

**LEAVING YOUR DIGNITY AT THE DOOR: MATERNITY  
IN WELLINGTON 1950 - 1970**

**by**

**Jane Ellen Esther Stojanovic**

**A thesis submitted to the Victoria University of Wellington  
in partial fulfilment of the  
requirements for the degree of  
Master of Arts (Applied)  
in Midwifery**

**Victoria University of Wellington, New Zealand**

**2002**

## ABSTRACT

This thesis describes the maternity system in Wellington between 1950 and 1970 particularly from the perspectives of consumers and midwives.

Four women consumers who experienced maternity in Wellington and two midwives who worked in Wellington's maternity hospitals during this period provided their oral testimonies as the main primary sources for this study. The author's recollections of being a student nurse and a consumer in Wellington and other primary and secondary sources are used to substantiate, explore and explain the topic.

The study traces the sociopolitical changes in New Zealand maternity from 1900 to 1970 creating a backdrop against which Wellington's maternity system, including the women, the hospitals, the workforce, maternity practices and the childbearing process are illuminated using the insights of women and midwives who experienced them.

*"That's what this lady who had had her baby, said to me, she said, You lose your dignity when you have your baby",* was a comment from one of the interviewed women.

This took me back to student days when a common saying was 'You leave your dignity at the door when you go in to have a baby'. These comments suggested the title for this thesis.

The oral testimonies of the six participants described positive and negative aspects of their maternity experiences, but the three strong themes that arose from their accounts included 'being alone', 'lack of autonomy' and 'uncaring attitudes'.

## ACKNOWLEDGMENTS

The author wishes to express sincere appreciation to Dr. Pamela Wood, the academic staff and the administrative staff at Victoria University for their support and assistance in the development and preparation of this thesis. Special thanks also to Alison Dixon, Maralyn Foureux, Joy Bickley and Joan Skinner for their encouragement and support over the years, particularly during the 'rocky' times.

Thanks are also due to the Wellington Hospital Nursing Directorate at Capital Coast Health for allowing me to use the photograph from the Wellington Hospital Nursing Archive.

Very special thanks are due to the six women, consumers and midwives, who shared their memories so freely and were proud to claim them, Ruth Belton, Kathleen Brosnahan, Helen van Kampen, Ivanka Marta, Noeline Ruston and Mabs Le Page.

Thanks are also due to Elizabeth Jull, Jan Warren, Gloria Johnstone, Wendy Batterbee and my midwifery colleagues at Massey University for their support, listening skills and help with finding literary treasures. Particular thanks are also due to my daughters, Katarina for her skills in transcribing, Ana and my mother, Joyce, for listening to me. Thanks also to all the other members of the whanau who coped with me and 'my thesis'.

My late husband, Dragan Stojanovic deserves my most heartfelt acknowledgement for his unstinting support and faith in my ability, and for his belief in the ongoing benefits of education.

## TABLE OF CONTENTS

Abstract .....	ii
Acknowledgments .....	iii
List of figures .....	v
Glossary .....	vi
Chapter 1. Introduction .....	7
Chapter 2. Twentieth Century Maternity in New Zealand .....	26
Chapter 3. Women of Wellington .....	55
Chapter 4. Wellington Maternity; Bricks, Mortar and the Workforce .....	89
Chapter 5. The Childbearing Process .....	111
Chapter 6. Discussion .....	156
Appendices .....	167
References .....	iv

## LIST OF FIGURES

Figure 1. ‘Of such is the kingdom of heaven’ 1960s photograph. ....	61
Otaki Birthing Centre Ltd.	
Figure 2. The Willis Street Obstetric Hospital. 1949 .....	93
Alexander Turnbull Library, Wellington, N.Z.	
Evening Post Collection, No. 90567 1/2.	
Figure 3. Postnatal room St Helens Hospital. ....	100
L. Barber and R. Towers, <i>Wellington Hospital 1847 - 1976</i> .	
Figure 4. Photograph of Wellington Hospital, .....	103
Author’s Collection.	
Figure 5. Birthing woman in lithotomy position. (St Helens Hospital 1969).....	139
Wellington Hospital Archive. Capital Coast District health Board.	
Figure 6. ‘The four-hourly clock’	
F. Truby King, <i>Feeding and Care of Baby</i> , 1940. ....	155

## GLOSSARY

<b>Ambulation</b>	To walk about
<b>Anaesthesia</b>	The removal of pain.
<b>Analgesia</b>	The reduction of pain.
<b>Asepsis</b>	Without infection
<b>Cervical</b>	To do with the cervix which is the opening of the uterus, (also known as the neck of the womb).
<b>Diaper</b>	A folded cloth napkin.
<b>Dilation</b>	The opening or stretching open of tissue. In labour, the cervix is dilated by the baby's head.
<b>Epidural Anaesthesia</b>	A form of regional anaesthesia used in childbirth which involves the injection of local anaesthetic into the lower portion of the spinal canal.
<b>Episiotomy</b>	The cutting of the perineum to assist the birth of the baby's head.
<b>Induction</b>	To bring about – usually in respect of labour. E.g to induce labour is to cause contractions of the uterus so the woman goes into labour.
<b>Inhalational</b>	(A`djective) inhaled or breathed in as in gas or vapour.
<b>Lithotomy</b>	A position used for birth where the woman lies on her back with her legs lifted into stirrups. (Figure 5.)
<b>Perineal</b>	(Adjective), derived from perineum, e.g perineal toilet, perineal muscles, perineal sutures.
<b>Perineum</b>	The anatomical name of the area of muscle and tissue between the vaginal opening and the anus.
<b>Retroversion</b>	Turning or leaning backwards as used e.g. retroversion of the uterus where the uterus tips backwards instead of leaning forward as normal.
<b>Stirrups</b>	Poles attached to the bed to hold the woman's feet above the bed.
<b>Suppository</b>	Medication given in the form of a pellet into the rectum. Usually, but not always, given to stimulate bowel action.
<b>Ultrasound</b>	Technology using sound vibrations too rapid to be audible which is used to visualise the baby in the uterus during pregnancy, and to listen to, and to graph the fetal heartbeat.

## *Chapter 1*

### **INTRODUCTION**

When I was a child, as children do, I enjoyed listening to my mother tell stories of my birth and babyhood. It was a way of validating who I am and made me feel secure and wanted. We laughed at my father's anxious behaviour and I was always pleased that I was a breastfed baby and that my mother had none of the problems caring for me, a second child, that she had caring for my older brother. My mother always attributed this to the care she had received in the homelike environment of a small private maternity home in Johnsonville, Wellington. I was born in 1945 in a small four-bed private maternity home, 'Ranui', in Fraser Avenue. The house is still there although now it is a private dwelling.

Prior to the 1950s small, private maternity homes were common, many having just one maternity bed so that they could avoid the regulation from the Health Department that came with having more than one inpatient.<sup>1</sup> In Wellington, the capital city of New Zealand, as in most urban areas, there were also larger private maternity hospitals including charitable institutions,<sup>2</sup> epitomized in Wellington by Bethany and Alexandra hospitals. There were several private maternity hospitals in upper Willis St., one of the main city streets, including Harris Hospital and the Willis St. Obstetric Hospital. There was also the state owned St. Helens Hospital and Training School for Midwives in Newtown, an old inner city area. Wellington Public Hospital catered only for abnormal maternity cases such as women with breast abscesses, or other medical and obstetric complications, until 1947, when the Wellington Maternity Annexe was opened.<sup>3</sup>

---

<sup>1</sup> P. Mein Smith, *Maternity in Dispute: New Zealand, 1920-39*, Historical Publications Branch, Department of Internal Affairs, Wellington, 1986, p. 1.

<sup>2</sup> J. Neill, *Grace Neill, The Story of a Noble Woman*, N.M. Peryer Ltd., Christchurch, 1961, p. 50.

<sup>3</sup> L. Barber & R. Towers, *Wellington Hospital 1847 – 1976*, Wellington Hospital Board, Wellington, 1976, App. 8.

When I reached adulthood and bore my children in the mid 1960s and early 1970s there were limited choices of where to have a baby. Homebirth was not available and it appeared that most of the small private maternity homes had disappeared. Later, as a trained midwife I realized that many of my colleagues were unaware that these facilities had existed at all, yet they had been quite numerous in the greater Wellington area. This piqued my curiosity. I wondered why such places had disappeared.

I was ‘trained’ as a nurse, then later as a midwife at a time when midwifery education was strongly influenced by nursing and medicine. I had a perception, fostered by my educators, of childbirth prior to medical control and hospitalisation as a wilderness where ‘Sairey Gamp’<sup>4</sup> type midwives harmed women with their lack of knowledge, negligence and lack of cleanliness. The view that many women had died because they were not in hospital and did not have access to hospital was common among the midwives and nurses at that time. The medical men who were our educators constantly reinforced to us the importance of medicine and hospitalisation as methods of saving women and babies. The changing social conditions and the advent of antibiotics were not mentioned as possible contributors to the lowering of the maternal mortality rate.

I had heard from my mother, of the kindness and skill of the midwife who had cared for her in the 1940s, but I had been delivered by a doctor and my mother never mentioned the word ‘midwife’, always talking of her as ‘the Matron’.

Exploring the history of midwifery during my midwifery training in the mid 1970s made me realise that I was forming my conclusions about the past on misinformation and, therefore, it was likely that so were many other midwives and maternity consumers. Researching this thesis has given me an opportunity to find some answers to questions raised during my experiences of the maternity system.

This chapter will explain my reasons for the choice of maternity in Wellington in the 1950s and 1960s as the topic for this thesis and will describe the scope of this study.

---

<sup>4</sup> A dirty and careless ‘monthly nurse’ portrayed by Charles Dickens and discussed further in Chapter 2.



I will then discuss the methodology of historical inquiry as a research method with particular attention to the method of oral history. The following section will trace the steps taken to carry out this research and the rationale behind them.

### **Scope of the study**

I decided that I would like to document the perceptions of the consumers and the midwives who experienced the environment of the apparently highly regimented maternity hospitals of the 1950s and 1960s and to attempt to illuminate some of factors which had created that environment. I hoped to demonstrate the effect that these had on the birthing experience of women and on midwives' practice. This study is not an institutional history. It is a descriptive historical study of Wellington's maternity environment based on the testimonies of women and midwives as the main primary sources. It describes how they perceived their maternity experience. Institutions, people, social issues and hospital routines that shaped the women's experiences are included, where necessary, as contextual information and to illustrate more fully what was happening in maternity in the 1950s and 1960s. My intention is to offer a 'picture' of the maternity experience in Wellington from the perspectives of the women and the midwives. I hope to illustrate an era in the history of maternity before the introduction (in Wellington) of technologies such as ultrasound and epidural anaesthesia which arrived in the 1970s and produced further changes in maternity practices.

The 1950s were a time when the post war baby boom was at its height, birth was almost totally hospitalised and there was a shortage of nurses and midwives.<sup>5</sup> It was also a time that small private maternity homes were giving way to larger hospitals provided by Hospital Boards.<sup>6</sup> The increasing medical control of childbirth culminated in the passing of the Nurses Act in 1971, when midwifery lost the legal right to be an autonomous profession for twenty years. The period of this study includes the years 1962 – 1965 when I worked in Wellington Hospital as a student nurse and my

---

<sup>5</sup> L. Barber & R. Towers, *Wellington Hospital*, p. 103.

<sup>6</sup> E. Papps and M. Olssen, *Doctoring Childbirth and Regulating Midwifery in New Zealand*, Dunmore Press, Palmerston North, 1997, p. 104.

experience as a consumer of maternity services in St Helens Hospital in 1966, 1967 and 1970. As a recently practising independent midwife I look back at that era and wonder how such regimentation of childbirth occurred and why it had persisted for so long. I realized that this phenomenon had encompassed a much longer time frame than I could hope to examine within the scope of this study but the ‘bookends’ of 1950, with the postwar ‘baby boom’, and 1970, just prior to the Nurses Act 1971, seemed logical and manageable.

The 1950s seemed a good starting point as although there was fairly minimal change in maternity practices between 1950 and 1970 there were other factors which affected childbearing. The hospitalisation, the medicalisation and the nursing socialization of midwifery were complete. There was a high birthrate, a nursing and midwifery manpower shortage<sup>7</sup> and hospitals were becoming larger and more impersonal. The end of the 1960s was also an effective end point for this study as it marked the time just prior to the introduction of technology such as ultrasound and epidural anaesthesia.

This study was planned to describe the maternity scene in Wellington during an era when midwifery had been subsumed by nursing, was controlled by medicine and nursing, and was practised in hospitals managed by those disciplines. Documentation of this era will be useful as it will increase our knowledge of midwifery history, by providing a small-scale study of maternity services in a specific urban setting in a particular time period.

*We need to know our past to understand our present. The present is a product of the past: we are moulded and conditioned by a past of which we are alarmingly ignorant.*<sup>8</sup>

Many younger midwives receive an impression of maternity practice in those years as extremely bad, or conversely, that women who stayed routinely in hospital for fourteen

---

<sup>7</sup> *AJHR*, 1945, H-31, p. 7.

days after the baby's birth did not have problems following the birth. It is important that there is a study which demonstrates the realities of the maternity environment of the 1950s and 1960s.

