known midwife during labour and birth) and the 'unknown midwife' model (where care is provided by an unknown midwife during labour and birth). Midwives in all the three models, believed that being 'with woman' was a central theme to providing woman centred care and all the midwives who were interviewed sought to achieve this within their midwifery practice.¹¹⁶⁵ However, midwives working within the private obstetric model and the 'unknown' midwife model described how they struggled at times to be 'with woman' due to the challenges of working within a medical model where hierarchal structures existed and the dominant philosophy was not deemed as woman-centred.¹¹⁶⁶ Midwives who worked within the private obstetric model and the unknown midwife model described how they formed supportive relationships with women who they had never met before, quickly building rapport with the woman, and striving to support her autonomy and choices within sometimes challenging circumstances.¹¹⁶⁷ These midwives recognised how power imbalances and disrespectful relationships between the midwives and obstetricians involved in the woman's care, led to a reduction in the midwives' and the women's autonomy and this had an impact on the midwives' emotional wellbeing.¹¹⁶⁸

The third model of care Bradfield et al. researched was the 'known' midwife model. Within this model, continuity of care during labour and birth was provided by a midwife known to the woman.¹¹⁶⁹ Central to the 'known' midwives' experiences of being 'with woman' was the trusting relationship that developed between the midwives and the women. Although the focus of the interviews was on labour and birth care, Bradfield et al. found that midwives consistently referenced care across the childbearing continuum,

¹¹⁶⁵ Bradfield et al, "Urgency to Build a Connection: Midwives' Experiences of Being 'with Woman' in a Model Where Midwives Are Unknown."; Bradfield et al, "Midwives 'with Woman' in the Private Obstetric Model: Where Divergent Philosophies Meet."; Bradfield et al, "'It's What Midwifery Is All About'"; Western Australian Midwives' Experiences of Being 'with Woman' During Labour and Birth in the Known Midwife Model."

¹¹⁶⁶ Bradfield et al., "Urgency to Build a Connection: Midwives' Experiences of Being 'with Woman' in a Model Where Midwives Are Unknown."; Bradfield et al., "Midwives 'with Woman' in the Private Obstetric Model: Where Divergent Philosophies Meet."

¹¹⁶⁷ Bradfield et al., "Urgency to Build a Connection: Midwives' Experiences of Being 'with Woman' in a Model Where Midwives Are Unknown."; Bradfield et al., "Midwives 'with Woman' in the Private Obstetric Model: Where Divergent Philosophies Meet."

¹¹⁶⁸ Bradfield et al., "Urgency to Build a Connection: Midwives' Experiences of Being 'with Woman' in a Model Where Midwives Are Unknown."; Bradfield et al., "Midwives 'with Woman' in the Private Obstetric Model: Where Divergent Philosophies Meet."

¹¹⁶⁹ Bradfield et al., "'It's What Midwifery Is All About'"; Western Australian Midwives' Experiences of Being 'with Woman' During Labour and Birth in the Known Midwife Model."

demonstrating that within this 'known' midwife model, being 'with woman' cannot be isolated to one section of clinical care, as it is integrated across the childbirth continuum.¹¹⁷⁰ This suggests that it is the ongoing relationship between the woman and the midwife that is the basis of being 'with woman' not the place of birth. Midwives also described building relationships with the woman's partner and family again demonstrating another integral part to woman-centred care. Midwives described how in 'knowing' the woman and developing a close relationship with her, they were able to confidently provide safe, culturally appropriate care that addressed women's needs even if women had complications during the pregnancy, or labour and birth.¹¹⁷¹ In providing care within the 'known midwife' model, midwives stated that it strengthened them as midwives and the midwifery profession as a whole. However, as demonstrated in other research, midwives described the challenges of being 'with woman' in a medicalised maternity system that does not value relationship based individualised care.¹¹⁷² Similar to the findings presented in this thesis, midwives working within all three models of care in Bradfield et al's study, spoke of supporting each other to overcome the challenges that they faced in striving to provide woman-centred care. Bradfield's study did not differentiate between the types of 'known midwife' participants in the study that included midwives employed within a midwifery group practice (MGP) under a mainstream maternity service and PPMs.¹¹⁷³ It is worth considering that the MGP midwives who are employed by the mainstream maternity system do not usually get to choose the women they care for. In contrast, midwives who work as PPMs can choose who they decide to provide care to. Another consideration is that the PPM is employed by the woman not the institution, which may also have impacts on the relationship.

As outlined in the Bradfield and colleagues' study, relationships are formed in many ways, with midwives building relationships with women during labour and birth. However,

¹¹⁷⁰ Bradfield et al., "'It's What Midwifery Is All About'; Western Australian Midwives' Experiences of Being 'with Woman' During Labour and Birth in the Known Midwife Model."

¹¹⁷¹ Ibid.

¹¹⁷² Bradfield et al., "'It's What Midwifery Is All About'; Western Australian Midwives' Experiences of Being 'with Woman' During Labour and Birth in the Known Midwife Model"; Fenwick et al., 2018. "The Emotional and Professional Wellbeing of Australian Midwives: A Comparison between Those Providing Continuity of Midwifery Care and Those Not Providing Continuity," *Women and Birth* 31 (1): 38-43; Ball et al., "Under Scrutiny: Midwives' Experience of Intrapartum Transfer from Home to Hospital within the Context of a Planned Homebirth in Western Australia."; Harvie, Karina, Mary Sidebotham, and Jennifer Fenwick. 2019. "Australian Midwives' Intentions to Leave the Profession and the Reasons Why." *Women and Birth*, online January 8, 2019.

¹¹⁷³ Bradfield et al., "'It's What Midwifery Is All About'; Western Australian Midwives' Experiences of Being 'with Woman' During Labour and Birth in the Known Midwife Model."

the PPMs in this current study wanted more than a limited, superficial relationship. They wanted a substantial relationship based on mutual trust and respect that developed over a prolonged time period. This ongoing community-based relationship that revolved around the childbearing woman is the foundation of the care provided by the PPMs, who believed this was the only way to be 'with woman' and provide true woman-centred care. Although most of the women they cared for did birth at home, the shared philosophy around birth, not place of birth, was the basis of this relationship.

The PPMs in this current study described how trust and belief in women was central to their philosophy. Previous research has demonstrated that women choose a PPM because they want continuity of carer with someone who shares the same philosophy as them.¹¹⁷⁴ Previous research around women's reasons and experiences of choosing a PPM to provide maternity care in WA, found that women employed a PPM because it was important for them to choose their own midwife, as they had identified what they wanted from the care the PPM could provide.¹¹⁷⁵ A major factor in this choice was that women wanted the midwife to have a certain type of philosophy. This shared philosophy between women and PPMs was a belief in a physiological birth with minimal interventions that involved the whole family, wherein the woman was considered the expert in her body and able to make informed decisions regarding her care during pregnancy, labour, birth and the postnatal period.¹¹⁷⁶ Women choosing a PPM developed a relationship with their caregiver that contributed to the women having a positive and empowering birth, which they reported strengthened the whole family.¹¹⁷⁷ The trusting relationship that the PPMs in this current study developed with women, was also woman-centred, individualised and based on a shared philosophy. Australian research demonstrates that women place a high value on the relationship they build with their midwife. Women expect to be partners in the sharing of knowledge and expect midwives to listen to them and accept their judgement and decisions.¹¹⁷⁸ This relationship and shared philosophy between the PPMs and the

¹¹⁷⁴Davison, "The Relationship is Everything: Women's Reasons for, and Experience of Maternity Care with a Privately Practising Midwife in Western Australia"; Jackson, Dahlen, and Schmied, "Birthing Outside the System: Perceptions of Risk Amongst Australian Women Who Have Freebirths and High-Risk Homebirths"; Sassine, "The Needs and Experiences of Women Who Choose Homebirth in Australia: A National Survey."

¹¹⁷⁵ Davison, "The Relationship is Everything: Women's Reasons for, and Experience of Maternity Care with a Privately Practising Midwife in Western Australia." Ibid.

¹¹⁷⁶ Ibid.

¹¹⁷⁷ Ibid.

¹¹⁷⁸Jackson, Dahlen, and Schmied, "Birthing Outside the System: Perceptions of Risk Amongst Australian Women Who Have Freebirths and High-Risk Homebirths" Homer et al., "The Role of the Midwife in Australia: Views of Women and Midwives."

women who access their care, sits in contrast to the medical model. The medical model reinforces the validity of the patriarchal philosophy, the superiority of science and technology and the importance of machines and institutions.¹¹⁷⁹

As previously discussed, the patriarchal mainstream maternity system assumes control over the childbearing woman; the childbearing body is viewed as a faulty tool that needs constant monitoring to ensure that it functions properly to produce the product, the baby.¹¹⁸⁰ In this medical model, the childbearing body is seen as uncontrollable, unbounded, unruly, leaky and wayward.¹¹⁸¹ In this paradigm, the demands that pregnancy and birth place on the female body are perceived to render it constantly at risk of serious malfunction or total breakdown.¹¹⁸² The culture of birth in Australia subscribes to the belief that childbirth is something that is dangerous and unpredictable, therefore it is appropriate for the woman to hand over control to the medical experts.

The concept of the medical system assuming control over the woman's body, rather than the woman retaining control is also supported by popular media. Universally the focus of childbirth generally centres on the birth of a healthy baby rather than the women's role in the childbirth process. Media images of pregnancy, labour and birth are often highly dramatic. Kitzinger argues that television programmes represent pregnancy, labour and birth as an emergency or a dramatic event which leads to social embarrassment, highly stressed personal relationships and chaos.¹¹⁸³ Similarly, Williams and Fahy assert that the way pregnancy and birth is portrayed in television, popular magazines and newspapers contributes to the way medicalised discourses and ideologies frame maternity care in Australia.¹¹⁸⁴ McIntyre, Francis and Chapman undertook a critical analysis of childbirth

¹¹⁷⁹ Katz Rothman, *Recreating Motherhood: Ideology and Technology in a Patriarchal Society*; Davis-Floyd, *Ways of Knowing About Birth: Mothers, Midwives, Medicine and Birth Activism*; Wagner, *Born in the USA: How a Broken Maternity System Must Be Fixed to Put Women and Children First*.

¹¹⁸⁰ Oakley, *The Ann Oakley Reader: Gender, Women and Social Science*; Katz Rothman, *Recreating Motherhood: Ideology and Technology in a Patriarchal Society*; Davis-Floyd, *Ways of Knowing About Birth: Mothers, Midwives, Medicine and Birth Activism*.

¹¹⁸¹ Kirkham, *Exploring the Dirty Side of Women's Health*.

¹¹⁸² Davis-Floyd, *Ways of Knowing About Birth: Mothers, Midwives, Medicine and Birth Activism*; Oakley, "Who Cares for Women? Science Versus Love in Midwifery Today."

¹¹⁸³ Kitzinger, *The Politics of Birth*.

¹¹⁸⁴ Williams, Gabrielle, and Fahy Kathleen. 2004 "Whose Interests Are Served by the Portrayal of Childbearing Women in Popular Magazines for Women?," *Australian Journal of Midwifery*, 17 (1): 11-16.

articles published in an Australian newspaper.¹¹⁸⁵ They found there were a range of views relating to the provision of maternity care in Australia, often involving polarised positions. Discourses generated from consumer opinion within this study of newspaper articles included: 'women need to be able to trust their caregivers to act in their best interests, not in the interests of the hospital doctors or midwives' and 'safe and secure in a relationship built on mutual trust with a known carer'.¹¹⁸⁶ Discourse from midwifery opinion in the newspaper articles included 'rates of medical intervention in Australia are too high', and 'medical intervention is not without risk, it comes with the potential of serious complications'.¹¹⁸⁷ In contrast, medical or obstetric opinion reported in the newspaper articles reflected the position that "they are the guardians of safety in childbirth; only they have the experience and training to achieve safe birth outcomes, and the introduction of non-medically led maternity services would threaten the health and safety of mothers and babies."¹¹⁸⁸ Obstetric discourses generated in this critical review were: 'modern medicine knows best'; 'women would be best served to listen to the experts'; 'the demonisation of women who choose to birth naturally'; and 'at least you have a healthy baby'.¹¹⁸⁹ This study of Australian newspapers also identified obstetric discourses which vilified midwives attending homebirth and included the statements "midwives act irresponsibly when attending a woman birthing at home and homebirth is a return to times past where mothers and babies died in vast numbers".¹¹⁹⁰

Another area of conflict in relation to birthing ideologies and a major factor that affects women's autonomy and their human rights during pregnancy and childbirth, is the perceived conflict between maternal autonomy and the rights of the foetus. The technocratic medical model mainly focuses on the physical aspects of pregnancy and the birth of a healthy baby. As previously discussed in this thesis, medical technology such as ultrasound, enables the foetus to be monitored externally. This supports the notion that the woman and foetus are separate, leading to some health professionals believing that it is ethically and morally justifiable to attempt to intervene against the wishes of the woman if

¹¹⁸⁵ Mcintryre, Meredith J, Karen Francis, and Ysanne Chapman. 2011. "Shaping Public Opinion on the Issue of Childbirth: A Critical Analysis of Articles Published in an Australian Newspaper," *BMC Pregnancy and Childbirth* 11 (47).

¹¹⁸⁶ Ibid.

¹¹⁸⁷ Ibid.

¹¹⁸⁸ Mcintryre, Francis, and Chapman, "Shaping Public Opinion on the Issue of Childbirth: A Critical Analysis of Articles Published in an Australian Newspaper."

¹¹⁸⁹ Ibid.