The medicalisation of childbirth and the nursification of midwifery changed the way maternity care was delivered and affected women's maternity experience. It is my belief that midwifery is a profession which desperately needs to understand its history because its knowledge and practice have been clouded by influences from the disciplines of medicine and nursing over generations. This has happened to such an extent that it takes major effort on the part of each individual midwife to identify what is in truth 'midwifery' as distinct from what are actually medical and nursing ideas of what should be midwifery practice and knowledge. As Katz Rothman has pointed out, in a comment on the epistemology of midwifery:

*I have come to see that it is not that birth is "managed" the way it is because of what we know about birth. Rather, what we know about birth has been determined by the way it is managed. And the way childbirth has been managed has been based on the underlying assumptions, beliefs and ideologies that inform medicine as a profession.<sup>9</sup>*

In this quotation Katz Rothman recognised that much birth information, and many of the rituals which have changed the experience of birth, are a product of medical intervention rather than being part of birth's natural progression. Researching history through the eyes of midwives and women helps us to sift out what has actually happened in maternity and trace the introduction of changes that occurred in midwifery practice so that we can assess the reasons for and the appropriateness of some practices which may be problematic in the changed maternity environment.

---

<sup>6</sup> Deidre Beddoes cited in B. Hunter, Oral history and research, part 1: uses and implications, *British Journal of Midwifery*, July 1999, Vol. 7, No. 7, p. 426.

<sup>9</sup> B. Katz Rothman, *Recreating Motherhood: Ideology and Technology in a Patriarchal Society*, W. W. Norton & Company, New York, 1989, p. 178.

There appears to be no literature addressing the New Zealand maternity environment in the 1950s and 1960s in depth. Kedgley, in her history of motherhood in New Zealand explores women's experiences of childbirth. Examples of those women's stories strongly suggest that birth in the 1950s and 1960s was institutionalized so that childbirth was altered to fulfill the needs of the nursing and medical environment rather than the needs of the woman.<sup>10</sup> Kedgley's work is part of a broader topic and studies New Zealand in general, as opposed to the narrower focus of this thesis on a specific urban setting.

Authors like Barber and Towers who wrote an account of the history of Wellington Hospital<sup>11</sup> and McDonald and McTulloch who examined the history of the Wellington Hospital Training School<sup>12</sup> have written from an institutional perspective. These accounts are administrative histories – they do not examine the lives and experiences of consumers and touch only lightly on the lives of matrons and medical and administrative dignitaries.

Nursing historians such as Annette Stevenson and Marie Burgess explore the history of nursing with particular attention to the Nightingale ethos and the rigidity and obedience of the nursing hierarchy.<sup>13</sup> Stevenson includes some aspects of maternity nursing in her thesis because it became part of the curriculum from 1957 onwards and her thesis explores the culture of nursing in Wellington Public Hospital during the 1950s.<sup>14</sup>

---

<sup>10</sup> S. Kedgley, *Mum's the Word, The Untold Story of Motherhood in New Zealand*, Random House, Auckland, 1996.

<sup>11</sup> L. Barber and R. Towers, *Wellington Hospital*.

<sup>12</sup> A. L. McDonald, and C. Tulloch, *Wellington Hospital: Educating Nurses for more than a Century, 1883 – 1991*, Wellington Hospital Nurses Reunion Committee, Wellington, 1991.

<sup>13</sup> M. Burgess, *Nursing in New Zealand Society*, Longman Paul, Auckland, 1984.

<sup>14</sup> A. Stevenson, 'Realities and rhetoric: general hospital nursing in New Zealand 1945 to 1960', MA thesis, Victoria University of Wellington, Wellington, 1997.

Marion Cooper's thesis concerns the professionalisation of midwifery<sup>15</sup> and essays written by Cooper<sup>16</sup>, Orchard<sup>17</sup> and de Vore<sup>18</sup> explore aspects of midwifery at an earlier time than this thesis. Papps and Olssen, in their study of the medicalisation and regulation of midwifery in New Zealand, examine the rise of medical and nursing control of childbirth and midwifery including the years 1950 to 1970 but are concerned with sociopolitical factors rather than childbearing women's experiences.<sup>19</sup>

Mein Smith's analysis of the years 1920 to 1939 has a wealth of information on the period when the fight to lower maternal mortality occurred resulting in long term effects on maternity practitioners and their practices but does not cover the era I wish to describe.<sup>20</sup> Parkes discusses the impact of the medicalisation of New Zealand's maternity services on women's experience of childbirth,<sup>21</sup> and Donley's *Save the Midwife* analyses the history of the political maternity environment in New Zealand and is useful in illuminating the politics of midwifery in the 1950s and 1960s.<sup>22</sup> Again these do not detail women's perceptions. There is therefore a niche which this thesis could fill in the history of maternity and midwifery.

---

<sup>15</sup>M. Cooper, 'Towards the professionalisation of New Zealand midwifery 1840-1921', M Phil thesis, Massey University, Palmerston North, 1998.

<sup>16</sup>M. Cooper, The midwives case 1920 – 1930, in Chick and Rodgers, eds, *Looking Back, Moving Forward: Essays in the History of New Zealand Nursing and Midwifery*, Department of Nursing and Midwifery, Massey University, Palmerston North, 1997, pp. 37 – 42.

<sup>17</sup>S.Orchard, More 'women of good character': Nurses who came to New Zealand as immigrant settlers during the period 1860 to 1883, in N. Chick and J. Rogers eds., *Looking Back, Moving Forward: Essays in the History of New Zealand Nursing and Midwifery*, Department of Nursing and Midwifery, Massey University, Palmerston North. 1997, pp. 5 – 16.

<sup>18</sup>C. de Vore, Midwives as business women, in Norma Chick and Jan Rogers eds., *Looking Back, Moving Forward: Essays in the History of New Zealand Nursing and Midwifery*, Department of Nursing and Midwifery, Massey University, Palmerston North, 1997, pp. 44 – 57.

<sup>19</sup>E. Papps and M. Olssen, *Doctoring Childbirth*.

<sup>20</sup>P. Mein Smith, *Maternity in Dispute*.

<sup>21</sup>C. M. Parkes, The impact of the medicalisation of New Zealand's maternity services on women's experience of childbirth, 1904, 1937, in L. Bryder, ed., *A Healthy Country: Essays on the Social history of Medicine in New Zealand*, Bridget Williams Books, Wellington, 1991, pp. 164 – 180.

<sup>22</sup>J. Donley, *Save the Midwife*, New Women's Press, Auckland, 1986.

This study therefore offers a descriptive historical account of maternity in Wellington in the 1950s and 1960s. It draws on the oral testimonies of four women who gave birth in Wellington during that period and two midwives, to illuminate the personal experiences of consumers and practitioners of the maternity service. To provide an adequate context for this, and to speculate on factors which led to the particular 1950–1970 environment, a description is also offered of the development of maternity services and midwifery in New Zealand in the twentieth century.

## Methodology

Historiography is the name of the process used by historians in carrying out historical inquiry.<sup>23</sup> It is the methodology of historical research incorporating theories, techniques and ideas which need consideration in any historical research.<sup>24</sup> These include theories and principles which influence the choice of topic, finding and accessing the sources of data, and analyzing, interpreting and reporting the data. Lusk also includes finding a theoretical framework for the research but I believe, as do many many historians, that historiography itself is the theoretical framework for historical research, because the theories in historiography have evolved from the peculiar intricacies and interpretive requirements inherent in researching past events.<sup>25</sup>

Inquiry into any past event or incident can be carried out using the methodology of historiography. There is no set manner in which historical research must be performed, rather the theory of historiography guides and leads the researcher in making choices which will result in a quality product.<sup>26</sup>

---

<sup>23</sup> R.L. Russell, Historiography: a methodology for nurse researchers, *Australian Journal of Advanced Nursing*, Vol 16, No. 1, Sept-Nov., 1998, p.141.

<sup>24</sup> B. Lusk, Historical Methodology, for Nursing Research, *Image: Journal of Nursing Scholarship*, Vol.29, No. 4, Fourth Quarter, 1997, p. 85.

<sup>25</sup> O. Church, Using Historical Sources, In Woods, N. F. and Cantanzaro, M. *Nursing Research: Theory and Practice*. C.V.Mosby, St Louis, 1988.

<sup>26</sup> B. Lusk, Historical Methodology, p. 85.

Historical inquiry is a method of research which attempts to explain and describe past events. As facts are dependent on the perspective of the person who records them 'truth' is ephemeral. History is a gathering of data which is interpreted by the historian and presented as a view of the event or topic that is being explored. It follows that the interpretation will differ depending on the perspectives of the researcher. The history of maternity in New Zealand would differ widely in interpretation depending whether an obstetrician, a consumer or a midwife was writing it. It is important to examine who is telling the story to identify from what perspective it is being told. In any historical research, indeed in any research, identifying the viewpoint of the researcher is crucial. Anyone writing history must situate themselves in relation to the history and explain their stance to give their findings credibility. As Cramer says in her dissertation on the nature of history:

*...history is relative to the historian since it is filtered through the human understanding and life experiences of the historian.<sup>27</sup>*

Important factors to be considered include the worth of the sources of the information the historian is using so that readers can make critical judgments as to their accuracy. The authenticity of historical research is based in part on the assessment of the sources from which the data has been taken. Primary sources of information are preferred but even these can be problematic because once again they depend on the perceptions of the person who created them and the reasons they survived in the historical record.

The opinions of the Obstetrical Society and those of the Health Department, for instance, regarding the use of forceps in the 1930s were totally opposite. According to Mein Smith, the Obstetrical Society was composed of younger, practising doctors, usually trained in New Zealand and Australia. The staff of the Department of health was made up of older doctors, usually British trained, non-practising and conservative in their views. The Department of Health favoured non-interventionist maternity

---

<sup>27</sup> S. Cramer, The Nature of History: Meditation on Clio's Craft, *Nursing Research*, Vol. 41, No.1, Jan/Feb., 1992, p. 37.

practice while the Obstetric Society believed in a more active management of birth which included maternal sedation and forcep assisted birth.<sup>28</sup> A history presented by the members of either group would begin from very different perspectives. A history from a more objective perspective would need to sift the different views and provide an argument regarding those differences.

History, by its very nature is subjective so to describe an era, as I am attempting to do, the more evidence I can gather to represent a larger number of views concerning the topic the more comprehensive the study will be. Lummis makes this point:

*If the subject is a social history then it is essential to attempt to collect all types of experience or to be aware of the experience which has not been recorded.*<sup>29</sup>

The use of both consumers and midwives in this study is an attempt to widen the range of experience of the interviewees so that more comprehensive information is forthcoming than would the case if the interviewees were limited to consumers only or to midwives only. Recording the words of women who used midwifery services and midwives who delivered the services is a way gathering data and increasing the authenticity of this research. My own experience as both a consumer and a midwife is also both useful and potentially problematic. While it offers a particular insight I must use it in a carefully considered way, mindful of my own particular views.

In this study I have used established methods of historical inquiry to help me to understand and explain what happened in the maternity setting in Wellington over the two decades being studied, focusing particularly on the experiences of a small number of women and midwives. Oral history is an extremely old method of recording historical data. Used in the form of oral tradition, it is the transferral of history verbally, usually from one generation to the next, often in the form of chants or stories.

---

<sup>28</sup>P. Mein Smith, *Maternity in Dispute*, p. 47.

<sup>29</sup>T. Lummis, *Listening to History*, Century Hutchinson New Zealand Ltd, Auckland, 1987, p. 31.



It is particularly important where writing is not part of the culture as in ‘old wives’ tales and Maori whakapapa and legends.<sup>30</sup>

Oral history is defined as “a method of gathering evidence”.<sup>31</sup> The method involves “tape-recorded historical information drawn from the speaker’s personal knowledge”<sup>32</sup> but the term can also be used to describe the information collected by this method, i.e., the tape or video which was produced. The term oral history is also used to describe the documentation produced by the researcher from the material gathered from the narrative or interview. The term ‘oral history’, therefore, describes both the process of gathering information using audio or video techniques and also the products of that process. ‘Oral history’, the product, i.e., the video or audio-tape or the documentation derived from the video or audio-tape can be labelled ‘oral testimony’.<sup>33</sup> ‘Oral evidence’ is where that testimony is used in an historical argument.<sup>34</sup>

I have used oral history as the pivotal primary source to give life and direction to the study and increase its authenticity, and research into other primary and secondary sources to substantiate and explain the findings from the oral histories.

### **The sources**

The quality of the source is crucial to any historical inquiry.<sup>35</sup> Primary sources in oral history are considered to be of higher quality in historical research if the people who are interviewed are named so that their identity is known.<sup>36</sup> This is important as the person telling the story will be influenced by his or her prejudices, viewpoint and

---

<sup>30</sup> M. Hutching, *Talking History: A Short Guide to Oral History*, Bridget Williams Books and Historical Branch Department of Internal Affairs, Wellington, 1993, p. 2.

<sup>31</sup> M. Hutching, *Talking History*, p. 1.

<sup>32</sup> P. Thompson, *The Voice of the Past, Oral History*, (3<sup>rd</sup> ed.) Oxford University Press, 2000, p. xi.

<sup>33</sup> M. Hutching, *Talking History*, p. 1.

<sup>34</sup> M. Hutching, *Talking History*, p. 1.

<sup>35</sup> R. L. Russell, *Historiography*, p. 141.

<sup>36</sup> R. L. Russell, *Historiography*, p.142.

experiences and this will affect what evidence they will give and, as importantly, what evidence they do not give.<sup>37</sup> Hunter points out that a disadvantage of oral history is that the information obtained is pertinent to the participant and may not necessarily be relevant to a wider group.<sup>38</sup> To have a population of informants who would truly represent the maternity system we would need also to interview ward-maids, nurse-aides, social workers, doctors, and representatives from as many other groups who were associated with maternity as possible. This would have been beyond the scope of this small study and this type of representation is rarely possible in historical research.<sup>39</sup>

The identification of informants helps us to understand the perspective of the informant and to recognise and accommodate the limitations of the research. Different women with differing levels of knowledge and experience will have varying perceptions of the same circumstance and differing experiences generally. To try to make the description of maternity more encompassing the study needed to include more than one woman's story. I decided that the only way that I could understand and illustrate the maternity culture of the era comprehensively was also to interview midwives who had worked in those decades and ask them to describe the maternity workplace and practices. The primary sources used for this study included the oral testimonies of midwives and women who had experienced maternity in multiple situations during the study period and they were very willing to be identified.

Other primary sources used in this study included medical and midwifery text books, contemporary to the period, and autobiographical books written by the 'players' of the time such as Doris Gordon,<sup>40</sup> Sir Fred Bowerbank<sup>41</sup> and others. The *Appendices to the Journals of the House of Representatives* and other archival material such as

---

<sup>37</sup> T. Lummis, *Listening to History*, p. 36.

<sup>38</sup> B. Hunter, *Oral history and research*, p. 428.

<sup>39</sup> T. Lummis, *Listening to History*, p. 36

<sup>40</sup> D. Gordon, *Backblocks Baby Doctor*, Faber and Faber, London, 1955. D. Gordon, *Doctor Down Under*, Faber and Faber, London, 1957.

<sup>41</sup> F. Bowerbank, *Doctor's Story*, Wingfield Press, Wellington, 1958.

documents from the Department of Health, were also accessed but the main primary sources for this study were the oral testimonies from the women and the midwives who experienced the maternity system of the 1950s and 1960s. Primary sources such as Gordon and Bowerbank gave a more personal view of background events and were helpful in creating an idea of the culture of medical practice of the time. An oral history tape in our family archives in which my mother, Joyce Jackson, discusses Wellington's maternity environment in the 1940s and her role as a young wife in the 1950s, was also a valuable resource, particularly in helping me to understand the early 1950s and women's role in society.<sup>42</sup>

My own experiences are used as another primary source to describe the maternity care of that era, but my perception has been influenced by years of midwifery practice in other settings. My memories, as a student nurse and as a consumer of maternity services are as useful and credible, and as potentially problematic as any other primary source because all of these are based on memory. My memories are, however, coloured by later midwifery experiences. For instance I remember certain aspects of the Wellington Maternity Annexe's nurseries but needed to check with the midwife interviewees as I could not remember whether the memories pertained to the 1960s or the 1970s. There were instances also when this was a problem for the midwives who were interviewed. Memory is a two-edged sword as it is not always reliable. When possible, therefore, a person's recollections need to be checked against the recollections of contemporaries and contemporary documentation for accuracy.<sup>43</sup>

Secondary sources were used more to explain background historical events rather than to describe the maternity 'scene'. The text by Papps and Olssen was a very useful source of information. Donley was helpful as were Parkes, Mein Smith and Cooper. As described earlier in this chapter they offer descriptions of maternity services, practice and policy from a variety of viewpoints. Kedgley's work was a very useful secondary source as it expressed some women's feelings regarding their maternity care and the

---

<sup>42</sup> J.F. Jackson, Oral History Tape, Stojanovic family archive, 2000.

<sup>43</sup> P. Thompson, *The Voice of the Past*, p. 180.

role of women in society. Authors like Barber and Towers provided some valuable insights into the organisation and management of the Wellington Public Hospital and the Wellington Hospital Board.

I felt it was not necessary to include details about treatments and procedures in this thesis as they are well covered by Adelheid Wassner in her account of Dunedin's maternity history.<sup>44</sup>

### **The study plan**

The plan for this thesis was to describe the era by narrating the interviewed women's stories and eliciting common issues from them. By placing those issues before the midwives for discussion, and by examining the background social, economic and political forces and identifying those which impacted on the women and the midwives, I thought that I would come close to producing a comprehensive 'picture' of the maternity environment. It did not quite work out in that way because different interviewees focused on different issues, all of which were informative and useful. In addition, when developing this thesis I found it was too contrived to have separate chapters relating to the themes emerging from the women's interviews and then separately relating the midwives' responses to them. I therefore decided to incorporate a description of the birth process itself and the way it was managed in those decades, and to use this as a structure for relating different issues raised by the women. Having this separate chapter on the birth process also enabled a wealth of material to be incorporated to give a detailed account of maternity and midwifery practice in the 1950s and 1960s which may not have been captured elsewhere and could have been lost if not accommodated in this manner.

Recording the words of women who used midwifery services, and midwives who delivered the services is a useful way of illustrating the maternity history of a particular time or place. It is important to 'gather' these memories before they are lost to us. It is

---

<sup>44</sup> A. Wassner, *Labour of Love, Childbirth at Dunedin Hospital 1862 – 1972*, Wycliffe Press, Dunedin, 1999.

important to create a picture of what it was actually like at that time and in that particular place for these particular women, as it is likely that their perceptions and experiences were shared by others. The stories told will complement the written history and records of the time and could be utilised as either a validating point of reference or a counterpoint to other historical research.

### **Method – Oral history interviews**

Owing to the size, scope and manageability of this study, the women interviewed were limited to four women who were available, accessible and interested. One woman was a friend, two were neighbours and one was the mother of another midwife. The only criterion for inclusion was that they had their babies in the Wellington district during the time-period 1950 to 1970. The criterion for the midwives was similar in that they must have worked as midwives in the Wellington area during the study period.

I followed the Code of Ethical and Technical Practice recommended by the National Oral History Association of New Zealand (NOHANZ) and the research was approved by the Victoria University of Wellington's Human Ethics Committee.<sup>45</sup> The interviewees were all given or sent information sheets and had time to reflect on their choice of participating before I approached them with consent forms, which they all signed. Examples of the information sheets and consent forms are attached as Appendix 1 and Appendix 2. The women and midwives that I approached were all very willing to participate, and all preferred to use their own names in the project rather than pseudonyms. They were all aware that they could cease their participation and withdraw their testimonies at any time if desired.

The security of their information was the next issue. The women gave verbal and written consent for their actual names to be used in this report and understood that their taped and transcribed interviews would be kept secure and private. They also appreciated that they would receive the tapes once the project was finished. They were aware that only I, my supervisor, Dr. Pamela Wood, and the person transcribing the

---

<sup>45</sup> Appendix 3.

tapes would have access to them.

Five of the interviewees chose to be interviewed in their homes, only Ivanka chose to be interviewed at my home. The interviews lasted between 60 to 90 minutes each. Each participant was interviewed once. Each interview was audio-taped and transcribed.

There was concern that discussing their experience might evoke painful memories or unresolved issues. However, this did not occur. Two participants showed some anger over some situations and this was acknowledged during the interview with no further action being required. Most of the interviews were accompanied by laughter and the women obviously enjoyed discussing what is, after all, a memorable part of a woman's lifetime. The midwives too seemed happy that their knowledge and experiences were being documented and I certainly enjoyed discussing 'old times' with them.

I do not claim that these stories represent the experiences of all women or all of the midwives working in Wellington at the time. Each interviewee's story is personal to her and dependent upon her situation during the study period. As maternity practices were reasonably standard, however, some of the experiences of these women were likely to have been shared by others. Hunter notes that:

*The role of the researcher is to encourage reminiscence, jog the memory and record the participants' words as accurately as possible.*<sup>46</sup>

The women seemed very comfortable with me and appeared to enjoy telling their stories. Some of the advantages of oral history as a method of gathering historical evidence is that it gives people a chance to share their stories and for the researcher a chance to enjoy the people's stories. As a midwife and as a woman, I enjoyed hearing the stories that these women shared with me and could empathise with the midwives as a midwife and with the women as a co-consumer.

---

<sup>46</sup> B. Hunter, Oral history and research, p. 426.

It must be borne in mind that one of the disadvantages of oral history is that the 'picture' described is circumscribed by the experiences of the participants. The breadth of the picture is limited by their perceptions and their understanding of what was occurring, and by the fact that they can only describe what their memory allows them to recall about what happened to them, in that place and at that time. The more participants whose experiences concur, the more authenticity their stories have as historical evidence. Differences however provide counterpoints and illustrate the individuality of experience.

The more alternative primary and secondary sources that reinforce their stories, the more credible is the research. I could only, because of time constraints, interview four women and two midwives for this study. However my own experiences and information from other sources do support and help to illustrate the 'scene'.

*The goal of the traditional historian is to determine what actually happened and why it was significant and to find the underlying causes of the events. Historians recognise that their evidence is incomplete and that we are viewing a past through 20th century eyes and with 20th century values whereas many values and beliefs of the period under study were quite different.*<sup>47</sup>

In relation to this study we are viewing the past through twenty-first century eyes at a time when midwives are able again to practice autonomously. This study was not intended as a criticism of past midwives or their practice, but as a way to examine the influences that produced the environment in which they practised, and to record the way that they practised.

The two midwives that I interviewed were very interested in the project, were pleased that their era was being documented and very willing to share their insights and

---

<sup>47</sup> C. Helmstadter, Deconstructing and Reconstructing History, *Journal of Professional Nursing*, Vol. 14, No. 3, May-June, 1998, p. 136.

memories. One midwife had been Matron of the St Helens Hospital in Wellington. The other had worked mainly in Alexandra Hospital and Wellington Public Hospital and also in the 'old St Helens Hospital' so they were able to describe a broad range of hospital experience.

The maternity consumers who were interviewed experienced maternity in a variety of Wellington's maternity hospitals and over a number of years, 1953-1970. Between them they had thirteen maternity episodes in the study time period and experienced eight maternity facilities. The women were all of European descent. Two were immigrants and two were New Zealand born. I have concentrated on the maternity environment for European New Zealanders as although there would be many commonalities with the experiences of European women, I believe the maternity history and experiences of Maori would be more productively explored from a Maori perspective.

The interviews were transcribed and then analysed with each woman's story being summarised and written from the information given. These stories formed the bulk of Chapter 3. Information concerning topics such as breastfeeding, hospitals and staff, labour care and others was then extracted from the transcriptions and each woman's comments compared, and then compared again with other sources such as contemporary text-books and the midwives' testimonies. At this time I realized the necessity of a chapter concerned with the birth process, as a way of incorporating material which was relevant but did not fit in the individual women's stories, as comparison and discussion were required to make sense of it.

Commonalities in the women's stories became apparent during the writing of the women's stories. During the process of extraction and comparison of topics described by the women they emerged with more obvious definition. The issues were identified more from the emotions inherent in the narratives and the persistence of similarities in phrases and contexts than by any planned extraction process.



## **Conclusion**

This study is a descriptive historical study of Wellington's maternity environment 1950 – 1970. It is not an institutional history, nor a description of particular hospitals or people. It is based on the accounts of a small number of women and midwives as the main primary sources and describes how they perceived their maternity experience. Institutions, people and social issues which shaped the women's experiences, are included as contextual information and to illustrate more fully what was happening in maternity in the 1950s and 1960s.

Although my research is specific to Wellington the findings could reasonably be used as an example when describing what was happening in maternity throughout New Zealand as the social, political and economic influences on maternity in other regions were closely aligned to the Wellington experience. This descriptive study, therefore, should add to our knowledge and understanding of the history of maternity in New Zealand.

This chapter has explored how and why I chose the topic of maternity in Wellington as my thesis subject and described the scope of my study. It has discussed the use of oral history as a research method and traced the conduct of the research including the involvement of six participants (two midwives and four women) who were consumers and providers of maternity services in the 1950s and 1960s. I have also discussed the use of my own memories as another primary source for this research and what other primary and secondary sources were useful to me in carrying it out. The next chapter will describe the factors which produced the maternity environment of the 1950s and 1960s in Wellington. Chapter 3 traces women's place in society in the 1950s and 1960s in Wellington especially in relation to their reproductive role. Chapter 4 examines the experience of childbearing in the 1950s, and 1960s, from the perspective of the four women interviewed. In Chapter 5 information provided by the two midwife interviewees as well as my own experiences and other sources enlarge on this account of the women's experiences. The final chapter summarises the study and identifies and discusses issues which emerged from the research.