¹¹⁹⁰ Ibid.

the foetus is thought to be at risk. This might occur, for example, where a woman chooses to birth at home despite having risk factors that would deem her unsuitable for homebirth within the medical model.¹¹⁹¹ In contrast to the technocratic medical model, the holistic midwifery model rejects the biomedical idea that a woman's body is a machine with the baby a product of the machine. The social midwifery model is based on the premise that the mother and baby form one integral and indivisible unit until after the birth and if the emotional and physical needs of the mother are met, then the baby's needs are also met. Due to the different ideologies described in this thesis and other literature, the perceived risks can lead health professionals to challenge women's right to autonomous decisions regarding their birth and maternity care. A recent meta ethnography explored the views, attitudes and experiences of midwives caring for women who make unconventional birth choices, which they defined as choices that fall out of national clinical guidelines.¹¹⁹² Feeley and colleagues found that their participants were a "certain type of woman", educated and independent, who wanted to avoid intervention and avoid a repeat of previous traumas.¹¹⁹³ The analysis also demonstrated that the midwives displayed conflicting views of maternal autonomy and although they agreed in principle that women had the right to make their own decisions, including going against medical advice, midwives working within the institutions expressed concern about the childbearing woman's decision making and the rights of the foetus. In contrast PPMs continued to support women's autonomy, even when for example, they chose to decline transfer from home to hospital for foetal problems.¹¹⁹⁴

Autonomy is another important theme that is identified in the literature relating to women's reasons for giving birth unattended by health professionals. Some women who freebirth state that true informed consent is not possible within the hospital environment, as women's choices are limited, and their decisions are often not supported, with women reporting bullying, coercion and threats if they do not comply with hospital policies.¹¹⁹⁵ Women stated that shared decision-making with midwives was an illusion. Unequal

¹¹⁹¹ Murphy-Lawless, *Reading Birth and Death: A History of Obstetric Thinking*; Toohill et al., 2019. "Trauma and Fear in Australian Midwives," *Women and Birth*, 32 (1): 64-71; Rigg et al., "Why Do Women Choose an Unregulated Birth Worker to Birth at Home in Australia: A Qualitative Study."

¹¹⁹² Feeley, Claire, Gill Thomson, and Soo Downe. 2019. "Caring for Women Making Unconventional Birth Choices: A Meta-Ethnography Exploring the Views, Attitudes, and Experiences of Midwives," *Midwifery* 72 (May): 50-59.

¹¹⁹³ Ibid.

¹¹⁹⁴ Ibid.

¹¹⁹⁵ Plested and Kirkham, "Risk and Fear in the Lived Experience of Birth without a Midwife"; Sassine, "The Needs and Experiences of Women Who Choose Homebirth in Australia: A National Survey."; Feeley et al., 2015. "Why Do Some Women Choose to Freebirth? A Meta-Thematic Synthesis, Part One," *Evidence based Midwifery* 13 (1): 4-9.

relationships were identified, with midwives seen as 'permission givers' and pregnant women as 'permission askers'.¹¹⁹⁶ Moreover, for some women they believe true autonomy is only attainable without a health professional present at the birth.¹¹⁹⁷

Women's autonomy and choices during pregnancy and birth can also be influenced by the perception of risk. The medical model sees birth as risky with the risks coming from the birthing body, whereas the women who believe in the holistic model of midwifery care believe that childbirth is inherently safe and risk arises from the medicalisation of birth and unnecessary interventions.¹¹⁹⁸ Cameron argues that to maintain the autonomy of the birthing woman, the concept of risk itself should become part of the dialogue that occurs between a woman and her caregiver, including the perceptions of what constitutes the most risk or the most acceptable risk in birth.¹¹⁹⁹

Multiple studies demonstrate that midwives recognise a mismatch between maternity services and what women want.¹²⁰⁰ The woman's right to choose how, where and with whom to birth are not being respected by the Australian maternity system and this contributes to midwives questioning their own professional and ethical boundaries.¹²⁰¹

¹¹⁹⁶ Hill, M. "I Was Not Allowed": The Words That Steal Our Birth Power."

¹¹⁹⁷ Freeze, R. 2008. "Born Free: Unassisted Childbirth in North America", PhD, University of Iowa; Feeley, Thomson, and Downe, "Caring for Women Making Unconventional Birth Choices: A Meta-Ethnography Exploring the Views, Attitudes, and Experiences of Midwives"; Feeley et al., "Why Do Some Women Choose to Freebirth? A Meta-Thematic Synthesis, Part One"; Jackson, Dahlen, and Schmied, "Birthing Outside the System: Perceptions of Risk Amongst Australian Women Who Have Freebirths and High-Risk Homebirths"; Rigg et al., "Why Do Women Choose an Unregulated Birth Worker to Birth at Home in Australia: A Qualitative Study."

¹¹⁹⁸ Davis-Floyd, *Ways of Knowing About Birth: Mothers, Midwives, Medicine and Birth Activism*; Holten, Lianne, and Esteriek de Miranda. 2016. "Women's Motivations for Having Unassisted Childbirth or High-Risk Homebirth: An Exploration of the Literature on 'Birthing Outside the System'," *Midwifery*, 38 (July): 55-62; Plested and Kirkham, "Risk and Fear in the Lived Experience of Birth without a Midwife."

¹¹⁹⁹ Cameron, H. 2012. "Expert on Her Own Body: Contested Framings of Risk and Expertise in Discourses on Unassisted Childbirth." Lakehead University.

¹²⁰⁰ Jackson, Dahlen, and Schmied, "Birthing Outside the System: Perceptions of Risk Amongst Australian Women Who Have Freebirths and High-Risk Homebirths"; Dahlen, Jackson, and Stevens, "Homebirth, Freebirth and Doulas: Casualty and Consequences of a Broken Maternity System."; Davison, "The Relationship is Everything: Women's Reasons for, and Experience of Maternity Care with a Privately Practising Midwife in Western Australia."; Hunter, "The Experiences of Privately Practising Midwives in Australia Who Have Been Reported to the Australian Health Practitioner Regulation Agency: A Qualitative Study"; Sassine, "The Needs and Experiences of Women Who Choose Homebirth in Australia: A National Survey"; Toohill et al., "Trauma and Fear in Australian Midwives"; Feeley et al., "Why Do Some Women Choose to Freebirth? A Meta-Thematic Synthesis, Part One."

¹²⁰¹ Reed, Rachel, Jennifer Rowe, and Margaret Barnes. 2016. "Midwifery Practice during Birth: Ritual Companionship." *Women and Birth* 29 (3): 269-78; Toohill et al., "Trauma and Fear in Australian Midwives," *ibid.* 32.

As previously discussed in Chapter Five, mainstream maternity care in Australia is based on a fragmented system wherein women will be cared for by multiple doctors and midwives.¹²⁰² In recent years there has been a move to incorporate more midwifery-led options and increased continuity of care, however, these are still delivered within the medical model of birth and are difficult to access for some women, particularly women with increased medically defined risk factors.¹²⁰³ Medicalisation of birth and the increased risk of interventions are a recurring theme in the literature on women's decision to birth outside the system. Some women are increasingly rejecting midwives as care givers as they believe midwives are unable to provide care that women perceive as uniquely tailored to their own needs and wants. There is a growing mistrust of midwives, because they are perceived by some women to be accepting of the medical model of care with the institution's needs rather than the woman's needs being paramount.¹²⁰⁴

Women who have freebirths and high risk homebirths also perceive professional guidelines as serving the needs of the healthcare professionals rather than women.¹²⁰⁵ In the context of excessively high rates of medical intervention, as seen in Australia and other parts of the world, women who chose freebirth or a homebirth with an unregulated health worker believe that the risk of complications during a hospital birth are higher than the risk of an unassisted homebirth.¹²⁰⁶ Some women fear a cascade of interventions once they enter an institutional place of birth therefore they are perceived as dangerous places. If these women cannot get registered midwives to support them in their choices, then the default is not to go into the mainstream system.¹²⁰⁷

¹²⁰² Tracy et al., 2013. "Caseload Midwifery Care versus Standard Maternity Care for Women of Any Risk: M@Ngo, a Randomised Controlled Trial."

¹²⁰³ Dahlen, Jackson, and Stevens, "Homebirth, Freebirth and Doulas: Casualty and Consequences of a Broken Maternity System."; Sassine, "The Needs and Experiences of Women Who Choose Homebirth in Australia: A National Survey"; Tracy et al., 2013. "Caseload Midwifery Care versus Standard Maternity Care for Women of Any Risk: M@Ngo, a Randomised Controlled Trial."

¹²⁰⁴ Rigg et al., "Why Do Women Choose an Unregulated Birth Worker to Birth at Home in Australia: A Qualitative Study"; Feeley et al., "Why Do Some Women Choose to Freebirth? A Meta-Thematic Synthesis, Part One."

¹²⁰⁵ Cole et al., 2019. "'Trying to Give Birth Naturally was out of the Question': Accounting for Intervention in Childbirth," *Women and Birth* 32 (1): e95-e101; Reed, Rowe and Barnes, "Midwifery Practice During Birth: Ritual Companionship."

¹²⁰⁶ Rigg et al., "Why Do Women Choose an Unregulated Birth Worker to Birth at Home in Australia: A Qualitative Study"; Jackson, Dahlen, and Schmied, "Birthing Outside the System: Perceptions of Risk Amongst Australian Women Who Have Freebirths and High-Risk Homebirths."

¹²⁰⁷ Jackson, Dahlen, and Schmied, "Birthing Outside the System: Perceptions of Risk Amongst Australian Women Who Have Freebirths and High-Risk Homebirths"; Rigg et al., "Why Do Women Choose an Unregulated Birth Worker to Birth at Home in Australia: A Qualitative Study."

These concerns are highlighted by a recent Australian study which explored “the needs and experiences of women who choose homebirth in Australia”.¹²⁰⁸ Sassine’s survey had responses from 1835 participants from all over Australia and included 1065 women who had experienced a homebirth with a PPM. Sixty percent of women reported their most recent birth had occurred in the last one to five years. The respondents also included women who had chosen to freebirth or employ an UBW to attend their homebirth. The majority of women cited the reason for this choice was that they were unable to find a registered midwife to support them due to their pregnancy being perceived as “high risk”.¹²⁰⁹ Sassine described how other women reported that midwives in their area were already “booked up or on leave and a few women were initially able to find a midwife to support them but due to a difference of opinion, philosophy or a perceived lack of support, lost trust in the midwife [PPM] or the system [for government employed midwives]”.¹²¹⁰ These women also commented on their “conscious choice not to have a registered midwife as they felt they could not be fully supported by the midwife who is limited by restrictions and guidelines, and that the pressure and restrictions placed on the midwife’s practice meant pressure and restrictions on them”. In Sassine’s survey, 53% of women had medically defined risk factors associated with their medical history or previous birth, or had declined diagnostic or screening testing that would exclude them from government funded homebirth programs. If risk factors were present that would prevent registered midwives from attending their births at home, 56% of the women responded that they would plan to freebirth or find a UBW to support them.¹²¹¹ Again, this study demonstrates that reducing women’s access to homebirth with a registered midwife does not make birth safer. As previously discussed, some women perceive risks differently to the medically defined risks, and these women will not simply default to hospital births if legislation and restrictions prevent midwives from attending planned homebirths.

As has been shown in other research, defining women’s choices in childbirth by their medically defined risk status reduces women’s autonomy. Plested and Kirkham’s recent study examined the lived experience of UK women who chose to freebirth, with the specific purpose of examining the risk discourse experienced by these women.¹²¹² Women

¹²⁰⁸ Sassine, "The Needs and Experiences of Women Who Choose Homebirth in Australia: A National Survey."

¹²⁰⁹ Ibid.53.

¹²¹⁰ Ibid.55.

¹²¹¹ Ibid.59.

¹²¹² Plested and Kirkham, "Risk and Fear in the Lived Experience of Birth without a Midwife."

described their encounters with the mainstream maternity system as “stepping into a risk obsessed system driven by fear”.¹²¹³ The study found the theme of risk emerged with two parts “risk-talking” and “risk taker”.¹²¹⁴ “Risk talking” was defined as a powerful and coercive way of talking utilised by health professionals to direct, persuade and control women. Women who declined procedures or made what health professionals deemed to be ‘risky’ choices, were “excluded, vilified and in some cases punished for their choices”.¹²¹⁵ These ‘punishments’ included inappropriate referrals to social services and implied threats that the child could be removed by the state if they did not comply.¹²¹⁶ Plested and Kirkham found this risk discourse ultimately led to women feeling alienated by the maternity care system, with little power to negotiate their preferred choices.¹²¹⁷ The second aspect of risk was being a “risk taker” this had both positive and negative connotations. The negative label of “risk taker” was given to women by health professionals, however women also described themselves as “risk takers”, seeing this as a positive self-identifying marker which demonstrated the move from fear-based responses to risk, to a normalisation of risk within a personal context.¹²¹⁸

Standardised policies and guidelines based on medical risk ‘labels’ do not enable care to be individualised. A lack of individualised care can also be considered a risk by some women, this is demonstrated in the comments from the inquest into the death of Baby P. As described above, Baby P was the second twin at a 2011 homebirth in Perth, attended by Lisa Barrett (an UBW) and Theresa, one of the PPMs interviewed in this current study. Baby P’s mother took full responsibility for her decisions to employ an UBW and birth her twins at home:

Looking back on what occurred, Baby P’s mother accepted responsibility for the decision to attempt a natural birth at home. She said that she considered risk, including what she considered to be the risks of a hospital birth, and she was not willing to ‘take the risk’ of a hospital birth... She understood what she was doing at the time and made an informed choice.¹²¹⁹

¹²¹³ Plested and Kirkham, "Risk and Fear in the Lived Experience of Birth without a Midwife."

¹²¹⁴ Ibid.

¹²¹⁵ Ibid.33.

¹²¹⁶ Ibid.

¹²¹⁷ Ibid.

¹²¹⁸ Ibid.

¹²¹⁹ Linton, "Coroner's Report: Inquest into the Death of Baby P."77.

During the inquest, Baby P's parents also described their concerns about being unable to have their own midwife provide clinical care during Baby P's birth in hospital. They also had fears about being coerced into childbirth interventions that Baby P's mother did not want and concerns about the lack of support in their birth choices from mainstream care:

from the perspective of Baby P's parents, what they were being offered did not match their expectations for the birth of their twins. Although they could make choices not to accept the medical advice and attempt a vaginal delivery with no epidural in place, and intermittent monitoring only, their choice was not supported, and they were concerned they might experience pressure to change their choices at some stage... They also were not offered other things important to them such as Baby P's mother's choice of midwife to perform vaginal examinations and water immersion in a bath during the delivery. This is less than ideal and I fully accept it would have been distressing for Baby P's parents, given they had hoped to replicate the positive experience they had with the birth of their first child at home.¹²²⁰

During the inquest, the midwifery expert Dr Catling raised concerns about the lack of flexibility in the mainstream maternity system, highlighting how the lack of individualised midwifery care pushes women to birth 'outside of the system':

there ought to have been more flexibility from the hospital's perspective to try to understand and accommodate the requests of Baby P's parents...Dr Catling's comment appears to be based on the view that it would have been a safer situation for Baby P's mother to birth in hospital, on any terms she requested, even if they were contrary to obstetric advice, than to have a home birth.¹²²¹

Not only did this force Baby P's mother to look elsewhere for her birth choices to be supported, but when she was unable to find a PPM to support her, she turned to an UBW. Coroner Linton recognised this in her comments:

The other issue in this case follows on from what Dr Catling observed about a need for greater flexibility by the hospital...It is suggested that individualised clinical risk management rather than a hospital policy of pure risk avoidance would prevent people such as Baby P's parents from feeling the need to seek alternatives to hospital care...In this case, as I have noted above, I find that Baby P's mother's strong preference was always for a home birth, if she could find someone to assist her. However, I do accept that she might not have gone to the

¹²²⁰ Linton, "Coroner's Report: Inquest into the Death of Baby P."57.

¹²²¹ Ibid.59

lengths of engaging Ms Barrett if she had felt that her birth choices were more able to be accommodated and supported in hospital.¹²²²

If Baby P's parents had been able to birth their twins in hospital with their chosen midwife and had their birth choices supported by someone who shared the same philosophy, they may not have chosen to employ an UBW and birth the twins at home. As demonstrated in the findings of the current study, when Theresa and some of the other PPMs had visiting privileges at hospitals (from the late 1970s until the late 1990s), women experiencing more complicated pregnancies such as twins, breech and VBAC were supported by their PPM to birth in hospital. This example highlights the current lack of choices for women in WA.

In other areas of Australia, PPMs have been granted admitting rights, enabling the PPM to admit and provide clinical midwifery care to women who choose them as their maternity care provider. A recent Australian study demonstrated that PPMs with access to admitting rights and caring for women with 'all risks' in a public hospital setting was not only safe but had excellent outcomes.¹²²³ The study reported the outcomes for 529 women and newborns accessing PPM care with visiting rights in Queensland. Comparing their results with national data, the researchers found that women accessing the PPMs and choosing to birth in hospital were more likely to be having their first baby, to commence labour spontaneously (84.7% vs 52.7%), experience a spontaneous vaginal birth (79% vs 54%) and to give birth without pharmacological pain relief (52.9% vs 23.1%). Fewer babies required admission to the newborn care unit (5.1% vs 16%). The caesarean section rate for the women receiving care from their PPM in hospital was significantly lower than the national average (13% vs 32.8%).¹²²⁴ These results indicate that PPMs providing care to women is a safe and effective option and could potentially be a way to reduce the medicalisation of birth and the high caesarean rate in Australia.

The Queensland study also provided qualitative data, which explored the PPMs views about the structures and processes contributing to their excellent clinical outcomes.¹²²⁵ The six midwives in this Queensland study perceived the continuity of carer, that led to the

¹²²² Linton, "Coroner's Report: Inquest into the Death of Baby P."60.

¹²²³ Fenwick, F, H Brittain, and J Gamble. 2017. "Australian Private Midwives with Hospital Visiting Rights in Queensland: Structures and Processes Impacting Clinical Outcomes," *Women and Birth* 30 (6): 497-505.

¹²²⁴ Ibid.

¹²²⁵ Ibid.

positive relationships built on trust and their belief in normal physiological birth, was fundamental to the positive clinical outcomes. The PPMs described a commitment to woman-centred care that values normality in birth. The ability of the midwives to continue to provide care in hospital within their shared philosophy ensured continuity of carer was maintained. This also enabled the women to make informed decisions relating to their care.¹²²⁶ The PPMs stated that they were proud of their achievement and it was proof that the PPM model of care was a “quality model”. They also hoped that the results would encourage other midwives to consider working within the PPM model.¹²²⁷

Midwives’ satisfaction with their work is particularly relevant, as another recent mixed method study by Harvie, Sidebotham and Fenwick found that midwives in Australia consider leaving the profession due to their deep dissatisfaction with their role as midwives and the midwifery organisation within the fragmented maternity system that they are employed in.¹²²⁸ Midwives from all states in Australia were invited to complete a survey via an email distributed through the Australian College of Midwives. In the survey, midwives described how they were unable to provide woman-centred care within the fragmented and medicalised maternity system in Australia. Of the 1037 participants (which included midwives from all Australian states) who completed the survey, almost half of the midwives had considered leaving the profession in the previous six months, 6.1% indicated that it was unlikely that they would be in the profession in one year’s time, with this number increasing to 27.1% when asked if they would remain in the profession in five years. Themes that arose from the qualitative data (taken from open ended questions in the survey) identified how the midwives described their working environment as a nightmare where they were unable to be “the midwife I wanted to be” due to the fact that they were “servicing the needs of the institution” and not the women they were caring for. The medicalisation of birth and the “rampant rates of intervention” also contributed to their dissatisfaction with the profession.¹²²⁹ Respondents to the survey felt that their expertise and their role as a midwife was not valued or recognised and that the limited opportunities to provide continuity of carer also restricted their autonomy and scope of practice. This study’s findings contribute to the growing evidence indicating midwives’ deep

¹²²⁶ Fenwick, Brittain and Gamble, "Australian Private Midwives with Hospital Visiting Rights in Queensland: Structures and Processes Impacting Clinical Outcomes."

¹²²⁷ Ibid.

¹²²⁸ Harvie, Sidebotham and Fenwick, "Australian Midwives' Intentions to Leave the Profession and the Reasons Why." Ibid.

¹²²⁹ Ibid.

dissatisfaction with the fragmented maternity system and medicalisation of birth and the benefits for midwives working within a continuity of carer model.¹²³⁰ These two recent Australian studies also support the feelings of the PPMs in this current study who described how they felt unable to provide woman-centred care within the institutions.¹²³¹

Legislation to enable PPMs to provide care to their clients in hospital was included in the national maternity reforms,¹²³² therefore from 2010, women with access to PPMs with admitting rights should have been able to receive Medicare rebates for their births in hospital under the care of a PPM.¹²³³ Despite this legislation, many PPMs have been unable to gain access to the hospitals for their clients, and only a few PPMs across Australia have admitting rights to hospitals.¹²³⁴ Despite international research that supports the benefits of midwifery-led care for 'all risk' women,¹²³⁵ the lack of support for any midwifery-led models of care is apparent from the recent AMA submission in response to the draft Strategic Directions for Australian Maternity Systems.¹²³⁶ The AMA state that "ideology and practitioner-specific agendas should not determine maternity policies and services" and that "policies and services should be evidence-based".¹²³⁷ The AMA stated in their

¹²³⁰ Harvie, Sidebotham and Fenwick, "Australian Midwives' Intentions to Leave the Profession and the Reasons Why."; Fenwick, Brittain, and Gamble, "Australian Private Midwives with Hospital Visiting Rights in Queensland: Structures and Processes Impacting Clinical Outcomes," *ibid.*30; Ball, L, P Curtis, and M Kirkham. 2002. "Why Do Midwives Leave?" *Royal College of Midwives*; Curtis, Penny, Lynda Ball, and Mavis Kirkham. 2006. "Why Do Midwives Leave? (Not) Being the Kind of Midwife You Want to Be." *British Journal of Midwifery* 14 (1): 27-31; Pugh et al., 2013. "Western Australia Facing Critical Losses in its Midwifery Workforce: A Survey of Midwives' Intentions." *Midwifery* 29 (5): 497-505; Fenwick et al., "The Emotional and Professional Wellbeing of Australian Midwives: A Comparison between Those Providing Continuity of Midwifery Care and Those Not Providing Continuity."

¹²³¹ Harvie, Sidebotham and Fenwick, "Australian Midwives' Intentions to Leave the Profession and the Reasons Why." *Ibid*; Fenwick, Brittain, and Gamble, "Australian Private Midwives with Hospital Visiting Rights in Queensland: Structures and Processes Impacting Clinical Outcomes," *ibid.*30.

¹²³² Roxon, Nicola. 2010. "National Health (Collaborative Arrangements for Midwives) Determination 2010," ed. Minister for Health and Ageing; National Health (Collaborative Arrangements for Midwives) Determination 2013. Amendment made under Subsection 84(1) of the National Health Act 1953. "Explanatory Statement."; National Health (Collaborative Arrangements for Midwives) Determination 2010. Amendment made under Subsection 84(1) of the National Health Act 1953.

¹²³³ *Health Practitioner Regulation National Law (WA) Act 2010 (WA)*.

¹²³⁴ Fenwick, Brittain, and Gamble, "Australian Private Midwives with Hospital Visiting Rights in Queensland: Structures and Processes Impacting Clinical Outcomes."

¹²³⁵ Tracy et al., 2013. "Caseload Midwifery Care versus Standard Maternity Care for Women of Any Risk: M@Ngo, a Randomised Controlled Trial"; Sandall et al., "Midwife-Led Continuity Models of Care Compared with Other Models of Care for Women During Pregnancy, Birth and Early Parenting."

¹²³⁶ Australian Medical Association (AMA). 2018. "AMA Submission: Draft Strategic Directions for Australian Maternity Services."

¹²³⁷ *Ibid.*1.

submission that “The AMA does not support the emphasis on midwifery-led continuity of care”.¹²³⁸ These comments ignore the substantial amount of evidence that supports midwifery-led care as appropriate and beneficial for women and babies. Stating that ideology and practitioner-specific agendas should not determine maternity care is also hypocritical and demonstrates an AMA agenda which recommends medical practitioners as lead maternity care providers. The submission highlights how medical ideology defines all pregnancy and birth as pathological, as it also recommends that all women should be assessed by an obstetrician or other medical practitioner at their first antenatal visit.¹²³⁹ The AMA state this assessment will help prevent adverse outcomes and provide women with the most appropriate model of care.¹²⁴⁰ In recommending that all women are assessed by a medical practitioner, this submission demonstrates the “too much too soon” medicalisation of birth described in *The Lancet* series which can lead to childbearing women receiving unnecessary medical intervention.¹²⁴¹ It also restricts women’s autonomy, rather than women choosing the model of care they desire, the choice is provided for them following a medical assessment.

The lack of admitting rights for PPMs in WA is another barrier to women’s autonomy. As there are currently no PPMs in WA with admitting rights to hospitals, women are forced to birth at home if they want a PPM to provide clinical care for them. As previously discussed, the increase in scrutiny and legislation led many of the PPMs in Australia to be reported when they continued to support women outside of ‘recommended guidelines’. If women’s choices are perceived by the institutions as being unsafe or risky, PPMs, as described in this current study and other research, fear being reported if they provide midwifery care. Some women, therefore, will inevitably be denied their preference for a PPM to provide continuing care, which many regard as an unacceptable situation. The next section will discuss other forms of knowledge and how the PPMs in this study described using intuition in their midwifery practice.

¹²³⁸ Australian Medical Association (AMA). 2018. "AMA Submission: Draft Strategic Directions for Australian Maternity Services."2.

¹²³⁹ Ibid.3.

¹²⁴⁰ Ibid.3.

¹²⁴¹ Shaw et al., "Drivers of Maternity Care in High-Income Countries: Can Health Systems Support Woman-Centred Care?"

Other Ways of Knowing, Trust and Relationship-based Care

The Western medical system embodies the biases and beliefs of the society that created it.¹²⁴² According to Davis Floyd, “the Western society’s core value system is strongly orientated towards science, high technology, economic profit and patriarchally governed institutions”.¹²⁴³ Therefore the maternity system also reflects these values. In the 17th century, Descartes and other philosophers established the philosophical separation of the mind and body. This separation of mind and body enabled the body to be viewed as a machine. As the dominant society was male-centred and patriarchal, the male body was (and still is) viewed as the “prototype for the properly functioning machine”.¹²⁴⁴ The female body— as it deviated from the male standard— is therefore the defective model, it is inherently faulty and dangerously under the influence of nature. Due to this unpredictability, it is in need of constant manipulation by man. This ideology is the foundation for the technocratic, medical model of maternity care.¹²⁴⁵

Since the 17th century when the philosopher Descartes led the Enlightenment, the dominant knowledge system has been the masculine ‘rational’ and ‘scientific’ one.¹²⁴⁶ Polkinghorne describes scientific knowledge as the use of deductive reasoning to uncover patterns and consistencies among controlled observations.¹²⁴⁷ This positivist way of looking at the world is considered an objective, and therefore superior ‘way of knowing’. Other forms of knowledge have been dismissed as subjective and therefore, unscientific and irrational. This stance is particularly relevant when we consider other ‘ways of knowing’ that are so often ignored. Belenky et al adopt the metaphor of voice and silence as the unifying theme in their feminist writings on “women’s ways of knowing and the long

¹²⁴² Davis-Floyd, *Ways of Knowing About Birth: Mothers, Midwives, Medicine and Birth Activism*.4.