## *Chapter 2*

### **TWENTIETH CENTURY MATERNITY IN NEW ZEALAND**

In this chapter I explore the changes to maternity services from 1900 to 1970. In particular the chapter will discuss the factors leading to the maternity environment of the 1950s and 1960s as context for this study.

Childbirth for European women in early twentieth century New Zealand was woman and midwife centred. Considered a normal part of a woman's role in life, the majority of births took place in the home and most midwives were married women who had borne children themselves. By 1970 virtually all births took place in hospital and were under the control of medical men and women. I would argue that the profession of midwifery had been subsumed by nursing and autonomous midwifery had virtually disappeared. In the 1950s and 1960s most midwives and midwife leaders were single women who worked in medically controlled hospitals which required midwives, mothers and babies to conform to regimented routines.

This chapter traces some of the more significant changes in the maternity services over the 1900 – 1970 period. It highlights the registration and regulation of midwives, examines the move from home birth to hospital birth and links these factors to the medicalisation and nursification of midwifery. Although these trends were common to western societies, examining how they occurred on our national stage provides a context for understanding the more specific locus of maternity services in Wellington in the 1950s and 1960s, explored in Chapter 4.

#### **Maternity in New Zealand in 1900**

This section looks at who practised midwifery in New Zealand at the beginning of the twentieth century, and how it was practised. There was no state provision or control of

midwifery at that time, and there was no formal institution or programme for the training of midwives in the country.

Midwifery today, represented by its professional body, the New Zealand College of Midwives, uses the World Health Organisation's definition of a midwife:

*A midwife is a person who, having been regularly admitted to a midwifery educational programme, duly recognised in the country in which it is located, has successfully completed the prescribed course of studies in midwifery and has acquired the requisite qualifications to be registered and/or legally licensed to practice midwifery...*<sup>48</sup>

This has not always been the image of a midwife. Midwives, over the years, have been characterised in many ways. Linguistically, this becomes clear by examining the names used for midwives in other languages. Two examples are 'sage femme' or 'wise woman' in French and *babica*, meaning little grandmother, in Serbian. The old English word 'midwife' itself means 'with woman', indicating the role of the midwife. The late nineteenth century 'Sairey Gamp' image was also portrayed, with great detriment to midwives, by Charles Dickens. Dr. Duncan MacGregor, the Inspector of Hospitals, in a 1906 report may have had this image in mind when he wrote:

*With the passing of the Midwives Registration Act, 1904, the day of the dirty ignorant careless woman who has brought death or ill-health to so many mothers and infants will soon end.*<sup>49</sup>

Historical research has shown that the 'Sairey Gamp' stereotyping was inaccurate and that most traditional midwives were respected members of their communities.<sup>50</sup> This image, penned by Charles Dickens in his book *Martin Chuzzlewit*, of a drunken, dirty,

---

<sup>48</sup> New Zealand College of Midwives, *Handbook for Midwifery Practice*, Christchurch, NZCOM, 1993, p.3.

<sup>49</sup> Cecil & Celia Manson, *Doctor Agnes Bennett*, Michael Joseph, London, 1960, p. 50.

<sup>50</sup> M. Cooper, 'The Midwives Case 1920 – 1930', p. 50.

old woman, who was a ‘monthly nurse’,<sup>51</sup> was often used by the medical profession as a way of discrediting the traditional midwife, and replacing her with ‘trained women’ who had been trained to work with and be subservient to doctors.<sup>52</sup> As a local example Sir Fred Bowerbank, a doctor who worked in Wellington, describes an encounter with a ‘Sairey Gamp’ in 1907 when describing a homebirth he attended in Duppa Street, Berhampore.

*The old woman who was acting as a nurse might have stepped straight from the pages of Dickens. Here was a ‘Sairey Gamp’ to the life. Her liquor-laden breath could not be disguised...*

He softens this criticism, however:

*In fairness to the maternity nurses, professional and amateur, for many of whom I had a high regard, the nurse I have described was an exception.*<sup>53</sup>

In 1900 the majority of midwives working in New Zealand were ‘traditional midwives’. Midwifery was practised more in the home than the hospital, far more frequently by untrained midwives, rather than trained midwives or doctors. Most women who were midwives were married. Most had borne their own children. It was not considered ‘proper’ in Victorian times for unmarried women to be involved in birth.<sup>54</sup> These women, who had no formal training as midwives, are called by various names: ‘lay midwife’, ‘traditional midwife’, ‘handywoman’, and sometimes, ‘the monthly nurse’; although the latter term can also be applied to women who visited the home and took over the care of the household for a month following the birth, without actually being the principal birth attendant. There seems to be some cross-over as some

---

<sup>51</sup> S.Orchard, More ‘women of good character’, p.12.

<sup>52</sup> A. Summers, Sairey Gamp: generating fact from fiction, *Nursing Inquiry*, No. 4, 1997, p.14.

<sup>53</sup> F. Bowerbank, *Doctors Story*, p. 83.

<sup>54</sup> M. Cooper, ‘Towards the professionalisation’, p. 67.

midwives obviously took over the duties of the ‘monthly nurse’ as well as attending the birth.

Some of the women who provided midwifery services were widows. It was a way of earning some money, or at least payment ‘in kind’.<sup>55</sup> Some of these ‘handywomen’ travelled to the homes of the women they attended and often stayed for up to a month taking over the care of the children and the housework. Others ‘took in’ women into their own homes. Sometimes midwives were taught by local doctors who were keen to have women with expertise to help them.

Midwives’ education had generally been of the apprentice type but midwifery schools had been established in Europe since the first was established in Munich in 1589. In the nineteenth century the European schools for midwives increased but this was not paralleled in Britain. There was some training available in Britain from the mid-nineteenth century. The London Obstetrical Society offered examination and certification for practising midwives and several lying-in hospitals offered training and education in Midwifery.<sup>56</sup> It is reported that one of New Zealand’s early midwives, a missionary’s wife, undertook training in maternity nursing prior to leaving for New Zealand.<sup>57</sup>

By 1900 the numbers of midwives in New Zealand who had done some training were beginning to increase but there was no training school available in New Zealand. There was some sort of midwifery education available, however, as Dr. Duncan MacGregor, had reported to Government in 1896 that:

*...the practice of granting midwifery certificates based on mere theoretical instruction ought to be discontinued.*<sup>58</sup>

---

<sup>55</sup> C. De Vore, *Midwives as business women*, p. 50.

<sup>56</sup> M. Cooper, *The midwives case*, p. 29.

<sup>57</sup> M. Cooper, *The midwives case*, p. 37.

<sup>58</sup> C. Manson and C. Manson, *Agnes Bennett*, p. 45

In 1900 the maternity service in New Zealand was provided mostly by lay midwives, some of whom had received tuition from other midwives or doctors. Roads were still very primitive and communication poor, making access to trained midwives or doctors for birth in many areas very problematic.<sup>59</sup> In urban areas there were private 'lying-in' hospitals owned by doctors or midwives, and these were often traditional midwives.<sup>60</sup>

## **Registration and Beyond**

This section explores the factors leading to the introduction of registration for midwives in 1904, and how this legislation impacted on midwives and their practice. The Midwives Act 1904 led to the replacement of the traditional midwives with trained, registered midwives who, although they could continue the midwifery tradition of autonomous practice, increasingly began to come under the control of medicine, and then nursing. Established by the Midwives Act, the St Helens Hospitals began training midwives and providing affordable maternity care for the wives of working class men who earned less than four pounds a week.<sup>61</sup>

Two linked ideologies contributed to the changes that took place in maternity in New Zealand. Eugenics, with its concept of the superiority of the white races, was a popular ideology of the time.<sup>62</sup> An idea of the importance of the British Empire was another. There was, therefore, national concern when it became apparent that the birth rate was dropping among the European population of Australia and New Zealand. This was highlighted in the findings of the New South Wales Royal Commission in 1904 which investigated the fall in birth rate in New Zealand and Australia. It found that the 'unfit' were having more babies than the 'better classes'.

---

<sup>59</sup> J. Rattray, *Great Days in New Zealand Nursing*, A.H. & A. W. Reed, Wellington, 1961, p. 42.

<sup>60</sup> C. Manson and C. Manson, *Dr. Agnes Bennett*, p. 48.

<sup>61</sup> J. Donley, *Save the Midwife*, p.36.

<sup>62</sup> J. Donley, *Save the Midwife*, p.32.

*At the time falling birth rates and the resulting 'race suicide' were of great concern throughout the British Empire.*

*It was feared the prolific non-white races would outbreed the less fertile white races and thus gain an advantage, first in the struggle for existence and secondly in the struggle for power.*

*If New Zealand was to be held as a British colony, she would have to increase her population.<sup>63</sup>*

The respectable poor of colonial society had a high infant mortality rate. One way of improving this and thus increasing the numbers of live adults was to improve maternity care for this group. A law regulating the practice of midwifery and providing for education and registration for midwives was perceived as a method of achieving this improvement.

The reform of nursing and midwifery providers from a lay, disorganized and unregulated group to an ordered and regulated professional group of women, was part of a wider, international movement.<sup>64</sup> These reforms did not occur in isolation but were paralleled in other parts of the western world.

The 1904 Midwives Act established a national New Zealand structure for training and registering midwives, a knowledge base for midwifery practice and a state midwifery service. This law was passed through the combined efforts of civil servants Grace Neill and Dr. Duncan MacGregor, and the Premier of New Zealand, Richard John Seddon.<sup>65</sup>

Grace Neill was a Scottish woman who had trained as a nurse in London. She had later moved to Australia with her doctor husband. After he died she had worked as a journalist to maintain herself and her son, then moved to New Zealand and joined the Department of Labour as the first woman Inspector of Factories. She was appointed as

---

<sup>63</sup> J. Donley, *Save the Midwife*, New Women's Press, Auckland, 1986, p. 32.

<sup>64</sup> M. Cooper, *Towards the Professionalism of New Zealand Midwifery*, p. 109.

<sup>65</sup> C. Manson and C. Manson, *Dr. Agnes Bennett*, p. 49.

Assistant Inspector of Hospitals, Asylums and Charitable Aid by Dr. Duncan MacGregor, who was in need of a competent female assistant<sup>66</sup> and saw her as his “ideal assistant”.<sup>67</sup> MacGregor was the Inspector General of Hospitals for New Zealand from 1886 until his death in 1906. He had been a member of the Central Board of Health from 1887 until its demise with the creation of the Department of Public Health and the Hospitals and Charitable Institutions Department in 1901.<sup>68</sup>

The question of state registration of nurses had been discussed by the Nurse Section of the International Council of Women in London in 1899 which Grace Neill had attended.<sup>69</sup> The Nurses Registration Act of 1901 had then been drafted and implemented by her, with MacGregor, to improve and control the quality of nursing in New Zealand. She had been influenced by ideas which she had absorbed whilst in England and by her experience among the poor in England, Australia and in the administration of charitable aid in New Zealand. These had given her an interest in improving conditions for the poorer women in society.

The findings of the New South Wales 1904 Royal Commission gave her and MacGregor an opportunity to support the Premier, in introducing a Bill that they believed would provide better quality maternity care by providing schools to educate midwives while at the same time providing affordable maternity care for poor (but respectable) women.

The Midwives Act 1904 was passed to establish state control of midwives. Registration for midwives became a legal requirement. The loss from their communities of the traditional midwives would have left many country areas with no midwife, so the register of midwives was divided into two classes to accommodate the

---

<sup>66</sup> Margaret Tennant, ‘Mrs Grace Neill in the Department of Asylums, Hospitals and Charitable Institutions’, *New Zealand Journal of History*, Vol.12, No.2, October, 1978, p. 7.

<sup>67</sup> J. Neill, *Grace Neil*, p. 27.

<sup>68</sup> , *A History of the Department of Health*, Victoria University Press, Wellington, 1995, p. 64.

<sup>69</sup> J. O. C. Neill, *Grace Neil*, p.38.



traditional midwives. 'Class 'A' Midwives' included women who had been trained in a recognised training school, in New Zealand or overseas. Many of these were single women. The midwives who, although untrained, had been in practice for at least three years and could show that they were of good character could apply to become 'Class 'B' Midwives'. Most of these women were married.<sup>70</sup> There is ample evidence that a number of lay midwives did not register but continued to practise for some years after the passing of the 1904 Act. For example, in 1921 there was a report to the Health Department that nine women were practising as lay midwives in the Hawera district.<sup>71</sup>

The Act which set in place training and registration for midwives, also placed authority over midwives firmly under the control of medical men. The 'Registrar' of both midwives and nurses was the Inspector-General of Hospitals; a medical practitioner. The Act also established each District Health Officer as the supervising authority over midwives practising in his area, giving him the power to temporarily suspend a midwife, investigate charges of malpractice, negligence or misconduct, and report to the Minister of Health any midwife who was convicted of an 'indictable offence'.<sup>72</sup>

Grace Neill's idea was to provide good, reasonably priced maternity care for the wives of working men, and to simultaneously produce competent trained midwives for New Zealand. To do this she planned to set up institutions which would perform the dual functions of providing affordable maternity care, catering for both inpatients and home-birthing women, and providing training for midwives. She suggested the hospitals be named the St Helens Hospitals after Seddon's birthplace in England. Seddon's goal was to reduce the maternal and infant mortality rates. The motivation of each was different but complementary.