¹²⁴³ *Ibid.*.4.

¹²⁴⁴ *Ibid.*.5.

¹²⁴⁵ Davis-Floyd, *Ways of Knowing About Birth: Mothers, Midwives, Medicine and Birth Activism*; Katz Rothman, *In Labour: Women and Power in the Birth Place*; Katz Rothman, *Recreating Motherhood: Ideology and Technology in a Patriarchal Society*; Oakley, "Who Cares for Women? Science Versus Love in Midwifery Today."

¹²⁴⁶ Polkinghorne, D. 2004. *Practice and the Human Sciences: The Case for a Judgment-Based Practice of Care*, Albany: State University of New York Press; Katz Rothman, *Recreating Motherhood: Ideology and Technology in a Patriarchal Society*; Davis-Floyd, *Ways of Knowing About Birth: Mothers, Midwives, Medicine and Birth Activism*.

¹²⁴⁷ Polkinghorne, *Practice and the Human Sciences: The Case for a Judgment-Based Practice of Care*.19.

journey they must make if they are to put the power back into the known and claim the power of their own minds and voices".¹²⁴⁸

Historically, midwifery was considered 'women's work' and knowledge was something that was shared between the woman and the midwife.¹²⁴⁹ Before midwifery became regulated, the empirically-trained midwife gained experience from attending births and knowledge was passed on through generations of midwives.¹²⁵⁰ Storytelling was an important part of sharing knowledge, with both childbearing women and midwives sharing stories.¹²⁵¹ Belenky et al state that their research into the way women viewed themselves and their relationship to knowledge, drew them "back into a kind of knowing that had all too often been silenced by the institutions".¹²⁵²

The PPMs in this study spoke about the other forms of knowledge that they used in their practice. They described using their intuition, 'listening to their gut' and always listening to the woman. The PPMs stated that talking about these subjective 'ways of knowing' was difficult at times, as they are not accepted forms of authoritative knowledge within the institutions. Belenky et al state that "conceptions of knowledge and truth that are accepted and articulated today have been shaped throughout history by the male-dominated majority culture".¹²⁵³ As previously identified in Chapter Eight, Jordan defined authoritative knowledge as the knowledge on the basis of which decisions are made and actions are taken.¹²⁵⁴ However, the maternity system in the Western World only gives authoritative status to the knowledge that is gained from linear modes of scientific inductive and deductive reasoning. Conscious deductive reasoning, which can be logically explained and replicated is the most 'machine-like' (masculine) form of human thought, whereas knowledge gained in other ways is considered illogical, unable to be replicated and therefore has no value (feminine). Such 'lesser' forms of knowledge have often been associated with women's ways of knowing. As such, women and their unique

¹²⁴⁸ Belenky Mary Field et al., 1986. *Women's Ways of Knowing: The Development of Self, Voice, and Mind*. New York: Basic Books.19.

¹²⁴⁹ Towler and Bramall, *Midwives in History and Society*; Ehrenreich and English, *Witches, Midwives and Nurses: A History of Women Healers*.

¹²⁵⁰¹²⁵⁰ Towler and Bramall, *Midwives in History and Society*.

¹²⁵¹ Ehrenreich and English, *Witches, Midwives and Nurses: A History of Women Healers*; Towler and Bramall, *Midwives in History and Society*.

¹²⁵² Belenky et al., *Women's Ways of Knowing: The Development of Self, Voice, and Mind*.20.

¹²⁵³ Ibid.5.

¹²⁵⁴ Jordan, "Authorative Knowledge and Its Construction."

understandings and knowledge systems, have been systematically excluded from the discourses of medical science.¹²⁵⁵

All the midwives and the doctors interviewed in this study stated they used intuition as a form of authoritative knowledge. The *Oxford Dictionary* defines intuition as “the ability to understand something instinctively without the need for conscious reasoning”.¹²⁵⁶ Intuition is often described in terms such as gut feelings, inner knowing, a sixth sense, insight, instinct, inner feelings, hunches, premonitions or foreboding.¹²⁵⁷ Unfortunately, these abstract notions have in the past been associated with witchcraft, feminine knowledge and mysticism, which has allowed scientists to denigrate the legitimacy of the role of intuition in clinical judgement.¹²⁵⁸ Nurse researchers Benner and Tanner state that knowledge gained from intuition should not be confused with mysticism, as they believe that intuitive knowledge only available where a deep background understanding of the situation exists.¹²⁵⁹ Johns defined intuition as ‘tacit knowing’ and the use of reflection as a means of accessing previous experiences in order to develop a ‘reservoir of tacit knowing’.¹²⁶⁰ Other researchers have described intuition as a form of reflexive patterning, where initially conscious reflection results in unconscious matching of previous experiences.¹²⁶¹ However, the concept of having a reservoir of previous knowledge supports the notion that only ‘experts’ can be intuitive. Nursing research has used this definition in their explanation of the ‘know how’, a tacit knowledge based on an experiential knowledge, therefore the more experience the practitioner has, the more

¹²⁵⁵ Davis-Floyd, *Ways of Knowing About Birth: Mothers, Midwives, Medicine and Birth Activism*.

¹²⁵⁶ *Intuition Oxford Dictionary*.

¹²⁵⁷ Green, S. 2004. "Meanings and Experiences of Parent Intuition and Competence," PhD, Florida State University; Davis-Floyd, Robbie, and Elizabeth Davis. 1996. "Intuition as Authoritative Knowledge in Midwifery and Homebirth," *Medical Anthropology Quarterly* 10 (2): 237-269; Davis-Floyd, *Ways of Knowing About Birth: Mothers, Midwives, Medicine and Birth Activism*.

¹²⁵⁸ Green, "Meanings and Experiences of Parent Intuition and Competence."2.; Ehrenreich and English, *Witches, Midwives and Nurses: A History of Women Healers*.

¹²⁵⁹ Benner, P, and C Tanner. 1987. "Clinical Judgement: How Expert Nurses Use Intuition." *American Journal of Nursing* 87 (1): 23-32.; Benner P. 1984. *From Novice to Expert: Excellence and Power in Clinical Nursing Practice*. Menlo Park, California: Addison-Wesley.

¹²⁶⁰ Johns, C. 1998. "Opening the Doors to Perception," in *Transforming Nursing through Reflective Practice*, ed. C Johns and D Freshwater, Oxford: Blackwell Science.

¹²⁶¹ Mok, H and P Stevens. 2005. "Models of Decision Making," in *Decision Making in Midwifery Practice*, ed. M Raynor, J Marshall, and A Sullivan, Edinburgh: Churchill Livingstone-Elsevier; Rolfe, G. 1998. "Beyond Expertise: Reflective and Reflexive Nursing," in *Transforming Nursing through Reflective Practice*, ed. C Johns and D Freshwater, Oxford: Blackwell Science.

intuitive they can be. Polkinghorne argues that intuition is a judgement-based practice that places intuition in a continuum of knowledge.¹²⁶²

The PPMs in this study did not articulate how or what intuition was, they just stated that they used it as a form of knowledge within their midwifery practice. A midwife's intuition is considered part of a midwife's practice, although it is not valued as highly as other forms of knowledge. The midwifery profession does allude to the use of other forms of knowledge within midwifery practice as an accepted form of knowledge. For example, The Australian College of Midwives (ACM) midwifery philosophy states a midwife's practice is "informed by scientific evidence, by collective and individual experience, and by intuition"¹²⁶³ and the Statement of Values and Ethics of the Midwives Alliance of North America (MANA) also refers to intuition stating "We value the wisdom of midwifery, an expertise that incorporates theoretical and embodied knowledge, clinical skills, deep listening, intuitive judgment, spiritual awareness and personal experience".¹²⁶⁴

There is a small but growing body of research in relation to intuition and other forms of knowledge in midwifery. American midwife, Elizabeth Davis, and anthropologist, Robbie Davis-Floyd, began exploring the use of intuition in midwifery practice in the late 1990s. Their research studied intuition as an authoritative knowledge and was based on interviews with 22 American homebirth midwives, of which 17 were empirically-trained midwives and five were formally trained and certified nurse midwives (CNM).¹²⁶⁵ The intention of the study was not to demonstrate that midwives used intuition, as Davis and Davis-Floyd were aware that midwives already used intuition in their practice. The intention was to explore if intuition was used as authoritative knowledge (as described by Jordan) to make decisions.¹²⁶⁶ Davis-Floyd conducted most of the interviews with midwives at a MANA midwifery conference in 1992 and 1993, and the midwives were asked to talk about incidents surrounding birth in which intuition had played a role. Davis and Davis-Floyd stated their goal was to:

¹²⁶² Polkinghorne, *Practice and the Human Sciences: The Case for a Judgment-Based Practice of Care*.

¹²⁶³ Australian College of Midwives, "Midwifery Philosophy."

¹²⁶⁴ Midwives Alliance of North America (MANA), "The Statement of Values and Ethics of the Midwives Alliance of North America (MANA)."

¹²⁶⁵ Davis-Floyd and Davis, "Intuition as Authoritative Knowledge in Midwifery and Homebirth."

¹²⁶⁶ *Ibid.*; Jordan, "Authorative Knowledge and Its Construction."

elicit as many “intuition stories” from the midwives as we could, so that we could begin to gain a sense of if and how much these midwives relied on intuition, of the results in the actual births of their acceptance or rejection of intuitive messages, and of their feelings about the value or usefulness of intuition as a diagnostic tool and guide to action—in other words, as a form of authoritative knowledge.¹²⁶⁷

An additional 20 stories were gathered at a workshop on intuition run by Davis at the 1993 MANA conference. Davis and Davis Floyd state that although they cannot be sure what role the workshop and the interviews played in the midwives’ opinions and ideas about intuition, the fact that the researchers were considered authoritative figures and were focusing their research on intuition “no doubt helped to validate or to enhance the idea of intuition as a legitimate source of authoritative knowledge”¹²⁶⁸ in the minds of the interviewees. Davis and Davis-Floyd found that the midwives they spoke to were highly skilled and competent in technical and biomedical skills and were able to use all knowledge in their decision making. The authors state that the midwives were “experts at balancing the protocols and demands of technically obtained information with their intuitive acceptance of women’s uniqueness during labour and birth”.¹²⁶⁹ Davis and Davis-Floyd concluded that the midwives considered intuition to be a source of authoritative knowledge within their practice and all the interviewees stated that learning to trust their intuition was an ongoing process. The data demonstrated that there was a difference in the way the empirically trained midwives and the formally trained clinical nurse midwives (CNMs) felt about the use of intuition. The CNMs began by regarding intuition with mistrust, then moved through lived experience into trust and the empirically trained midwives began with trusting intuition and then confirmed this trust in intuition through lived experiences.¹²⁷⁰ The experiences of PPMs interviewed for this study reflect and confirm the findings of the American study. When the intuition was validated by the outcome of the birth and the support of other midwives, this strengthened the midwives use of intuition in their practice. One of the CNMs in Davis and Davis-Floyd’s study told a story about a case when her intuition told her there was a problem, however the objective data indicated that all was well, and as her intuitive knowledge was not valued it was not acted upon:

¹²⁶⁷ Davis-Floyd and Davis, "Intuition as Authoritative Knowledge in Midwifery and Homebirth."245.

¹²⁶⁸ Ibid.245.

¹²⁶⁹ Ibid.260.

¹²⁷⁰ Ibid.249.

I had a situation where I had all the objective data for a really nice birth... But the whole time my heart and chest were telling me “things are not going right”. And I was trying to get my physician back up to intervene and he was saying, “based on these objective criteria, things are going to be okay” and they were not... the baby was born with Apgars of 2 and 2.¹²⁷¹

Valuing one form of knowledge over another can have negative consequences, as Jordan states “to legitimise one kind of knowing devalues, often totally dismisses, all other ways of knowing, those who espouse alternative knowledge systems are often seen as backward, ignorant, or naïve troublemakers”.¹²⁷²

The CNMs interviewed in Davis and Davis-Floyd’s study reflected on how important apprenticeship-based training was for midwives. She believed that midwives with the same philosophy and training would listen and validate the intuitive knowledge and therefore give it authoritative status:

I think we need to listen to our intuition, and we need to keep apprenticeships so we can talk to each other during these decisions. If you can say to other midwives you’re working with “I’m having a bad feeling about this” even though everything else—all the objective criteria—look good, you need to trust those feelings. That’s what I’ve learned.¹²⁷³

Interestingly, research on what being an ‘expert’ midwife entails has demonstrated that caregivers who are defined as ‘experts’ use intuition in their care of childbearing women. Berg and Dahlberg’s 2001 study of Swedish midwives’ care of high-risk women during pregnancy, childbirth and early parenting, demonstrated that expert midwives used knowledge that they described as “sensitive knowledge” alongside the more accepted “theoretical” (scientific) knowledge.¹²⁷⁴ The ten midwives in this Swedish study spoke about the importance of developing a relationship with the woman and their belief in the natural process of birth even with women who had risk factors. The midwives described how good knowledge was essential in the care of women at high risk or with obstetric complications.¹²⁷⁵ They described this good knowledge as:

¹²⁷¹ Davis-Floyd and Davis, "Intuition as Authoritative Knowledge in Midwifery and Homebirth."250.