Neill had drafted and implemented the 1901 Nurses Registration Act, enabled by

---

<sup>70</sup> M. Cooper, *Towards the Professionalisation*, p. 67.

<sup>71</sup> C. De Vore, *Midwives as Business Women*, p. 48.

<sup>72</sup> E. Papps and M. Olssen, *Doctoring Childbirth*, p. 85.

“overwhelming” support from the nursing profession.<sup>73</sup> Support for the Midwives Act was much less than for the Nurses Registration Act. The majority of midwives were untrained, and enforced registration was a threat to many of them. Passing the Midwives Act was, therefore, a more difficult proposition. Some doctors had part or full ownership of maternity homes and did not welcome the idea of the state intruding on their preserves.

*They feared not so much the initial loss of patients as the threat of future state control.*<sup>74</sup>

With the support of the Prime Minister and some astute political manoeuvring the Bill was passed and the St Helens Hospitals and their associated training schools for midwives came into being.

A new type of midwife evolved from the passing of the 1904 Midwives Act and the 1901 Nurses Registration Act. This was the development of the registered nurse-midwife. A lay person could study for twelve months to become a midwife. A nurse registered under the Nurses Registration Act 1901 could train in six months.<sup>75</sup> I would argue that this was the beginning of the nursification of midwifery.

The first St Helens Hospital to open was in Rintoul Street, Wellington, in May 1905, followed by others in Dunedin and Auckland. Slowly until 1920, others were opened in Christchurch, Gisborne, Invercargill and Wanganui.<sup>76</sup> They were administered by the Department of Health until 1966 when they passed to the control of the Hospital Boards.

Each St Helens hospital had a medical superintendent. Otherwise, they were managed

---

<sup>73</sup> J. O. C. Neill, *Grace Neill*, p.51.

<sup>74</sup> J.O.C. Neill, *Grace Neill*, p. 51.

<sup>75</sup> E. Papps and M.Olssen ,*Doctoring Childbirth*, 1997, p. 84.

<sup>76</sup> Hester Maclean, *Nursing in New Zealand, History and Reminiscences*, Tolan Printing Company, Wellington, 1932, p. 59.

and staffed by midwives, who called doctors to help only when needed. Later, doctors were appointed as 'staff doctors' who were employed to come in to deal with problems when necessary. There was pressure even in the early days for the St Helens Hospitals to cater for medical students particularly in Dunedin, the site of the Otago Medical School. The New Zealand Branch of the British Medical Association considered that any state maternity hospital should be able to be used to train medical students and should be administered by them.

*To this Grace Neill was adamantly opposed. Her St Helens were to be used for the comfort of working men's wives and the training of midwives, not embryo doctors....*  
*...The medical school put up a very bitter fight but Seddon, as always, completely backed her opinion.<sup>77</sup>*

Included in the 1961 biography of Grace Neill written by her son is a 'Tribute to a Great Woman' written by Flora Cameron, Director, Division of Nursing. She wrote that Seddon had told a deputation of the Trades and Labour Council in September 1905 that:

*Medical men should never think of taking a student to the bedside of one of their paying patients, or to a private Maternity Home.*  
*The women who would go to these St. Helens Maternity Homes would be of as great delicacy of feeling as any women among the paying patients of the country and it would be out of place for him to agree to the admission of the students. It would at once defeat the purposes for which this Home was established.<sup>78</sup>*

The struggle between midwifery and medicine over the rights to use the St Helens hospitals to teach students continued throughout the life of these hospitals. In 1918

---

<sup>77</sup> J.O.C. Neill, *Grace Neill*, p. 55

<sup>78</sup> Flora J. Cameron, 'A Tribute to a Great Woman', in J.O.C. Neill, *Grace Neill*, p. 93.

medical students were admitted to the Dunedin St. Helens Hospital and in 1929 it ceased to train midwives in favour of the medical students. In 1921 the St Helens hospitals in Auckland, Wellington and Christchurch were also opened to medical students and the three smaller St Helens hospitals were instructed to be available to medical students. The Matrons from Gisborne and Wanganui replied that they had insufficient patients to train midwives and doctors. The women did not protest until the 1930s when Seddon's daughter, Mrs Mary Stuart Hay, discovered what was happening and mounted an eventually unsuccessful public campaign to fight the use of the St Helens hospitals for teaching medical students.<sup>79</sup> Grace Neill, discussing the medical fraternity's attitude to St Helens hospitals, in a private letter to Seddon had written:

*Some of the doctors were in favour but these were in the minority. They objected to the thorough training of midwives in an institution.... The doctors considered that if well-trained midwives were turned out each year it could affect their practice. St Helens' patients were only expected to pay three or four guineas and the doctors thought it possible that some patients might be admitted who really could afford to pay a doctor's fee and a midwife's fee.*<sup>80</sup>

In their efforts to prevent a campaign by the doctors, Seddon had required Grace Neill to set up the buildings for the hospitals and training schools in a very short time-frame. Most of the St Helens hospitals were existing buildings, usually large houses which were adapted for their new purpose. Some of them were not particularly suitable and needed alterations or were replaced at a later date.<sup>81</sup> This is reflective of the haste in which they were bought and the need for Neill to keep the costs low so as to avoid criticism about the spending of public money.<sup>82</sup>

---

<sup>79</sup> C. Parkes, The impact of the medicalisation of New Zealand's maternity services on women's experience of childbirth, 1904 -1937, in L Bryder ed., *A Healthy Country: Essays on the Social History of Medicine in New Zealand*, Bridget Williams Books, Wellington, 1991, p. 175.

<sup>80</sup> F. J Cameron, 'A Tribute to a Great Woman', p. 93.

<sup>81</sup> J.O.C. Neill, *Grace Neill*, p. 96.

<sup>82</sup> J.O.C Neill, *Grace Neill*, p. 56.

Despite the loss of several of the original hospitals as training schools, the St Helens hospitals provided training for midwives until 1979 when midwifery education was transferred to tertiary educational facilities following the Carpenter Report of 1971.<sup>83</sup> The loss of their educational function, at a time when centralization of maternity services into large medically controlled hospitals was considered more efficient, resulted in their closure in the 1980s, despite strong protests from women.

### **Hospitalisation – The better option?**

This section examines the move toward hospitalisation for birth, how and why this occurred and how it affected childbirth practices and midwifery. As birth moved into hospital, midwives lost their autonomy and became nursified and medicalized. By the end of this period, the Nurses Act 1971 legally confirmed the midwives' loss of autonomy by legislating that midwives were nurses, and were no longer able to practise without being under the jurisdiction of a medical practitioner. This state of affairs continued until the Nurses Amendment Act of 1990 re-established midwifery as a profession separate from and different to nursing and returned to midwives the ability to practise autonomously.<sup>84</sup>

In 1927 fifty-eight percent of New Zealand births took place in maternity hospitals. By 1936 this had risen to almost eighty-two percent.<sup>85</sup> A hospital was defined as an institution having two or more beds.<sup>86</sup> Many midwives took in only one woman at a time so that they would not be classified as a hospital and be subject to the attendant regulations. What factors caused this shift from a birthing system based on home-birth to one of predominantly hospital birth? According to Donley, women accepted hospital birth because of

---

<sup>83</sup> E. Papps, M. Olssen, *Doctoring Childbirth*, p.126.

<sup>84</sup> E. Papps, M. Olssen, *Doctoring Childbirth*, p.167.

<sup>85</sup> J. Donley, *Save the Midwife*, p. 39.

<sup>86</sup> P. Mein Smith, *Maternity in Dispute*, p.1.

*...their economic situation or living conditions, for a rest from household chores and the care of large families, or because (increasingly) they were lured by the promise of 'painless childbirth'.<sup>87</sup>*

This section explores the development of this new type of maternity service, a service based mostly in hospitals and clinics, delivered by doctors and trained midwives. A service that offered knowledgeable support to help the woman and her family cope with a (usually) normal life transition changed into a service that controlled both the woman and the birth process itself. The development of hospitalisation for childbirth was led by the medical profession and closely linked to the developments in anaesthesia and asepsis.

The name 'obstetrician', adopted by men attending births, appears to have come into use about the mid-nineteenth century. As the men-midwives gained status, that of the midwives fell. According to Schnorrenberg during the eighteenth century in England the profession of midwifery had begun to decline and the midwives of the nineteenth century were mostly uneducated women of low status.<sup>88</sup> She attributed this to three major influences; the most important being the professionalisation of medical practitioners and the emergence of 'Victorian' ideas regarding women's role in society. The increase in scientific knowledge that occurred over that time she considered to be a lesser factor. The rise in the popularity of physicians attending births was, however, closely associated with their control of drugs and medicine including anaesthetics such as chloroform.<sup>89</sup> Internationally there was a movement to improve public health subsequent to four main developments in medicine, namely vaccination, anaesthesia, asepsis and antisepsis, and the increased knowledge of microbiology as a causative factor in disease.<sup>90</sup>

---

<sup>87</sup> J. Donley, *Save the Midwife*, p. 40.

<sup>88</sup> B. Schnorrenberg, Is childbirth any place for a woman? The decline of midwifery in eighteenth century England. in P.K. Wilson, ed., *Childbirth Changing Ideas and Practices in Britain and America to the Present*, Vol. 1, Garland Publishing, London, 1996, p. 157.

<sup>89</sup> E. Papps and M. Olssen, *Doctoring Childbirth*, 1997, p. 73.

<sup>90</sup> M. Cooper, Towards the professionalisation of New Zealand midwifery, p. 109.

Queen Victoria in 1853 used chloroform and in so doing made its use respectable and popular, especially with the upper classes. Midwives were becoming more used by the lower socio-economic groups and less by the higher groups.<sup>91</sup> The social status gained by doctors has continued and it could be considered that today it is still a factor in women choosing to have doctors to attend their births. The doctors found that it was more convenient to attend births in hospital and with the introduction of strict asepsis and twilight sleep in the 1920s and 1930s, their preference for birth in hospital increased.<sup>92</sup> This is explained by Bowerbank in his discussion about the Alexandra Maternity Home in Wellington:

*Where possible, to my great relief, I used to attend my patients there, because conditions in some of the homes were frequently most unsatisfactory....*<sup>93</sup>

Dr. Kenneth Pacey, a well-known obstetrician who was still practicing in the 1940s and 1950s is quoted in Manson and Manson discussing maternity in Wellington on the early twentieth century:

*The vast majority of women had their babies in their own homes. Since many of these were humble in the extreme, the environment left much to be desired. Yet here were dealt with the major complications of obstetrics.*

*Some of the graver emergencies were sent to the general hospital, but the others, such as the high forceps deliveries, the breech deliveries, were coped with on the spot.*<sup>94</sup>

---

<sup>91</sup> B. B. Schnorrenberg, *Is Childbirth any place for a woman*, p. 164.

<sup>92</sup> P. Mein Smith, *Maternity in Dispute*, p. 81.

<sup>93</sup> Bowerbank, Sir Fred. *Doctor's Story*, p. 81.

<sup>94</sup> C. Manson and C. Manson, *Doctor Agnes Bennett*, Michael Joseph, London, 1960, p. 49.

Central to the development of hospitalisation as the preferred option for birth and postnatal care, was the ‘selling’ of the idea that the medical profession and their hospitals could provide a safer, pain-free birth.<sup>95</sup> The use of anaesthetic agents for pain relief had begun with chloroform, but this was of limited use as it was really only useful with the delivery of the baby. When ‘twilight sleep’, invented by Professor Gauss in Germany, was introduced to New Zealand in the 1920s, the medical profession was able to advertise its ability to provide ‘painless childbirth’ throughout the process.

‘Twilight sleep’ did not take away all of the pain of childbirth but it did remove the woman’s memory of the pain, so the consumer’s perception was of a painless labour and birth.<sup>96</sup> To achieve the desired effect doctors used a cocktail of drugs, particularly the barbiturate known as Nembutal and Scopolamine (hyoscine). These were often augmented by the use of chloroform in the second stage of labour. This was a very intensive regime which required increased observation and monitoring of the semiconscious woman, necessitating interventionist techniques such as regular vaginal examinations because of the birth attendant’s inability to ‘read’ the progress of the labour by noting the behaviour of the woman.<sup>97</sup> This normal behaviour was no longer present in the sedated mother. In the process of achieving ‘painless childbirth’, therefore, the woman gave up control of her birth process to the birth attendants and became an ‘invalid’ to be tended, observed and monitored.

The labour changed from the normal because the woman could no longer obey her instincts and move into positions to aid the baby’s descent through the pelvis and reduce pain. She could no longer eat and drink during labour, to refuel her body for its increased energy requirements. Often she did not have the ability to push the baby out so forcep deliveries became much more common.