¹²⁷² Jordan, "Authorative Knowledge and Its Construction."2.

¹²⁷³ Davis-Floyd and Davis, "Intuition as Authoritative Knowledge in Midwifery and Homebirth."250.

¹²⁷⁴ Berg, M, and K Dahlberg. 2001. "Swedish Midwives' Care of Women Who Are at High Obstetric Risk or Who Have Obstetric Complications." *Midwifery* 17 (4): 259-66.

¹²⁷⁵ Ibid.

good theoretical obstetric and medical knowledge, good practical experience and 'sensitive knowledge,' a developed ability to use one's senses. Knowledge became embodied, lived out and thus a part of daily work, when it was integrated within the midwife. It developed over time and increased with extended working experience. Midwives also spoke about a more integrated level of embodied knowledge, which could develop as professional experience increased... It was called 'intuition' by several midwives and was seen as an unparalleled tool to understand and determine a woman's condition and needs... It could also be expressed as 'sense of worry or uneasiness' or as 'feeling that things were not quite right'.¹²⁷⁶

Berg and Dahlberg believed that the midwives in their study needed to be courageous in using their intuition as a form of knowledge due to its lack of credibility in the mainstream maternity system.¹²⁷⁷ All the midwives in their study described the use of intuition as a legitimate form of knowledge that was used alongside their other 'expert' midwifery skills.¹²⁷⁸ Kennedy conducted a Delphi study with 64 'expert' midwives and 71 recipients of midwifery care in an attempt to achieve consensus on dimensions of exemplary care.¹²⁷⁹ This American study identified the dimensions of exemplary care as: therapeutics (how the midwife decided to use specific therapies in practice), caring (the midwife's relationship with the woman and her family) and profession (how the profession of midwifery was enhanced by exemplary practice).¹²⁸⁰ A follow up study to substantiate the findings was conducted with 11 midwives who took part in the original study. Many of the midwives used the term "the art of doing nothing" to describe a process of care that entered on the midwife's presence with the woman during labour and birth and the creation of an environment which supported pregnancy and birth as a normal physiological process.¹²⁸¹ The midwives described using intuition within their normal midwifery practice and acknowledged the strong relationship that developed between the midwife and the woman which enabled them to use these other ways of knowing.¹²⁸²

A meta-synthesis by Downe, Simpson and Trafford explored the accounts of midwifery skills during labour and birth, and the practices, beliefs and philosophies by non-

¹²⁷⁶ Berg and Dahlberg, "Swedish Midwives' Care of Women Who Are at High Obstetric Risk or Who Have Obstetric Complications."263.

¹²⁷⁷ Ibid.

¹²⁷⁸ Ibid.

¹²⁷⁹ Kennedy, Holly. 2002. "A Model of Exemplary Midwifery Practice: Results of a Delphi Study," *Journal of Midwifery and Women's Health*, 45 (1): 4-19.

¹²⁸⁰ Ibid.

¹²⁸¹ Kennedy, "A Model of Exemplary Midwifery Practice: Results of a Delphi Study."

¹²⁸² Ibid.

physician practitioners who were termed expert, exemplary, excellent or experienced.¹²⁸³

The findings of this study suggested that the “overlapping concepts of wisdom, skilled practice and enacted vocation may offer a theory of expert intrapartum non-physician maternity care”.¹²⁸⁴ The concept of wisdom was synthesised from the themes of ‘education through training and experience’ and ‘knowledge’. The authors stated that the themes “seemed to coalesce into something that was beyond intellectual knowledge, years of experience or book learning education”. Using the following quote by Meeker (1981), Downe, Simpson and Trafford summarize their use of the term wisdom:

a state of the human mind characterised by a profound understanding and deep insight. It is often, but not necessarily accompanied by formal knowledge. Unschooled people can acquire wisdom, and wise people can be found among carpenters, fisherman, or housewives.

Wherever it exists, wisdom shows itself as a perception of the relativity and the relationships among things. IT is an awareness of wholeness that does not lose sight of particularity or concreteness, or of the intricacies of interrelationships. (Meeker, 1981).¹²⁸⁵

Downe and associates identified the theme ‘Skilled practice’ as made up of reflective competence, confidence, judgement and the capacity to use technical skills with the aim of keeping birth normal. ‘Enacted vocation’ encapsulated the values of belief, trust and courage with the use of intuition and connected companionship. ‘Belief’ included both the belief in the woman’s capacity to give birth and the process of physiological childbirth. ‘Trust’ was a “consequence and a cause of the midwives’ strong belief in normality”.¹²⁸⁶ The authors describe this trust between women and midwives as a “virtuous circle, reinforcing trust and belief in the midwife, and empowering the midwife to offer it back to the next labouring woman”.¹²⁸⁷ ‘Connective companionship’ is described as more than just being present in the room with the labouring woman, but the essence of a relationship or connection the expert midwife has with the woman.¹²⁸⁸ The authors stated that as the practitioners in their review “became more expert, they appeared to (re)value and to

¹²⁸³ Downe, Soo, Louise Simpson, and Katriona Trafford. 2006 "Expert Intrapartum Maternity Care: A Meta-Synthesis," *Journal of Advanced Nursing* 57 (2): 127-40.

¹²⁸⁴ Ibid.137.

¹²⁸⁵ Ibid.134.

¹²⁸⁶ Downe, Simpson, and Trafford, "Expert Intrapartum Maternity Care: A Meta-Synthesis."135.

¹²⁸⁷ Ibid.136.

¹²⁸⁸ Ibid.136.

express qualities such as trust, belief and courage, to be more willing to act on gestalt intuition and to prioritise connected relationships".¹²⁸⁹

In this current WA study, the relationship that formed between the PPMs and the women they cared for became the foundation that everything else was built upon. The PPMs and doctors interviewed trusted each other's judgement. As intuition was considered an authoritative and valued knowledge, the PPMs would feel confident in expressing their use of this knowledge in their midwifery care. The PPMs relationships with each other, the doctors who supported them and the women they cared for were built upon a shared philosophy. This philosophy was the trust and belief in women and physiological birth. This premise recognises that the woman, not the midwife, is the expert; therefore, the midwife would listen to and acknowledge the woman's own embodied knowledge. All the PPMs and doctors in this study described listening to the woman and acknowledging concerns or assurances even if 'objective' knowledge was contradictory.

Increasingly, faith in the science and technology available in the birth environment within current maternity care settings has led women and their caregivers to trust machines rather than women's reported experience of their own observation. A common example is the woman who knows her labour is progressing rapidly, and states she needs to push her baby out, but as the midwives do not have the 'objective and scientific' evidence provided by doing a vaginal examination they do not listen to her.¹²⁹⁰ This classic scenario describes the failure to listen and acknowledge the woman's embodied knowledge. A recent international study conducted by researchers from Australia, the UK, New Zealand and the USA, used a web-based questionnaire to explore 'gut instinct' that something was wrong in women who identified that they experienced 'gut instinct' during pregnancy.¹²⁹¹ The findings showed that 110 (75%) of the 146 women who had a stillbirth experienced a 'gut instinct' that something was wrong during the pregnancy.¹²⁹² The authors state that many of the participants encountered "institutional barriers that they could not overcome, when narrating how they tried to articulate their concerns and seek intervention they

¹²⁸⁹ Ibid.136.

¹²⁹⁰ Lawrence-Beech and Phipps, "Normal Birth: Women's Stories".74. Downe, Soo. 2010. "Debates about Knowledge and Intrapartum Care," In *Essential Midwifery Practice: Intrapartum Care*, ed. Denis Walsh and Soo Downe, Oxford: John Wiley & Sons, Incorporated.

¹²⁹¹ Warland et al., 2018. "'They Told Me All Mothers Have Worries ', Stillborn Mother's Experiences of Having a 'Gut Instinct' That Something Is Wrong in Pregnancy: Findings from an International Case–Control Study," *Midwifery*, 62 (July): 171-176.

¹²⁹² Ibid.

commonly used words like “begged” and “pleaded”. This finding suggests there is a need for maternity care providers to always listen to a pregnant woman’s concerns and requests, addressing them appropriately”.¹²⁹³ The authors empathised with the importance of good quality communication between women and their care providers and suggest that “continuity of care may be beneficial to pregnancy outcome, as women’s concerns and experiences can be shared within a trusting professional-patient relationship”.¹²⁹⁴ The approach described in these examples sadly adheres to the technocratic medical model of care which distrusts knowledge that cannot be validated with technology and science.

The provision of individualised midwifery care as described by the PPMs and doctors in this thesis, is supported in Winter’s 2002 study of how independent midwives in Scotland assessed women’s progress during labour.¹²⁹⁵ Three main categories were identified from the in-depth interviews with six midwives. The first category, ‘knowing’ described the different types of knowledge, including intuition, that the midwives used to make decisions. The second category ‘physical knowledge’ included observations of various signs displayed by the woman during labour, and the third category was ‘knowledge of the woman in labour’.¹²⁹⁶ Similar to the findings of this current research, the midwives in Winter’s study described their relationship with the childbearing women as the foundation of their knowledge and shared how working outside of the constraints of the medicalised institutions enabled them to utilise a complex and diverse range of knowledge and skills.¹²⁹⁷ Olafsdottir’s study of six Icelandic midwives ‘inner knowing’ used storytelling to explore how midwives develop and use different kinds of ‘inner knowing’ and how the relationship the midwife had with the woman impacts this knowing.¹²⁹⁸ The core narrative of this Icelandic study was the importance of the midwife being present with the woman at birth. The participating midwives also described how they developed a reciprocal relationship with the women, using and developing different types of knowledge which included “an

¹²⁹³ Warland et al., ““They Told Me All Mothers Have Worries ”, Stillborn Mother’s Experiences of Having a ‘Gut Instinct’ That Something Is Wrong in Pregnancy: Findings from an International Case–Control Study.”174.

¹²⁹⁴ Ibid.176.

¹²⁹⁵ Winter, C. 2002. "The Progress of Labour: Orderly Chaos? How Do Independent Midwives Assess the Progress of Labour?" Masters, University of Dundee, Scotland; Winter, C and M Duff. 2010. "The Progress of Labour: Orderly Chaos," in *Childbirth, Midwifery and Concepts of Time*, ed. Christine McCourt, New York: Berghahn Books.

¹²⁹⁶ Winter, "The Progress of Labour: Orderly Chaos? How Do Independent Midwives Assess the Progress of Labour?"

¹²⁹⁷ Ibid.; Winter and Duff, "The Progress of Labour: Orderly Chaos."

¹²⁹⁸ Olafsdottir, O.A. 2011. "An Icelandic Midwifery Saga Coming to Light "with Woman" and Connective Ways of Knowing" PhD, University of West London, UK.

inner knowledge of sensing if mother and baby are safe".¹²⁹⁹ The Icelandic midwives' stories often used a mixture of scientific and medical language even though they might be talking about intuitive midwifery skills, demonstrating their comfort with combining different types of knowledge.¹³⁰⁰ Their stories acknowledged the importance of technology and safe care but put it into context with also developing a trusting relationship with the woman. The midwives stories also emphasised the woman and the midwives belief in normal physiological birth.¹³⁰¹ Olafsdottir states that "when the midwife learns and listens to an inner voice, her connective knowing, she balances different ways of knowing and knowledge systems. Furthermore, she bases "her work on midwifery ideologies, preserving and promoting normal birth".¹³⁰²

Another study which supports the idea that midwives combine different types of knowledge in their practice, is a 2008 study by Lauren Hunter.¹³⁰³ Hunter explored the ways of knowing, described by American midwives through textual analysis of poems. The research findings showed that the midwives used three prominent ways of knowing: self-knowledge, grounded knowledge and informed knowledge.¹³⁰⁴ Self-knowledge was the midwife's belief in "what she knew, knowing what she believed and acting upon these beliefs".¹³⁰⁵ The midwives believed that the purpose of a midwife was to be 'with woman', they believed that birth was a "blessed event" and a normal process, and women were powerful and capable of giving birth.¹³⁰⁶ The midwives' self-knowing also allowed them to recognise the history of midwifery as a profession of 'women being with women'. They believed that women brought their own power, strength and embodied knowledge.¹³⁰⁷ Grounded knowledge was identified as the knowledge the midwives gained from the lived experiences of attending women during birth. Through grounded knowledge the midwives in Hunter's study were able to give individualised care and recognised the unique relationship between the woman and her midwife. Informed knowledge was knowledge that the midwife had learned from a respected source. The midwives acquired this form of

¹²⁹⁹ Olafsdottir, "An Icelandic Midwifery Saga Coming to Light "with Woman" and Connective Ways of Knowing."110.

¹³⁰⁰ Ibid.

¹³⁰¹ Ibid.

¹³⁰² Ibid.156.

¹³⁰³ Hunter, Lauren P. 2008. "A Hermeneutic Phenomenological Analysis of Midwives' Ways of Knowing During Childbirth," *Midwifery*, 24 (4): 405-15.

¹³⁰⁴ Ibid.

¹³⁰⁵ Ibid.410.

¹³⁰⁶ Ibid.410.