---

<sup>95</sup> E. Papps and M. Olssen, *Doctoring Childbirth*, p. 111.

<sup>96</sup> E. Papps and M. Olssen, *Doctoring Childbirth*, p. 119.

<sup>97</sup> E. Papps and M. Olssen, *Doctoring Childbirth*, p. 122.



The drugs did not only sedate the mother, but also her baby, increasing the number of babies requiring resuscitation at birth. These interventions created a cycle of intervention – increased risk – increased intervention. Because the women required intensive monitoring they had to birth in hospital where they and their babies were exposed to hospital pathogens and cross infection.<sup>98</sup> The increased interventions, vaginal examinations and instrumental deliveries were linked to a corresponding rise in puerperal infection.<sup>99</sup> Puerperal fever became an issue in the 1920s due to the rise in maternal mortality and morbidity caused by its increased incidence. With the number of cases rising it became publicly controversial. The medical fraternity was inclined to blame the increase in puerperal fever on midwives, although the increase in sepsis was linked to the use of more interventionist techniques.

A Board of Health Special Committee had, in 1921, pointed out the link between puerperal sepsis and instrumental deliveries and advised that the medical profession and the public should have it drawn to their attention. The public were advised that:

*Childbirth is a normal physiological process, and to the healthy woman in healthy surroundings is attended with very small risk.*<sup>100</sup>

In 1923, between July and November, there were six cases of puerperal sepsis at a respectable private maternity home (Kelvin Hospital) in Auckland. Five of the women died. The fear and anxiety aroused by this led to an enquiry. The Kelvin Hospital Commission's report defended the doctors and hospital staff and laid the blame on the Health Department.<sup>101</sup> As sepsis was a notifiable condition which had not been notified properly, and in some cases not at all, this blame was not accepted by the Department, but as a result the Department launched the 'Campaign for Safe Motherhood' in 1924.

---

<sup>98</sup> E. Papps and M. Olssen, *Doctoring Childbirth*, p. 122.

<sup>99</sup> Also known as Childbirth fever, Puerperal Fever or Puerperal Sepsis.

<sup>100</sup> Special Committee on Maternal Mortality in N.Z., *AJHR*, 1921, H-31 B, p. 4.

<sup>100</sup> P. Mein Smith, *Maternity in Dispute*, 1920-39, 1986, p. 23.

<sup>101</sup> P. Mein Smith, *Maternity in Dispute*, p. 21.

The forceps delivery rate was not mentioned. The campaign was directed toward antenatal care, asepsis, hospital policy and midwifery training.<sup>102</sup>

As part of this campaign severely restrictive practices were introduced by Dr. Tom Paget, Inspector of Maternity Hospitals, in his effort to reduce the risk of infection. Henry Jellett, who became Consultant Obstetrician to the Health Department in 1924, was also influential in the devising of Paget's recommendations: 'The General Principles of Maternity Nursing and the Management of Aseptic Technique and the Puerperium' ('H-Mt.20') ruled maternity practice for twenty-five years,<sup>103</sup> but affected maternity practice in varying degrees for at least fifty years. These practices reduced the woman's ability to birth normally and to breastfeed normally, changing the midwife's role still further. One result of the draconian aseptic measures introduced with Paget's H-Mt.20 regulations was that the woman's need to be mobile in labour, even when not sedated, was sacrificed to the requirements for a 'sterile field' for the birth of the baby. It also meant that women could no longer birth where they laboured, needing to be transferred at the last, panting and pushing, to a special delivery room. By the 1950s birth took place in a room very similar to an operating theatre, under very similar conditions to a surgical operation. Even in the 1970s, student midwives spent much time in acquiring the skills of sterile technique, and learning how to cover the woman correctly with sterile drapes which required the woman to remain in a horizontal position and necessitated the use of the lithotomy position and 'stirrups' to hold her legs in place.

Parkes, while lauding the lowering of the maternal mortality rate which partly resulted from the introduction of aseptic techniques comments:

---

<sup>102</sup>P. Mein Smith, *Maternity in Dispute*, p. 23.

<sup>103</sup>J. Donley, *Save the Midwife*, p. 42.

*Thomas Paget, Henry Jellett and the hundreds of midwives who put their reforms into practice may be justly remembered for their crusade against sepsis and unnecessary maternal death. Yet a narrowly clinical approach ignored birth as an emotional experience, resulting in treatment both frightening and degrading for many women. Those who demanded a more humanitarian approach were overwhelmed by the clamour for increased specialisation and training for doctors.*<sup>104</sup>

The aseptic techniques introduced in the 1920s are credited with hugely lowering maternal mortality from puerperal sepsis well before the introduction of antibiotics.<sup>105</sup> It was considered necessary to teach doctors, midwives and nurses the importance of stringent asepsis. Perhaps the severity of such measures helped to disseminate the message but other ways of lowering the risk of sepsis such as increased homebirth, the separation of maternity wards from general wards, careful hand-washing and glove wearing would have done much to improve the situation without the need to allow the use of such depersonalising procedures to persist for so many years.

Although the Health Department introduced Paget's measures to combat puerperal fever, generally the Department supported midwifery with its lower rates of intervention. Midwives and Plunket nurses<sup>106</sup> were operating State antenatal clinics in four cities. The Department had criticised doctors for 'meddlesome midwifery' and set up the midwifery-run antenatal clinics. The doctors felt undervalued and threatened, and did not want their practice controlled by "a set of busybodies in the bureaucratic hive in Wellington".<sup>107</sup> In 1927 they formed the Obstetrical Society, the intention to do so being ostensibly sparked:

---

<sup>104</sup> C. Parkes, *The impact of medicalisation*, p. 180.

<sup>105</sup> P. Mein Smith, *Maternity in Dispute*, 1986, p. 66.

<sup>106</sup> Plunket nurses are nurses who work for an organization called the Plunket Society established by Sir Frederic Truby King in 1907. Their main focus was to support mothers to care for their babies.

<sup>107</sup> D. Gordon, *Doctor Down Under*, p. 53.

*...because a sanitary inspector - a man licensed to inspect drains -had presented himself before a surgeon of the English Royal College demanding reasons why the latter had done a Caesarean Section.*<sup>108</sup>

Dr. Doris Gordon was pivotal in the formation of the Obstetrical Society and was also successful in organising an endowment fund to establish a Chair of Obstetrics at Otago University. She believed that to maintain control of maternity, the doctors needed to change the public perception of birth. As Mein Smith points out:

*Because health officials insisted that childbirth was a normal healthy process, she believed that a fledgling Obstetric Society needed to educate the public to accept the alternative view that maternity was 'highly dangerous'.*<sup>109</sup>

Doris Gordon was a very enthusiastic proponent of pain-free labour and had been instrumental in the introduction and dissemination of the techniques of 'Twilight Sleep'. As a powerful lobby group, the Obstetrical Society was able to alter the political power balance in their favour.<sup>110</sup> In response to their lobbying, hospitalisation came to be perceived by the public as a safer option for birth because of all the 'things that could go wrong', although hospitalisation and 'painless childbirth' actually induced iatrogenic effects.

Women and midwives lost their confidence in, and knowledge of, the natural birth process and became socialised into believing that to give birth safely they needed instruction and supervision by the male dominated, interventionist medical profession. Midwifery became part of the 'hospital team' approach to birth, a team under medical control, in the process losing not only autonomy but also the ability to understand and

---

<sup>108</sup> D. Gordon, *Backblocks Baby Doctor*, p. 207.

<sup>109</sup> P. Mein Smith, *Maternity in Dispute*, p. 43.

<sup>110</sup> P. Mein Smith, *Maternity in Dispute*, p. 41.

‘read’ the normal process of birth from the woman’s behaviour.<sup>111</sup> These changes, induced by hospitalisation, sedation and the resulting mortality and morbidity, enforced a regime of birth practices, many of which continued in various forms until at least the early 1980s.

The perception of childbirth held by midwives altered as a result of being only exposed to medically influenced birth. They accepted the birthing behaviour and events seen in hospital birth and measured by medical criteria, as the normal and natural progression of childbirth. They accepted iatrogenic outcomes as the norm. They lost the knowledge of birth that had been handed down for centuries from women to women. This is pointed out by Michel Odent discussing the medicalisation of birth:

*Midwives were no longer mothers helping other mothers, thanks to their personal experience and specifically feminine sensitivity. Instead, they became professionals who were taught how to control the birth process.*<sup>112</sup>

The maternity system in New Zealand when the St. Helens hospitals were set up in 1904 had consisted of small private hospitals, usually owned and managed by midwives, doctors or both. The large public hospital catered for few maternity cases, usually only if there were also medical problems. This started to change in the 1920s. Mein Smith explains:

*In 1920 most New Zealand mothers had their babies at home, or in small unlicensed one-bed homes run by the local maternity nurse or midwife. Approximately 65 per cent of births took place outside hospitals (a hospital being defined as an institution having two or more beds).*

---

<sup>111</sup> E. Papps and M. Olssen, *Doctoring Childbirth*, p. 121.

<sup>112</sup> M. Odent, *Primal Health*, Century, London, 1986. p. 66.

*Another four per cent occurred in the State St. Helens Hospitals, five percent in Hospital Board or Salvation Army hospitals and about 26 percent in private hospitals. Assistance at homebirths or in the one-bed homes was often provided by a midwife working alone, with a medical practitioner's advice being sought only when necessary.*<sup>113</sup>

The introduction of the H-Mt.20 regulations changed the way maternity care was delivered, requiring a special room for birth, and because the mothers were kept in bed and could not care for their babies, nurseries were set up to keep the babies in a separate room.<sup>114</sup> There were also added requirements due to the need for extra sanitary arrangements. For many small maternity facilities these requirements meant costly alterations, which many could not afford, as the 1920s was also a time of economic depression.<sup>115</sup> By the late 1930s many of the handywomen who had provided maternity accommodation were retiring, often in response to the financial and political pressure. De Vore comments that:

*Health Department regulations increasingly demanded new equipment and facilities in an attempt to meet the goal of safe maternity practice. During the depression years midwives in private practice or who owned private hospitals operated in a harsh economic climate and received poor financial returns. Constant concern about the effects of maternal death or hospital closures meant midwives had to constantly guard their good reputations for fear of financial ruin. Competition from untrained colleagues, strict legislation which allowed 'one at a time' hospitals to operate, and lack of support from doctors added to the stress.*<sup>116</sup>

---

<sup>113</sup> P. Mein Smith, *Maternity in Dispute*, p. 1.

<sup>114</sup> J. Donley, *Save the Midwife*, p. 45.

<sup>115</sup> C. De Vore, *Midwives as businesswomen*, p. 46.

<sup>116</sup> C. De Vore, *Midwives as businesswomen*, p.54.

The increasing demand for birth in hospital, brought about mainly by medical lobbying and gate-keeping, was straining existing obstetric accommodation. The Kelvin Commission had recommended that the Health Department and Hospital Boards should provide maternity beds for all classes of women, paid according to means. In response to this the Health Act 1932 legislated that the Hospital Boards must take responsibility for providing maternity beds where required.<sup>117</sup>

In 1930 it was decided by the Nurses and Midwives Registration Board that only the Auckland, Wellington, Christchurch and Invercargill St Helens Hospitals were to be training Schools for Midwives. This was because these four were considered to be “large enough or well enough equipped to give a complete training”.<sup>118</sup> In 1932 the other three St Helens Hospitals were turned over to their local Hospital Boards.

By 1935 the high maternal mortality due to sepsis had waned, and the Health Department had changed its relationship with the Obstetric Society, altering the balance of political power in the process to the benefit of the doctors. Although the Health Department continued to campaign against ‘meddlesome midwifery’ and the forcep rate did decline, caesarean section started to become more accepted and the medical profession had become more politically powerful. During the economic depression many women, unable to pay medical fees, had returned to midwifery care, and this was seen as a threat by doctors. When the 1937 - 38 Committee of Inquiry into Maternity Services recommended doctor attendance at all births, this was partly in response to demands from women’s organisations which having accepted the Obstetrical Society’s assurances that hospitalisation was necessary for birth, were now asking for hospitalisation to be free and home-help available so that all women could birth in what they considered were optimum conditions. The inquiry also promoted maternity care by doctors rather than midwives or clinics, by recommending continuity of care by the family doctors as the best care.<sup>119</sup>

---

<sup>117</sup> J. Donley, *Save the Midwife*, p. 45.

<sup>118</sup> H. Maclean, *Nursing in New Zealand*, p. 270.

<sup>119</sup> P. Mein Smith, *Maternity in Dispute*, p. 119.

The Social Security Act 1938 provided free maternity care for all women including hospitalisation and care by the doctor that she chose. The Act can be seen as the ‘coup de grace’ for the autonomous midwife. Generally doctor attendance at birth had been favoured by the wealthier in society, midwives by the poorer; medical attendance had thus become a status symbol. With the combined effect of the Obstetrical Society’s promotion of pain-free, ‘safe’ birth and with free medical attendance and hospitalisation being offered by the Labour government, and strongly promoted as the preferable option, it is not surprising that the bulk of women accessed doctors for their maternity care, considering that now they could have both a doctor and a midwife attending their births, and a free fourteen day rest in hospital.