¹³⁰⁷ Ibid.411.

practical and objective knowledge during professional midwifery education, continuing education or some other respected source not experientially.¹³⁰⁸

A more recent Australian study explored how PPMs in Australia understand and use intuition. Reid conducted in-depth interviews with 12 PPMs and found that all the midwives used intuition in their practice.¹³⁰⁹ Two themes, 'trust' and 'knowledge' emerged from the data. Within the theme 'trust', the midwives talked about three aspects of trust that influenced their intuition. These three subthemes were; 'trust residing in their relationship with the woman'; 'trust in the woman themselves to take responsibility and make informed choices'; and 'trust in their own midwifery knowledge and skills, which included trusting their intuition'.¹³¹⁰ The second theme identified from the data was 'knowledge' and was described in four ways by the midwives;

as knowledge gained through formal midwifery education and training; social and cultural knowledge learnt or modelled from within the institution that created a negative bias towards normal labour and birth; these attitudes and biases had to be un-learnt when the midwives began working privately; and knowledge gained and developed through many years of practice and had elements of wisdom attached to it.¹³¹¹

Similar findings were found by Fry, in her study of seven UK independent midwives' experiences of using intuition.¹³¹² Again, the essential component in the midwives' use of intuition was the relationship "founded on a mutual connection and then developed throughout the time and continuity independent practice affords. This provides the midwives with a relational way of knowing the woman and her baby".¹³¹³ Fry believes that integral to the midwives' intuitive knowledge was the midwives' awareness and understanding of the woman, stating "utilising midwifery intuition appeared to be the midwife's close and ongoing relation with the woman".¹³¹⁴

¹³⁰⁸ Hunter, "A Hermeneutic Phenomenological Analysis of Midwives' Ways of Knowing During Childbirth."411.

¹³⁰⁹ Reid, F. 2014. "From Alchemy to Epistemology: Intuition and Private Midwifery in Australia" Masters of Midwifery, University of Technology, Sydney, Australia.

¹³¹⁰ Ibid.63.

¹³¹¹ Ibid.63.

¹³¹² Fry, Jane. 2016. "A Descriptive Phenomenological Study of Independent Midwives' Utilisation of Intuition as an Authoritative Form of Knowledge in Practice", PhD, Bournemouth University, UK.

¹³¹³ Ibid.189.

¹³¹⁴ Ibid.192.

It is evident from this study of PPMs in WA and the literature explored in this chapter that other forms of knowledge are utilised as authoritative knowledge within midwifery practice. Midwives use of intuition as a form of knowledge, is supported by the reciprocal and ongoing relationship between the childbearing woman and the midwife. This relationship is based on trust in both the woman and the midwife's knowledge, and the shared philosophy that birth is a normal physiological process. This philosophy also recognises that women are the experts of their own bodies and have their own intuition and 'ways of knowing'. Midwifery authoritative knowledge acknowledges and understands that there are multiple ways of knowing and multiple knowers. As midwives believe in holistic care, they are inclusive in their conceptualisation and practice of multiple ways of knowing, such as intuitive knowledge and embodied knowledge. Midwives and childbearing women are confident in using these forms of knowledge within their relationship as they are accepted and recognised as authoritative knowledge.¹³¹⁵

Summary

In this discussion chapter, the findings of this current study have been explored within the context of the relevant literature. The discussion was presented under the headings; The suppression of autonomous midwifery; the reduction of women's autonomy in childbirth; and other ways of knowing, trust and relationship-based care. The following chapter concludes this thesis and provides the study's limitations and strengths and the recommendations arising from the findings of this WA study of PPMs.

¹³¹⁵ Davis-Floyd and Davis, "Intuition as Authoritative Knowledge in Midwifery and Homebirth."; Davis-Floyd, *Ways of Knowing About Birth: Mothers, Midwives, Medicine and Birth Activism*.

Chapter Eleven – Looking Backwards; Moving Forward

Concluding Chapter

This chapter concludes this study of Privately Practising Midwives (PPMs) in Western Australia (WA). In this final chapter, a brief overview of the study's findings will be offered, and the study's limitations and strengths will be noted. Building on the discussion points highlighted in the previous chapter, recommendations for midwifery practice, education and suggestions for future research will be provided. The research question asked:

“How has private midwifery in WA evolved from 1830 to 2018, and what can midwives providing private midwifery care today, learn from the experiences of WA midwives who provided this type of midwifery care in the past?”

This post revisionist feminist historical study used oral history interviews and archival documents to reconstruct the history and explore the experiences of WA PPMs. To achieve the research objective the following questions were considered during data collection and analysis:

- What reasons were cited for choosing to work as a Privately Practising Midwife?
- How did the Privately Practising Midwife work? Did she provide care to women at home or in a hospital setting?
- What was the Privately Practising Midwife's experience of providing private midwifery care?
- Were there any barriers or benefits to providing private midwifery care? Did this change over time?
- What were the views, and experiences of hospital based midwives and doctors towards Privately Practising Midwives and women who used their services?
- What can midwives today learn from the experiences of Privately Practising Midwives?

The findings were presented in five chapters, beginning with the background and archival findings, followed by four chapters focusing on the oral histories of the study's participants. Chapter Five presented the archival data and provided the historical context of this study by exploring midwifery in WA from 1829 to 2018. Chapters Six to Nine presented an interpretation of the qualitative data taken from the in-depth interviews with fifteen midwives and three doctors. Similar themes were discovered throughout the history of PPMs in WA, providing rich data that described the experiences of these midwives. Four main interrelated themes and subthemes emerged.

The first major theme was 'Midwives in the community: the journey of the Privately Practising Midwife (PPM)' and its subthemes 'Building a relationship and providing continuity of carer' and 'Birth within the home'. This described how central to the experiences of the PPMs, was their desire to work within the community. An important part of being a community midwife was the ability to provide care in the community, usually in the childbearing women's own homes with the midwives providing care throughout the pregnancy, labour and birth and into the postnatal period. All the PPMs interviewed in this study were also nurses; however, the majority had initially trained as nurses, with the sole aim of becoming community midwives. By the 1950s when birth in hospital became the norm for WA women, those who chose a PPM as their birth attendant, continued to birth at home. All the midwives who were interviewed in this study stated that central to their work as a PPM was the individual relationship between themselves and the childbearing women they provided care for. The PPMs valued the opportunity to build a relationship with childbearing women and provide continuity of carer.

The second major theme was 'Trusting women and birth is central to midwifery philosophy' and its subthemes 'Medicalisation of birth' and 'Midwives use of intuition and the concept of authoritative knowledge'. The midwives and doctors interviewed as part of this study all spoke about having a distinct philosophy that was central to their practice of being a PPM. Midwives described their midwifery philosophy as being holistic and woman centred whereby the woman was always at the centre of care. This philosophy resulted in a partnership-based relationship, which enabled the midwife to provide the woman with relevant information enabling her to make informed choices. Therefore, all decisions relating to her care were made by the childbearing woman, not the midwife. A component of the midwifery philosophy shared by midwives in this study was the belief that birth was a normal physiological process, and this included the midwives trusting women's knowledge

and instinct to birth their babies. Midwives trusted birth itself as a normal physiological function that needed little, if any, intervention for the majority of women. All the midwives interviewed spoke of the childbearing woman being the expert, not the midwife, as they believed she knew her body better than the midwives or anyone else.

The sub theme 'medicalisation of birth' encapsulated the contrast between the medicalisation of birth reflected in the mainstream care options and the PPMs' philosophy of providing woman centred, individualised and holistic care through the support of physiological birth. For these midwives, the medicalisation of birth within the mainstream maternity system contributed to their seeking alternative ways of working as a midwife. The only way the PPMs believed they were able to provide midwifery care that was in keeping with their ideology, philosophy and beliefs around birth was by working as a PPM within the community, supported by the medical doctors who also subscribed to the same philosophy.

The second sub theme 'Midwives use of intuition and the concept of authoritative knowledge', described how the PPMs used intuition as a form of authoritative knowledge within their midwifery practice. PPMs within this study also described and valued woman's embodied knowledge and intuition. The women's knowledge was acknowledged by the midwives as valued knowledge, demonstrating the midwives' trust and belief in women as the experts in their bodies.

The third major theme identified in this study, 'Power and control of the Institutions' described how the midwives and doctors interviewed in this study felt that the mainstream maternity system in Western Australia, which they defined as a 'patriarchal' institution, sought to control women and midwives. The PPMs spoke at length about the politics of birth and the 'persecution and reporting of midwives' (which was identified as a subtheme). Those interviewed had either had experience of this themselves or had witnessed the persecution of other PPMs. With the increased surveillance and the vexatious reporting of PPMs, the midwives in this study felt it was getting harder to practice autonomously and to provide true holistic midwifery care to the women they supported.

The subtheme 'Legislation: jumping through the hoops and all the red tape' explored the PPMs concerns that the increasing restrictions on their scope of practice was reducing women's access to PPMs. The fear, stress and inability to meet the increasing requirements

led some PPMs to stop practising midwifery altogether and others to stop providing private midwifery care.

The final theme explored within this thesis was 'Breaking through the fear: continuing to support women and each other' and its two sub themes, 'Collaboration' and 'Getting educated and gaining power'. 'Breaking through the fear: continuing to support women and each other' describes how the PPMs and doctors in this study were at times persecuted, faced vexatious reporting and were often marginalised. Some had ceased practice altogether due to the stress and increasing legislation. However, despite these challenges they were adamant that they would continue to support women and each other to enable current PPMs to provide midwifery care that aligned with their philosophy. Their faith and belief in women and birth contributed to their decision to support each other, just as they shared the same passion for supporting and empowering women. The midwives interviewed in this study reflected on how the work of being a PPM was challenging but manageable because of the support they received from each other and the knowledge that they made a difference to the women they had provided midwifery care to.

The subtheme 'collaboration' explored how the PPMs and doctors interviewed in this study felt that collaboration was an essential part of safe care for women and babies. However, differences in ideology, the hierarchy of the professions and related power imbalances contributed to situations that were less than optimal for women, midwives and doctors. This subtheme also highlighted how despite legislative changes to support PPMs' access to hospitals and funding, there were still no PPMs with admitting rights in WA hospitals.

The final subtheme in this current study 'getting educated and gaining power' described how the PPMs and doctors interviewed had always been involved in education, both officially and unofficially. They felt that it was an essential part of their roles as health professionals. The PPMs and doctors felt that it was important that they educate the community and other health professionals about the impact of the medicalisation of birth on all women. They also wanted to influence the next generation of health professionals to change practice and promote woman-centred care and the midwifery (social, holistic) model of care.

Study Limitations and Strengths

A limitation of this study is that the interview participants were all from the same geographical area in Australia, as the study was conducted within the state of Western Australia. The majority of the midwives and all of the doctors who were interviewed, worked within the Perth metropolitan area. The sample of in-depth interviews conducted with PPMs was small, but this is appropriate based on the number of PPMs working throughout the time period (1970-2018). The data collected from the in-depth interviews reflects a time span of 40 years, providing a good example of midwives' experiences throughout this time period.

The aim of this research was to gain an understanding of the experiences of PPMs in a specific West Australian context. Therefore, the strength of this study is that it provides insight into the previously untold history of PPMs in WA, providing greater understanding of the experiences of these midwives. The rich descriptions provide an in-depth understanding of the challenges and triumphs of these midwives and the doctors who supported them and address a gap in the existing literature.

Recommendations for Midwifery Practice and Education

Midwifery led continuity of care is considered the gold standard of maternity care; research demonstrates that continuity of midwifery care has excellent outcomes for both women and babies.¹³¹⁶ Benefits to midwifery led continuity of care include the reduction of the likelihood of medical interventions during labour and birth, less preterm births, and a significant reduction in foetal loss prior to 24 weeks.¹³¹⁷ Midwifery led continuity of care decreases interventions, increases spontaneous vaginal birth and increases maternity care satisfaction rates.¹³¹⁸ Midwifery-led care has excellent outcomes for all risk women,¹³¹⁹ however women get most satisfaction when they are able to build a positive relationship with their midwife.¹³²⁰ In this context, rather than directing care, the midwife works with

¹³¹⁶ Sandall et al., "Midwife-Led Continuity Models of Care Compared with Other Models of Care for Women During Pregnancy, Birth and Early Parenting."

¹³¹⁷ Ibid.

¹³¹⁸ Ibid.

¹³¹⁹ Tracy et al., 2013. "Caseload Midwifery Care versus Standard Maternity Care for Women of Any Risk: M@Ngo, a Randomised Controlled Trial."

¹³²⁰ Davison, "The Relationship is Everything: Women's Reasons for, and Experience of Maternity Care with a Privately Practising Midwife in Western Australia."

the woman so that she can direct and control her own birthing experience, and in turn feel confident in her new role as a mother.¹³²¹ The proven benefits of midwifery-led care for 'all risk' women and the positive relationship formed between the woman and her midwife is also a cost-effective option.¹³²² Therefore it is essential that regardless of risk status, women are able to access one to one midwifery care, within the mainstream maternity system. With so many consistent benefits and positive outcomes prevailing from both international and Australian studies of midwifery led continuity of care, it is extremely concerning that this model of care only accounts for eight percent of the public maternity services currently provided within Australia.¹³²³ As discussed within this thesis, access to maternity care in Australia is dominated by a medical monopoly over health funding agreements and an over-medicalised medical model of care.¹³²⁴

The Australian Government states it is committed to the provision of a nationally consistent approach to implementation and delivery of maternity services, and increased access to midwifery care through continuity of care models.¹³²⁵ The expansion of a program which supports autonomous midwifery practice would provide more choice for women, which in turn would allow midwives increased access to a greater portion of healthcare funds that medical stakeholders have worked so hard to keep under their own control. The Australian Government's recent suggestions to increase women's access to midwifery led care in Australia,¹³²⁶ has been met with strong resistance from the Australia Medical Association (AMA), demonstrating the power and influence the AMA continues to have over the implementation of maternity models of care. This challenge is highlighted in the recent AMA submission in regard to the draft Strategic Directions for Australian Maternity Service, the AMA state that they do not support the emphasis on midwifery led continuity

¹³²¹ Davison, "The Relationship is Everything: Women's Reasons for, and Experience of Maternity Care with a Privately Practising Midwife in Western Australia."

¹³²² Toohill et al., 2012. "A Non-Randomised Trial Investigating the Cost-Effectiveness of Midwifery Group Practice Compared with Standard Maternity Care Arrangements in One Australian Hospital," *Midwifery*, 28 (6): 874-879.

¹³²³ Dawson et al., "Caseload Midwifery in Australia: What Access Do Women Have?"; Dawson et al., "Operationalising Caseload Midwifery in the Australia Public Maternity System: Findings from a National Cross-Sectional Survey of Maternity Managers."

¹³²⁴ Davis-Floyd et al., 2009. *Birth Models That Work*. Berkeley, California: California Press, Ltd.; Australian Government Department of Human Services. Medicare; Department of Health. 2018a. "Medicare Benefits Schedule Review Taskforce: Report from the Participating Midwife Reference Group."

¹³²⁵ Commonwealth of Australia. 2009. "Improving Maternity Services in Australia: The Report of the Maternity Services Review."

¹³²⁶ Australian Medical Association (AMA), "AMA Submission: Draft Strategic Directions for Australian Maternity Services."

of care within the draft.¹³²⁷ In their submission, the AMA demonstrates the medical discourse that ignores the Australian and international evidence that clearly demonstrates the excellent outcomes for both women and babies who received midwifery-led continuity of care. This AMA submission led to the removal of this emphasis in the draft Strategic Directions document.¹³²⁸

Despite consumer demand persistently exceeding supply, the reform of Australian maternity services and implementation of continuity of midwifery care models and access to Medicare benefits for women remains slow.¹³²⁹ At present a limited amount of private midwifery care is funded by the Australian public health care system or private health insurance companies. Furthermore, the Medicare rebates that women are entitled to for their private midwifery care does not reflect the care provided and there are no Medicare rebates for homebirths attended by PPMs. Another concern is the lack of private indemnity insurance (PII) available to PPMs providing care during labour and birth at home. The research indicates that more regulation of the practice of PPMs, rather than making birth safer, restricts women's access to safe and effective midwifery care. This approach not only reduces women's autonomy but has the potential to push homebirth underground with an increasing number of women giving birth unattended by any health professional and choosing to receive care from an unregistered birth worker (UBW) or to freebirth.

It is essential that the government provides women and their families with affordable options to access private midwifery, including the option to birth at home with a midwife of their choosing. Providing support for women choosing homebirth with a PPM through Medicare rebates would improve access to continuity of care with a registered midwife, as it would make it a viable option for women who at present are unable to access this due to the costs involved. The Australian government needs to find a solution to the lack of PII for PPMs attending homebirth. Continual extension of the exemption is not appropriate and contributes to the rhetoric that PPM attended homebirth are uninsurable and therefore dangerous. Providing PII and Medicare rebates for PPM attended homebirth would also

¹³²⁷ Australian Medical Association (AMA), "AMA Submission: Draft Strategic Directions for Australian Maternity Services."

¹³²⁸ Australian Health Ministers' Advisory Council. 2018. "Strategic Directions for Australian Maternity Services Draft November 2018."

¹³²⁹ Department of Health. "Medicare Benefits Schedule Review Taskforce: Report from the Participating Midwife Reference Group."

make this more attractive to midwives as a career option and more accessible to childbearing women, thereby making it a more acceptable mainstream pathway.

One of the barriers identified within this thesis and supported by the midwifery literature, is the lack of collaboration and respect between PPMs and other health professionals. Pathways for collaboration and referral between health professionals that are respectful and reciprocal should be legislated. Rather than the midwife being expected to access collaboration with GPs and obstetricians, medical professionals should be required to demonstrate referral pathways to support woman-centred midwifery led care. Collaborative agreements should be a requirement from both sides (midwifery and obstetric), and penalties for medical professionals and health services which do not provide workable collaboration agreements and admitting rights for PPMs should be introduced.

The role of regulation in midwifery is to protect the public, however as identified in this study and supported by other Australian research, the persecution and reporting of PPMs may be having the opposite effect.¹³³⁰ Therefore, it is essential that a balance is found that maintains professional standards for PPMs and ensures that they are held accountable for their practice, but that also validates PPMs in their attempts to support women to make autonomous decisions in regard to their choices during pregnancy, labour, birth and the postnatal period. This is particularly relevant when women are deemed to be making choices outside of recommended guidelines. At present there is no legislation that supports midwives who provide midwifery care to women who choose care outside of recommended guidelines.

At the time of writing (mid 2019), PPMs do not have admitting rights to hospitals in WA, despite the release of a Health Department Operational Directive mandating this measure in February 2014. This means that PPMs are currently unable to provide midwifery care to their clients in the hospital setting. Therefore, if women who are receiving continuity of midwifery care from a PPM wish to birth in hospital, they must be admitted under the care of the hospital obstetrician, with midwifery care provided by a midwife employed by the hospital. As discussed within this thesis, in these circumstances the PPM

¹³³⁰ Rigg et al., "Why Do Women Choose an Unregulated Birth Worker to Birth at Home in Australia: A Qualitative Study"; assine, "The Needs and Experiences of Women Who Choose Homebirth in Australia: A National Survey"; Hunter, "The Experiences of Privately Practising Midwives in Australia Who Have Been Reported to the Australian Health Practitioner Regulation Agency: A Qualitative Study" *ibid.*; Jackson, Dahlen and Schmied, "Birthing Outside the System: Perceptions of Risk Amongst Australian Women Who Have Freebirths and High-Risk Homebirths."

would be relegated to a support person with no rights to provide clinical care. This situation is unacceptable, as women who have employed a PPM to provide continuity of care should be able to be cared for by their chosen registered midwife during labour and birth, either at home or in a hospital setting. This inability to receive midwifery care from their midwives may influence women's decisions to birth at home because they want to receive care from the PPM that they have a trusting relationship with. Privately Practicing Midwives should therefore be given admitting rights to hospitals. If women choose to birth at home or decline recommended care, there is no safety mechanism for the midwife to continue to provide care to these women without risking the persecution and reporting that has been highlighted in this thesis and other research. Introducing a duty of care for all midwives may help protect midwives who continue to support women who are making an informed and autonomous choice to choose care outside of recommended guidelines. Supporting PPMs to attend women who choose to homebirth outside of recommended guidelines may also reduce the women choosing to birth with an UBW or to freebirth.

As discussed within this thesis, the Australian maternity system is based on the technocratic medical model, which only sees birth as normal in retrospect.¹³³¹ To support a holistic social model of maternity care it is essential that hospitals and maternity care providers review policies, guidelines and clinical practice to promote a woman-centred philosophy of childbirth.¹³³² Education of all maternity care providers should be ongoing and include post registration education on promoting and supporting women within the social holistic model of midwifery care and the promotion of normal physiological birth. A move to a community based, midwifery-led care model for all women, with pathways to access specialised obstetric support as needed, is a proven, cost effective way of providing safe woman-centred care.¹³³³ This approach ensures that women receive the appropriate level of care, reducing unnecessary interventions and promotes physiological birth with the associated benefits for women and babies. Education programs that inform all maternity health care professionals working in private and public hospitals and the community about

¹³³¹ Wagner, *Born in the USA: How a Broken Maternity System Must Be Fixed to Put Women and Children First*; Davis-Floyd, *Ways of Knowing About Birth: Mothers, Midwives, Medicine and Birth Activism*; Katz Rothman, *Recreating Motherhood: Ideology and Technology in a Patriarchal Society*.

¹³³² Wagner, *Born in the USA: How a Broken Maternity System Must Be Fixed to Put Women and Children First*; Davis-Floyd, *Ways of Knowing About Birth: Mothers, Midwives, Medicine and Birth Activism*.

¹³³³ Fenwick, Brittain, and Gamble, "Australian Private Midwives with Hospital Visiting Rights in Queensland: Structures and Processes Impacting Clinical Outcomes."

the role and scope of the midwife could encourage the acceptance of this model of care as a mainstream option.

Although midwifery is once again recognised as a separate profession in legislation, it is still governed by a board of nurses and midwives. For midwifery to be fully recognised as a profession independent from nursing a separate governing board could be established. A separate governing midwifery board, which includes representation from PPMs who provide homebirth services, would provide PPMs with more support, particularly during investigations. Therefore, another recommendation is the need to establish a separate midwifery board.

The majority of PPMs in this study became nurses prior to becoming midwives, not because they wanted to be nurses but because it was the only way to gain their midwifery qualification at the time. Historically, medicine and nursing established control over midwifery education which enabled them to dictate the type of education midwives received. This dominant medicalised model has contributed to the normalisation of the medical model of birth and the reduction of autonomous midwifery practice. In Australia, direct entry Bachelor of Midwifery programs do exist. However, they are not well supported within the maternity services (industry), where the dominant opinion is that midwives also need to have nursing qualifications.¹³³⁴ At present, there are no direct entry undergraduate midwifery education programs in Western Australia, however one university is submitting an application for accreditation to the Australian Nursing and Midwifery Accreditation Council to commence a graduate entry Master of Midwifery program. Potential applicants must have completed an undergraduate degree but not necessarily a nursing degree. Therefore, more education needs to be provided to industry and the wider community to promote the scope and role of the midwife, and to promote midwifery as a distinct separate profession to nursing. Universities could also consider offering direct entry undergraduate midwifery programs.

Although midwifery theoretical education is now delivered within the university, the majority of practical experience is gained within the medical model in the hospital environment. A move to a community-based education, would enable midwifery students to gain their clinical midwifery experience within a woman-centred— not institution centred—model of care. A move to community-based midwifery education would also

¹³³⁴ Leap, Nicky, Pat Brodie and Sally Tracy. 2017. "Collective Action for the Development of National Standards for Midwifery Education in Australia," *Women and Birth* 30 (3): 169-76.

normalise this model of care, again attracting the midwives of the future to see this as the mainstream model of care.

To summarise, the recommendations for midwifery practice and education from this current study are:

- All women regardless of risk status should have access to midwifery-led continuity of carer, including PPMs. To enable women to have the option of a PPM to provide continuity of care, this care model should be supported by government funding and private health insurance.
- Government Medicare rebates that adequately reflect the care provided by a PPM should be a priority. Medicare rebates should be offered for a complete care package not just individual items. A lump sum payment would reflect the importance and benefits of continuity of carer and reflect the benefits of relationship-based care. The payment should be given to the woman to enable her to choose her care provider. Place of birth should not be relevant to Medicare rebates.
- Affordable private indemnity insurance (PII) that includes labour and birth care at home should be available for PPMs.
- Admitting rights to hospitals for PPMs to enable them to admit and care for women under their own name. Public hospitals that do not provide admitting rights in a timely manner should be penalised. For example, this could be a part of the accreditation process for hospitals, with hospitals that do not provide opportunities for midwives to gain admitting rights not being able to achieve accreditation.
- Hospital and maternity care providers to review their policies and guidelines to promote individualised woman-centred care and promote the holistic social model of care.
- A move to a community based, midwifery-led care model for all women, with pathways to access specialised obstetric and hospital based support as needed.

- Collaborative agreements required for obstetrician and GPs to demonstrate their collaboration with midwives and promote the holistic social model of care and decrease unnecessary medical interventions in Australia.
- Legislative support for PPMs and other midwives who continue to provide care to women choosing care outside recommended guidelines.
- Strengthening and supporting midwifery as a separate profession from nursing with the establishment of a governing Midwifery Board.
- Education needs to be provided to industry (maternity services) and the wider community to promote the scope and role of the midwife, and to promote midwifery as a distinct separate profession to nursing and midwifery led care as a safe option for women.
- Universities in WA must have direct entry midwifery education programs that are accessible without the need of a nursing qualification.
- A move to a community-based education, to enable midwifery students to gain their clinical midwifery experience within a woman-centred holistic model of care.

Research Recommendations

This study is a post revisionist feminist historical study, which used oral histories conducted via in-depth interviews with PPMs and doctors and archival data to explore their experiences. Women's oral histories are important in feminist historical research as the voices of women have often been silenced in historical discourse.¹³³⁵ The notion that 'women speaking their truth' results in new knowledge of gendered lives grounded in women's experiences, is a central theme to feminist research.¹³³⁶ Midwives are predominantly women, caring for women. Feminist theory identifies reproduction as both the site of the woman's "worst exploitation and greatest power";¹³³⁷ therefore, any research relating to women and midwives must recognise the importance of feminist discourse. More feminist research into the experiences of midwives, particularly those

¹³³⁵ Damousi, "Does Feminist History Have a Future?"

¹³³⁶ Ramazanglu and Holland, *Feminist Methodology, Challenges and Choices*; Belenky et al., *Women's Ways of Knowing: The Development of Self, Voice, and Mind*.

¹³³⁷ Kaufmann, "Introducing Feminism."6.

midwives who are marginalised such as PPMs, is recommended. One of the areas highlighted in this current study, and supported by other research, is the power and control of the maternity service institutions and the persecuting and reporting of PPMs who do not subscribe to the medical ideology. Further research into the experiences of PPMs who have been reported to the Australian Health Practitioners Regulation Authority (APHRA) could be considered. Another concern highlighted in this current study was the lack of admitting rights to hospitals for PPMs. Therefore, research into why PPMs have been unable to gain admitting rights to hospitals in WA is also a recommendation.