Midwives and hospitals were also catered for in the government payments for maternity services. Midwives could claim payment from the Health Department for homebirth care and were still legally able to provide care without a doctor’s involvement but most women chose medical care and the midwives were, therefore, forced to work with doctors.

### **Strengthening Hospital Control, 1940s – 1960s**

The new scheme took a while to come into existence as doctors and the Health Department wrangled over its details. Doctors were concerned about too much state control and it took three years before their boycott of the scheme was finally settled.<sup>120</sup> The four remaining St Helens hospitals maintained their midwifery focus and provided midwifery care but were seen as not providing adequate pain relief by many women because they did not routinely provide ‘twilight sleep’.

Doctors had become the ‘gate keepers’ for maternity care and advised women to birth in hospital for safety reasons.<sup>121</sup> After 1938 the maternity system was required to provide free maternity inpatient care to all women, with a fourteen day stay. Because

---

<sup>120</sup> D. Dow, *Safeguarding the Public Health*, p. 122.

<sup>121</sup> J.F.Jackson, oral history tape, 2000.



the Hospital Boards had been given the responsibility of providing maternity beds the late 1940s and early 1950s saw the mushrooming of Hospital Board owned and run maternity hospitals. Some of these, including the Wellington Hospital Maternity Annexe were hastily converted military hospitals. Others like the Paraparaumu and Elderslea Maternity hospitals were purpose-built new buildings.<sup>122</sup>

In 1945 the Annual Report of the Health Department states:

*Hospital Boards have had to assume responsibility for an increased number of maternity beds due to (1) The majority of births now taking place in hospitals. (2) The number of private maternity beds having decreased, and (3) The birth rate having increased. There is being experienced an acute shortage of midwives, and it will be essential to train more if the standard of obstetrical nursing is to be maintained.*<sup>123</sup>

The baby boom following the Second World War, combined with a nursing shortage, exacerbated the shortage of maternity beds.<sup>124</sup> The five day working week introduced by the Labour Government made the nursing shortage even worse. Gordon sums up the situation:

*...the five day working week, started kicking out of the nest all the good things socialism had tried to evoke. Costs soared and almost overnight came a crisis in staff shortages. Private maternity hospitals closed at the rate of one a month, and hospital boards, ordered to accommodate maternity cases, found they had neither space nor staff.*<sup>125</sup>

---

<sup>122</sup> L. Barber and R. Tower, Wellington Hospital, p. 100.

<sup>123</sup> *AJHR*, 1945, H-31, p.6.

<sup>124</sup> H. Campbell, *Mary Lambie, A Biography*, The New Zealand Nursing Education and Research Foundation, Wellington, 1976, p. 63.

<sup>125</sup> D. Gordon, *Doctor Down Under*, p.105.

The severe maternity bed shortage is illustrated by Gordon's story of the graphic unofficial instructions she received from the Obstetrical Society (by then the Obstetrical and Gynaecological Society), on her appointment to the position of Director of Maternal Welfare in 1946.

*Whenever you come across an empty soldiers' ward for God's sake snivel us a maternity unit. We dread births on back seats of taxis, and taxi drivers are fed up with blood and tears. The remaining private hospitals, fearful of fines dare not admit a case a little out in her dates when they are overfull already, so the poor patients have to tear around all the other maternity homes asking in vain for a bed....*  
*...the taxi driver, sensing urgency, lands the outfit at the general hospital and helps shove his fare into a wheelchair. The chair and a porter set off at a run for the women's ward only to be met at the door by sister. "Maternity Case? Oh no! I cannot admit you here. I've no staff and no facilities for maternity. I'm sorry I can't..."*  
*"No such word as can't!" says the baby....<sup>126</sup>*

### **The Nursification and Medicalisation of Midwifery**

This section examines the effect that the disciplines of nursing and medicine had on midwifery. The Midwives Act 1904 began the process of putting midwifery under the control of medicine and began the introduction of the nursing culture into midwifery by creating the nurse-midwife. Maternity's move toward hospitalisation increased the momentum of the nursification of medicalisation of midwifery.

Papps and Olssen state that nursing and midwifery were two very different professions with separate traditions and histories. They maintain that "nursing developed as subordinate to, and in the service of doctors" whereas midwifery had: "an ancient tradition of occupational independence ...its subordination has been a function of its

---

<sup>126</sup>D. Gordon, *Doctor Down Under*, p.103.

suppression.”<sup>127</sup> Papps and Olssen also point out that although nursing and midwifery as professions were closely aligned in New Zealand from the early twentieth century, they were two distinct professions with their own regulatory Registration Acts. From 1925 that changed when both disciplines were regulated by the same Nurses and Midwives Registration Act. This Act also enabled women to register as maternity nurses. Some traditional midwives became classed as maternity nurses, able to care for women only under the direction of a doctor or midwife.

Midwives were numerically a much smaller group than nurses. They had no representative organization of their own and consequently found it difficult politically to prevent negative changes to their profession. Nurses in the 1930s also supported the Obstetrical Society’s agenda to promote doctor/nurse care for women in St Helens hospitals over midwifery care.<sup>128</sup> It was expected, particularly by nurses and doctors, that maternity nurses would replace midwives completely and all maternity care would be under medical jurisdiction.

In 1937, the Committee of Inquiry into Maternity Services in New Zealand advocated the Obstetrical Society’s policies and in 1946 the Committee of Inquiry into Maternal Hospital Staffing issued a report which criticised the St. Helens training programme and questioned the need for midwives at all, now that usual doctor attendance at birth had been established. Both committees’ recommendations were to have significant influence in the subsequent years.<sup>129</sup>

After the Second World War there was a grave shortage of nurses and midwives which was intensified in maternity hospitals due to the post war ‘baby boom’. Consequently the 1946 Committee of Inquiry looked beyond staffing and examined the maternity service. From this a committee was formed which excluded midwifery representation but included medical and nursing representation. The committee recommended

---

<sup>127</sup> E.Papps and M. Olssen, *Doctoring Childbirth*, p. 137.

<sup>128</sup> E. Papps and M. Olssen, p. 125.

<sup>129</sup> E. Papps and M. Olssen, p. 126.

inclusion of maternity into the general nurse training syllabus. They perceived nurse-midwifery as improving the service. This was resisted by a nurse and midwife, Mary Lambie, the Health Department's Director, Division of Nursing, who recognised the problems inherent in the plan and managed to stop its implementation until after her retirement in 1950.<sup>130</sup> However, in 1957, changes were finally made to the nursing curriculum to incorporate a basic maternity component. These nurses were registered as 'General and Obstetric Nurses' and were able to register as midwives after undertaking an additional six months training in a St Helens hospital and sitting an examination for State Registration. The opportunity for a woman to train as a midwife without first being a nurse was lost after the direct entry maternity nursing programme was phased out gradually over some years.<sup>131</sup> Of the registered nurses who did train as midwives, many became midwives only as a way of gaining an 'extra certificate' as this was an advantage if promotion was sought.<sup>132</sup>

Nurses were taught to monitor, observe and care for patients; diagnosis was the prerogative of medicine. Midwives, once autonomous practitioners, were now being used as nurses with some extra midwifery knowledge. If they detected aberrations from the normal they were to call for medical help but also they now often had to gain medical and nursing approval to care for the normal. For instance, they would be required to follow medically formulated protocols which dictated whether the woman could eat or drink or walk about, be examined or given analgesia. This was particularly noticeable if the midwives were practising within the public hospital system which also provided training for doctors because the educational needs of doctors took priority.<sup>133</sup> In the clinical situation a midwife who may have had years of experience would be required to work in a subservient situation to a newly graduated doctor with little experience.

---

<sup>130</sup> H. Campbell, *Mary Lambie*, p. 63.

<sup>131</sup> J. Donley, *Save the Midwife*, p. 99.

<sup>132</sup> Personal experience.

<sup>133</sup> J. Donley, *Save the midwife*, p.46.

Nurses had been trained into this hierarchical hospital system. When they then trained as midwives they brought their nursing socialization into midwifery. Instead of normal, healthy people, women came to be perceived as 'patients' who were to receive care as dictated by the doctor, the hospital policies and routines. Both the women and the midwives usually accepted this as necessary. The woman's childbearing role was perceived as a medical process rather than a normal womanly function. Once direct entry midwifery was phased out and only nurses could become midwives the nursing discipline of caring for ill people under medical supervision became reinforced within the discipline of midwifery. Midwives became invisible, being addressed by hospital staff and patients as 'Sister', 'Matron', 'Staff Nurse' and 'Nurse'.

Instead of attending the woman in her pregnancy, birth and postpartum period, midwives were attached to areas within the hospital, working in antenatal clinic, nursery, ward or the delivery suite. They developed expertise in their particular areas and lost the skills, knowledge and confidence to oversee the whole progression of childbirth. Most midwives lost the confidence to work outside the hospital and were socialised into the 'medical model' perception of birth.

This transformation of the maternity system happened over decades and was a gradual change, apparently accepted by most midwives with little resistance. Doctors were seen as important, knowledgeable and benevolent. Men and women listened to them and accepted their advice, and doctors were teaching the student midwives. Midwifery leaders were also qualified nurses as generally 'Ward Sister' status would not be awarded to a midwife unless she was also a registered nurse. Midwifery educators were also nurse-midwives and usually had the status of 'Sister'. This meant that the clinical and theoretical components of midwifery were taught by doctors and nurse-midwives who, of course, imbued their teaching with the cultures and expectations of their professions. When in 1971, the law removed midwives' ability to attend women without the participation of a doctor it merely legitimised what was, by then, an established pattern of maternity service.

This chapter has explained how the private, home-based midwifery system of the 1900s evolved into a medical, publicly funded hospital-based maternity system. It has examined the factors instrumental in changing maternity from a lay, unregulated, home-based midwifery service to a professional, nurse-led midwifery service which by 1970 was medically controlled within the hospital system.

The professionalisation and nursification of the midwifery service started with the passing of the Midwives Act 1904 and the formation of the St Helens Hospitals and Training Schools for Midwives. Although St Helens hospitals provided a service delivered largely by midwives, this Act also placed midwives' practice under medical control. Despite homebirth and midwifery being supported by the Health Department, technological progress, especially the developments in asepsis and anaesthesia, aided the medical profession in making hospital and medically controlled birth attractive to women. The Obstetric Society was formed to resist control from the Health Department, and once formed became a strong lobby group, achieving both of its aims - the setting up of a Chair of Obstetrics at Otago University and the reforming of the maternity service. The Social Security Act 1938, granting free medical, midwifery and hospital care to women, accelerated the hospitalisation of birth and aided in the almost total transformation of midwives into maternity nurses who were skilled in their own areas of hospital nursing, but who had lost the knowledge and confidence to care for birthing women outside the hospital system.

This chapter is contextually important as it explains how the maternity service of the 1950s and 1960s evolved. It identifies the factors which created the maternity environment being studied. These included the reasons why traditional birthing practices were replaced with medicalized and nursified midwives and facilities, and the reasons why women and midwives accepted hospitalisation as the only option for childbirth.

## *Chapter 3*

### **WOMEN OF WELLINGTON**

This chapter begins with a brief general discussion of women's place in society in the 1950s and 1960s in Wellington. The first section will illuminate women's role in society focusing on society's expectations of women as wives and mothers, and their knowledge of sex, contraception and birth. The implications of these for the nursing and midwifery workforce will also be mentioned. The discussion in this first section provides context for positioning the stories of the women interviewed in this study. The second section introduces the four women interviewees and relates their accounts of giving birth in Wellington in the time period studied. The third section introduces the two midwives who were interviewed. Their responses to issues raised in the women's stories are included later in this thesis.

#### **Women in Wellington**

This section will describe some of the influences on women's lives in Wellington in the 1950s and 1960s. To create a context for considering the stories of the women interviewed, which are presented later in this chapter, information is drawn predominantly from secondary sources, personal knowledge, and the audiotape of an interview given by my mother that is held in our family archive.

Marriage and family life were considered the ideal, proper fulfilment for a woman. Married women were expected to be full-time mothers and home-makers. This created a situation where maternity services, were provided mainly by an hierarchy of single women who staffed the hospitals. From 1950 to 1970, with the advent of reliable contraception and some changes in attitude, there was a slow increase in the number of married women joining the workforce.

Wellington in the 1950s was a conservative and somewhat insular society, mainly of British ethnicity but with increasing numbers of immigrants from post-war Europe and from Britain and Asia. The culture was British-based with many Wellingtonians still referring to Britain as 'home'.<sup>134</sup>

Society was based around the idea of family life, which was held up as the ideal. One indication of the importance of family life was the notorious 'six o'clock swill'. Alcohol was sold only until 6 pm apparently in a misguided attempt to ensure that men would spend their evenings at home with their families. This resulted in the fast intake of alcohol on empty stomachs with consequent high levels of drunkenness.<sup>135</sup> It was common for women to avoid using suburban transport after 6pm to avoid the 'drunks' at the bus-stops and railway stations until the law was changed to allow more liberal conditions for the sale of alcohol following a referendum in 1967.