Feminist narrative research brings to light a perspective of those involved in the phenomena under study. Midwifery research using narrative methodologies offers a familiar approach to participants, as storytelling is a natural way of sharing knowledge. Using narrative approaches to midwifery research places the midwife at the centre of the research, reinforcing women as the experts in birth and supports and places values on other forms of knowledge. Women and midwives in Australia are affected by the patriarchal medical ideology that surrounds pregnancy and birth. Research that recognises and values women and midwives' experiences can be central to building knowledge and can challenge the socially-constructed roles that are central to maintaining the dominant medical ideology.

In using oral histories and a feminist perspective, a storytelling approach was used in this study. Storytelling aims to rebalance the power relationship between researcher and participant by allowing the participant to tell their story; the researcher hands control of the content of the story to the interviewee. Research participants can tell their stories in their own way and reflect on their experience in their own time, without preconceived bias or constant disruption.

One of the findings of this current study was the PPMs use, and value of, intuition and other ways of knowing. Further research into how midwives use other ways of knowing in their practice and its association around the relationship between the midwife and the woman she is providing midwifery care to and/or the midwife's previous clinical experiences is recommended.

To summarise, the recommendations for further research from this current study are to conduct research into:

- Why PPMs have been unable to gain admitting rights to hospitals in WA.

- The experiences of WA PPMs who have been reported to APHRA.
- The use of storytelling in midwifery practice.
- The experiences of women and midwives who subscribe to the holistic social model of maternity care.
- The experiences of PPMs, to explore how the midwife-woman relationship influences knowledge development.
- The use of intuition and other ways of knowing in midwifery.

The PhD Journey: A Brief Self-Reflection

The journey of a PhD is so huge, it is difficult to put it into words. However, as a midwife there are no better ways to describe the process than in using the words of pregnancy and birth. The initial planning, the meeting with potential supporters, the care during the process, the transition, full of fear and doubt, the big push to completion and finally the end product in your arms!

The journey included so much, the anxieties, the opinions, the self-absorption, the fear, the pain, the pleasure and the tears of challenges and successes. I never imagined how hard it would be or how personal. I never imagined the level of support I would need or how my supporters would rise to the challenge, exceeding all my expectations. I pushed myself to my limit and in the process, I learnt that I am capable of so much.

I became an early riser, I learnt to run and during these early morning runs I did a lot of thinking, I thought about feminism and midwifery and the people I have interviewed and read about. The journey was so personal, these midwives' stories became my stories. I was so privileged to be told them and I hope that in recording them, others will learn from them. I have developed so much as a researcher, I have learnt so much, I am ready for the next challenge.

Final words: “The Problem is the Birth Machine is Out of Control” Marsden Wagner ¹³³⁸

The primary goal for any research is to provide insight into the phenomena under study and contribute to knowledge. This thesis fills a gap in knowledge in the history of Western Australian midwifery with an attempt to understand how autonomous midwifery practice is provided in the community by PPMs. The suppression of midwifery is not a new concept, however this study highlights that the dominance of the patriarchal medical model continues to suppress midwifery leading to a reduction of women’s autonomy. There is a need to act before midwifery as an autonomous profession ceases to exist in Australia.

¹³³⁸ Wagner, *Pursuing the Birth Machine: The Search for Appropriate Birth Technology / Marsden Wagner*.315.

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Appendix One – Participant Information Letter for Privately Practising Midwives (PPM)



Participant Information Letter for Privately Practising Midwives (PPM)

Looking back and moving forward: a history and discussion of privately practising midwives in Western Australia Introduction

My name is Clare Davison and I am a midwife. I am also studying at the School of Nursing, Midwifery and Paramedicine at Curtin University for a Doctoral Degree by research (PhD).

The overall aim of my study is to generate new and useful knowledge by documenting and discussing the history of private midwifery in WA. To do this I want to study the experiences, social pressures, values and attitudes of the Privately practising midwives (PPM) and others such as the families they cared for and health care professionals who may have worked with them.

Why am I doing this study?

The study aims to discover how private midwifery in Western Australia (WA) has evolved from 1830 to the present day and what can midwives providing private midwifery care today learn from the experiences of WA midwives who provided this type of midwifery care in the past.

Understanding the development and evolution of midwifery can help future directions of the profession.

What is involved in taking part in the study?

If you decide to take part in the study you will be asked to participate in an interview lasting approximately 60 minutes. This would preferably be face to face but if you are unable to do this it can take place over the telephone. During the interview you will be asked general information about yourself such as your age, when you left school, your work. You will then be asked to talk about your experience of working as a privately practising midwife. You will be asked some specific questions about your experiences during the interview. With your permission, the interview will be recorded using a digital voice recorder. Following analysis of the interview you may be telephoned to clarify any points you may have made during the interview. The interviews will be done at a time that is suitable for you and in a place where you feel comfortable.

What are the potential risks to taking part in the study?

A potential risk is that recalling a difficult or upsetting experience may cause distress. If this happens, the audio recorder will be switched off at your request and should you wish you can withdraw from the study. Details for counsellors will be provided should you wish to utilise these. These contact details are; Centre care; 9325 6644, centrecare.com.au (offers counseling in metropolitan areas, the southwest and rural areas); Lifeline 24/7 crisis line 131114; Gosnell's women's health and wellbeing service, 9490 2258.

What are the potential benefits to taking part in the study?

A potential personal benefit you may experience is the opportunity to tell your story; to reflect on and explore your experiences of providing private midwifery care. Your experiences will also contribute to the development of knowledge, which can aid maternity care providers in all areas to improve care and the services they provide.

Do I have to take part?

Participation in the study is voluntary. If you do not wish to take part or wish to withdraw at anytime you are free to do so. Any information provided by you will not be included in the study and will be destroyed if you withdraw.

Privacy

Historical research participants are usually not anonymous as the participants have been selected because of their identity, however it is entirely the participant's decision whether to have their name revealed or not and pseudonyms can be used if requested by participants.

If you wish to remain anonymous all the information provided by you will remain private and confidential. Only my academic supervisors and I will have access to your personal details. Any information that may identify you will be removed during transcripts of the interview if you desire and I will give you a false name. Results of the study may be published in professional journals and presented at conferences however the material will contain no identifiable information about you.

You will only be identified if prior consent is given.

Storage of information

All of the collected material will be stored in a locked filing cabinet for 7 years and then destroyed. The master computer containing personal details will be kept in a separate location to the interview transcripts. All files will be password protected. All data will be managed in accordance with the Australian National Health and Medical Research Council (NHMRC) guidelines.

Who has approved the study?

Ethical approval for this study has been granted by the committee for Human Research Ethics Committee at Curtin University.

Who to contact for more information about this study:

If you would like any more information, please do not hesitate to contact myself and/or one of my supervisors for this study. Our contact details appear at the end of this information sheet. My supervisors or I would be very happy to talk to you if you have any questions.

Clare Davison (PhD candidate)	0403 968409 or email clare.l.davison@student.curtin.edu.au clare.davison@gmail.com
Professor Yvonne Hauck	email y.hauck@curtin.edu.au Tel no. +61 8 9266 2076
Associate Professor Bobbi Oliver	email b.oliver@curtin.edu.au Tel no. +61 8 9266 3215

Who to contact if you have any problems about the organisation or running of the study?

This study has been approved by the Curtin University Human Research Ethics Committee (RHDS-193-15) The Committee is comprised of members of the public, academics, lawyers, doctors and pastoral carers. Its main role is to protect participants. You may contact the Ethics Officer on (08) 9266 9223 or the Manager, Research Integrity on (08) 9266 7093 or email hrec@curtin.edu.au.

What do I do if I would like to take part in this study?

If you would like to take part in this research study please read and complete the consent form provided with information sheet and return it in the envelope provided and I will contact you to make an appointment for interview.

THANK YOU

Appendix Two – Participant Information Letter for Health Professionals



Participant Information Letter for Health professionals

Looking back and moving forward: a history and discussion of privately practicing midwives in

Western Australia

Introduction

My name is Clare Davison and I am a midwife.

I am also studying at the School of Nursing, Midwifery and Paramedicine at Curtin University for a Doctoral Degree by research (PhD).

The overall aim of my study is to generate new and useful knowledge by documenting and discussing the history of private midwifery in WA. To do this I want to study the experiences, social pressures, values and attitudes of the Privately practicing midwives and others such as the families they cared for and health care professionals.

Why am I doing this study?

The study aims to discover how private midwifery in Western Australia (WA) has evolved from 1830 to 2014 and what midwives providing private midwifery care today can learn from the historical experiences of the midwives who provided this type of care. Understanding the development and evolution of midwifery can help future directions of the profession.

What is involved in taking part in the study?

If you decide to take part in the study you will be asked to participate in an interview lasting approximately 30-60 minutes. This would preferably be face to face but if you are unable to do this it can take place over the telephone. During the interview you will be asked general information about yourself such as your age, when you left school, your work. You will then be asked to talk about your experience of working with privately practicing midwives. You will be asked some specific questions about your experiences during the interview. With your permission, the interview will be recorded using a digital

voice recorder. Following analysis of the interview you may be telephoned to clarify any points you may have made during the interview. The interviews will be done at a time that is suitable for you and in a place where you feel comfortable.

What are the potential risks to taking part in the study?

A potential risk is that recalling a difficult or upsetting experience may cause distress. If this happens, the audio recorder will be switched off at your request and should you wish you can withdraw from the study. Contact details for counselors will be provided should you wish to utilize these.

What are the potential benefits to taking part in the study?

A potential personal benefit you may experience is the opportunity to reflect on and explore your experiences of working with privately practicing midwives. Your experiences will also contribute to the development of knowledge, which can aid maternity care providers in all areas to improve care and the services they provide.

Do I have to take part?

Participation in the study is voluntary. If you do not wish to take part or wish to withdraw at anytime you are free to do so. Any information provided by you will not be included in the study and will be destroyed if you withdraw

Privacy

If you wish to remain anonymous all the information provided by you will remain private and confidential. Only my academic supervisors and I will have access to your personal details. Any information that may identify you will be removed during transcripts of the interview if you desire and I will give you a false name. Results of the study may be published in professional journals and presented at conferences however the material will contain no identifiable information about you.

You will only be identified if prior consent is given.

Storage of information

All of the collected material will be stored in a locked filing cabinet for 7 years and then destroyed. The master computer containing personal details will be kept in a separate location to the interview transcripts. All files will be password protected. All data will be managed in accordance with the Australian National Health and Medical Research Council (NHMRC) guidelines.

Who has approved the study?

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Who to contact for more information about this study:

If you would like any more information, please do not hesitate to contact myself and/or one of my supervisors for this study. Our contact details appear at the end of this information sheet. My supervisors or I would be very happy to talk to you if you have any questions.

Clare Davison (PhD candidate) 0403968409
clare.davison@gmail.com

Professor Yvonne Hauck email y.hauck@curtin.edu.au
Dr Bri McKenzie email b.mckenzie@curtin.edu.au

Who to contact if you have any problems about the organisation or running of the study?

This study has been approved by the Curtin University Human Research Ethics Committee (RHDS-193-15). The Committee is comprised of members of the public, academics, lawyers, doctors and pastoral carers. Its main role is to protect participants. You may contact the Ethics Officer on (08) 92669223 or the Manager, Research Integrity on (08) 92667093 or email hrec@curtin.edu.au.



What do I do if I would like to take part in this study?

If you would like to take part in this research study please read and complete the consent form provided with this information sheet.

THANKYOU

Appendix Three – Consent Form for Research Participants



Consent Form for Research Participants

PLEASE NOTE THAT PARTICIPATION IN RESEARCH STUDIES IS VOLUNTARY AND PARTICIPANTS CAN WITHDRAW AT ANY TIME.

I

Given Names

Surname

have read the information explaining the study entitled

Looking back and moving forward: a history and discussion of privately practising midwives in Western Australia

- I have read and understood the information given to me.
- I have had the opportunity to ask questions and any questions I have asked have been answered to my satisfaction.
- I understand that the interviews will be audio recorded and transcribed
- I understand I may withdraw myself, and any information I may have provided during my participation in the study, at any stage, without any detriment to myself. All audio recordings and transcripts will be destroyed at the time of withdrawal.

Please indicate if you would prefer to remain anonymous and have a pseudonym provided

- I agree that research data gathered from the results of this study may be published, provided that names are not used

or

- I give consent for my name to be published Yes No Please circle

I agree to participate in this study

Signature Date.....

Address.....

Phone Number (H)..... (W).....

Mobile

Email.....

Researchers signature..... Date.....

Appendix Four – Interview Guide

Interview Guide

PPMs Interview questions

First of all, tell me about you!

1. why did/do you choose to work as a privately practising midwife?
2. How did/do the you work as a PPM? Did/do you provide care to women at home or in a hospital setting?
3. What was your experience of providing private midwifery care?
4. Were there any barriers or benefits to providing private midwifery care? Did this change over time?
5. What were the views, and experiences of hospital-based midwives and doctors towards you and other privately practising midwives and women who used their services?
6. What do you think midwives today can learn from your experiences?

Health professionals interview questions

First of all, tell me about you!

1. Have you worked with a privately practising midwife (PPM)?
2. How, in what capacity?
3. Were there any barriers or benefits to working with PPM's?
4. What your experience of working with the private midwife?
5. What were the views of your colleagues towards you working with the privately practising midwives and women who used their services? Can you give an example?
6. Did your experiences change over the time you worked with the PPM?
7. Will you continue to work with PPM's?

Women's' interview questions

1. What was it like receiving care from a privately practising midwife?
2. Can you offer some examples of what you liked about the care?
3. What made you decide to seek care from a privately practising midwife?
4. What reaction did you receive for this decision from your partner, family, and friends?
5. What reaction did you receive for this decision from other health professionals (eg your general practitioner)?