Following the stresses of 1930s depression and the Second World War there was a post-war boom in New Zealand. The 1950s and 1960s were a time of full employment and relative prosperity. The National Party ran the country and:

*embodied and articulated the concern for normalcy, security, prosperity and comfort which pervaded New Zealand society throughout the 1950s and, to a lesser extent the 1960s.*<sup>136</sup>

The place for a woman in society was that of home-maker. Other than nursing and teaching there were few career choices open for women. Most women's occupations were poorly paid, or at least paid less than those of men, as the male head of the household was expected to provide for his family. This made life very difficult for women on their own, particularly women who had children but no spouse. There had always been a societal expectation that a woman would immediately leave work to

---

<sup>134</sup> K. Sinclair, *The Pelican History of New Zealand*, Penguin Books, Auckland, 1980, p. 326.

<sup>135</sup> K. Sinclair, *The Pelican History of New Zealand*, p. 300.

<sup>136</sup> K. Sinclair, *The Oxford Illustrated New Zealand History*. Oxford University Press, Auckland, p. 120.



care for her husband when married. Her husband would be 'the provider'. Most women did not work following marriage and received a 'housekeeping allowance' from their husbands. It was common for women not to know how much their men-folk actually earned.<sup>137</sup>

Life was very hard for the unmarried mother. It was considered that she had brought shame to her family. Many women who became pregnant married quickly and then proclaimed the birth of the baby as premature. Forty percent of 'first babies' were born less than eight months after marriage.<sup>138</sup> Abortion was illegal and although there were 'back street abortionists' for many women that was not a preferred option.<sup>139</sup> Most babies of unmarried mothers were 'put up for adoption'. There was no financial support for single mothers and because of the shame felt by the families few of them would openly support their pregnant daughters. A few grandmothers adopted or took care of their grandchildren, often pretending they were their own. Women hid their pregnancies, travelling to other towns until after the baby's birth and subsequent adoption. Some families took in pregnant 'girls' in exchange for household help, or the pregnant women would be accommodated by a charitable institution such as the Salvation Army. Because of the general disapproval of sex before marriage there was often quite a punitive attitude, even by hospital staff, toward the unfortunate unmarried mother.<sup>140</sup>

In the 1950s technology had not reached family life in a major way. Only twenty percent of homes had telephones.<sup>141</sup> Many houses had cold running water only. Refrigerators were rare, as were washing machines. Most homes had a large 'copper' heated with a wood or coal fire with which to boil the washing, and tubs, washboards,

---

<sup>137</sup> J.F. Jackson, oral history tape, 2000.

<sup>138</sup> K. Sinclair, *The Pelican History*, p. 300.

<sup>139</sup> S. Kedgley, *Mum's the Word*, p. 85.

<sup>140</sup> S. Kedgley, *Mum's the Word*, p.186

<sup>141</sup> S. Kedgley, *Mum's the Word*, p. 152.

Sunlight soap and hand ‘wringers’ to complete the labour intensive task.<sup>142</sup> For those who did not have a ‘copper’, a large empty kerosene tin was used, as a pot, on the kitchen stove for boiling babies’ nappies. The new growth of housing estates meant that many women were isolated from the support of their extended families. Most families, especially in the suburbs, did not have cars so public transport was the norm.

Running a home and bringing up children was, for most women, a full time occupation. It was usually performed alone, without help, because apart from gardening and ‘handy-man’ work, men were not expected to help in the home. By the 1950s the idea of the woman working only in the home was slowly beginning to change. A number of women who had worked during the war decided they wanted to continue working, and the economy needed workers. In the 1960s the number of women entering the workforce accelerated, partly due to the rise of women’s movements both in New Zealand and overseas.<sup>143</sup>

Women were socialised into the idea that the only significant path to fulfilment as a woman was by marrying and caring for a husband and a family. Idealistic messages glamorising the roles of wife and mother pervaded popular literature and the women’s environment. A framed photograph which hung in the Otaki Maternity Hospital is reproduced on the next page as an example of the idealistic view of motherhood which characterised the study period. Women’s magazines, books and films fostered the idea of marriage and childbearing as the only way to happiness for women. The education system also contributed to this. Female secondary school students would often be steered toward subjects such as sewing and home economics. Clerical skills were also taught, but with the idea that working in an office was a respectable way to pass the time until marriage. Even books read at primary school level, such as those written by Enid Blyton, a popular children’s author, idealized the nuclear family and portrayed the mother as happily cooking and cleaning house and waiting for ‘father’ to return from work.

---

<sup>142</sup> J.F. Jackson, oral history tape, 2000.

<sup>143</sup> K. Sinclair, *The Pelican History of New Zealand*, p. 321.

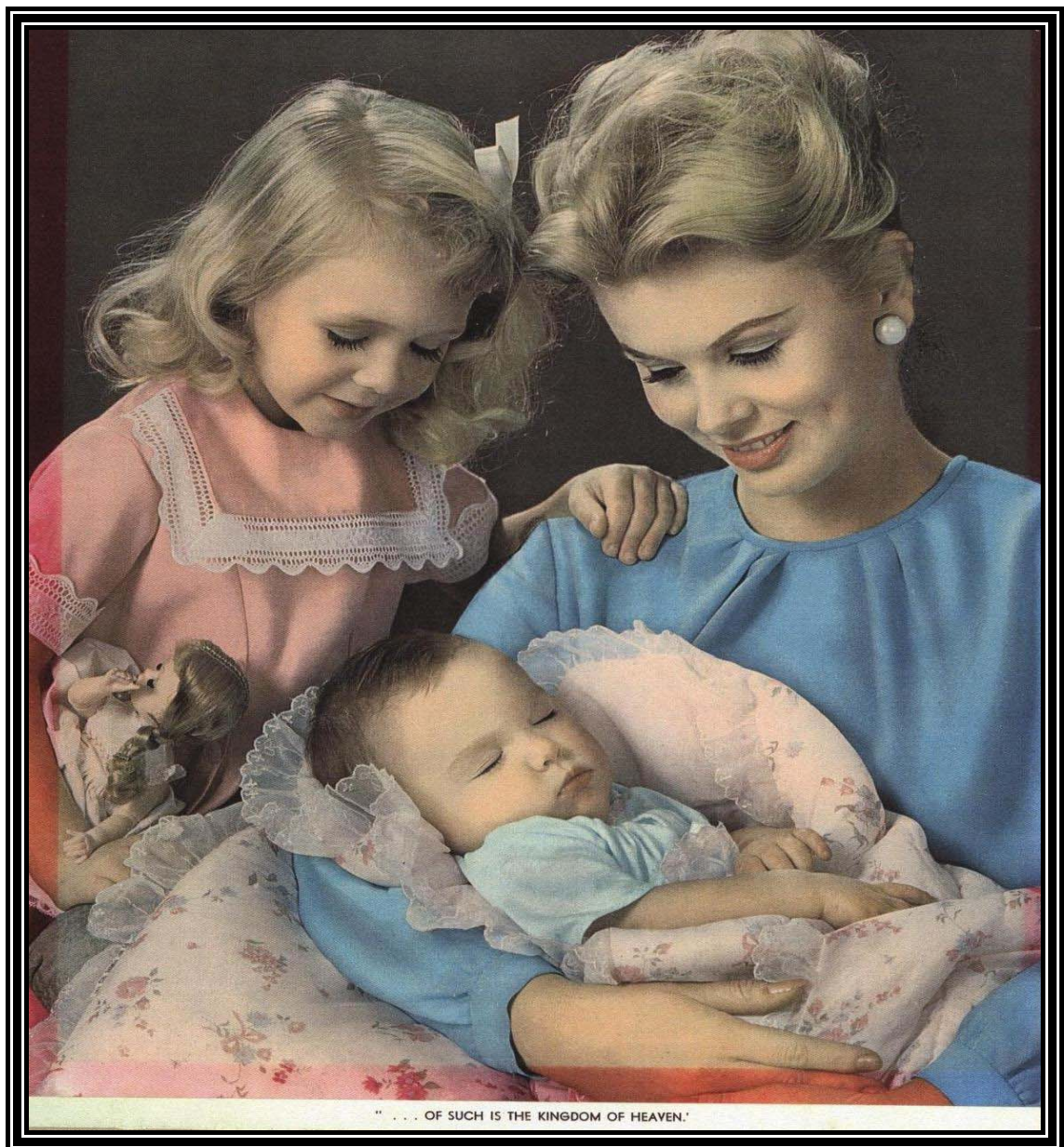


Figure 1

‘Of Such is the Kingdom of Heaven’ This early 1960s framed photograph hung in the Otaki Maternity Hospital until it closed in 1995 and is now the property of the Otaki Birthing Centre Ltd. It epitomizes the idealization of motherhood that was common in the 1960s.

Many women were content in this situation and enjoyed being mothers and home-makers. Others found that they needed, sometimes reluctantly, to go out to work for financial reasons.<sup>144</sup> Some women who were not as happy as housewives as they had expected to be hid their depression and then felt guilty because they were unhappy, while other women who needed to work, frequently felt guilty about their dual role and feared that they were not 'good' mothers. Even in the early 1970s the pressure on women to stay home with their children was still very strong: A contemporary example of advice to families offered by a high-profile doctor associated with the Plunket Society exemplifies this:

*It is impossible to ignore the supreme importance of the mother to her children when they are young. Throughout the formative years there is nothing, and nobody, who can take her place in the home. Unless there is a clear need to earn money when the family is young – as there is in the case of some widows – the mother is better in her home. It is an empty place without her. A new refrigerator, a motorcar are not sufficient recompense to a young child for the absence of his mother.*<sup>145</sup>

Men whose wives worked could also feel inadequate as providers because of the societal expectations of the time.

In 1945 there were only 2.7 per cent of married women in the workforce. This had increased to 12.9 per cent by 1956.<sup>146</sup> By 1976 the proportion of women aged fifteen to sixty-four who worked was forty-two percent.<sup>147</sup> Thus the majority of the nursing (and midwifery) workforce were unmarried women. The only permanent nursing staff in Wellington Public Hospital in the 1950s and 1960s was this hierarchy of mostly single

---

<sup>144</sup> J.F. Jackson, oral history tape, 2000.

<sup>145</sup> N. Begg, *The Child and his Family*, Whitcoulls Ltd, Christchurch, 1975, p.20.

<sup>146</sup> S. Kedgley, *Mum's the Word*, p. 152.

<sup>147</sup> K. Sinclair, *The Pelican History*, p. 321.

women.<sup>148</sup> If a nurse married, until 1965 at least, she was expected to leave the hospital to become a housewife. There were a few married ex-staff nurses who became 'General Duty' nurses usually working between 9am and 3pm. Some of these qualified nurses were used only for mundane duties such as putting linen away. It was considered that they were no longer interested in a nursing career because they were married. Once a nurse became pregnant she was expected to resign. My personal experience as a pregnant, married staff nurse in Wellington Public Hospital in 1965 was that I could carry on working as a theatre nurse, but it was only allowed because I was out of the public view working in the operating theatre. A student nurse was not allowed to marry during her training as it was considered 'a waste of training' because she would become pregnant and be unable to continue.

Women often married quite young (the norm for marriage in 1955 was 21 years old) and without contraception most marriages were followed quite quickly by children.<sup>149</sup> Contraception, or advice on contraception, was available but difficult for many women to access. Doctors were the gatekeepers for contraceptive information. Many doctors were opposed to birth control, and frequently women were too shy to question their (usually male) doctors on the topic.<sup>150</sup> A reflection of medical thought can be found in a contemporary textbook for obstetricians.

*The gynaecologist or family practitioner is frequently asked by married women of all classes for advice and instruction on birth control. ... It is not for him to advise the newly married who for personal reasons desire to prevent the occurrence of pregnancy, unless ... the state of health or very special circumstances indicate that to delay the occurrence of pregnancy would be definitely to her benefit.*<sup>151</sup>

---

<sup>148</sup> A. Stevenson, 'Realities and rhetoric', p.38.

<sup>149</sup> S. Kedgley, *Mum's the Word*, p.157.

<sup>150</sup> P. Mein Smith, *Maternity in Dispute*, p. 110.

<sup>151</sup> J. M. Kerr, et al., *Combined Textbook of Obstetrics and Gynaecology*, Livingstone, Edinburgh, 1944, p. 833.

In 1936, in response to the need for information, a group of Wellington women had established the precursor of the Family Planning Association, the Sex, Hygiene and Birth Regulation Society, so that they could make a submission to the Committee of Inquiry into Abortion set up by government.<sup>152</sup> By 1953 when the first Family Planning Clinic opened in Auckland,<sup>153</sup> some information was available. In a book of advice for pregnant women published under the auspices of the New Zealand Obstetrical and Gynaecological Society is a section entitled 'Advice to the Newly Married' containing information about both sexual intercourse and contraception.<sup>154</sup> Women often did not know how pregnancy happened, as sex was quite commonly not discussed at all before marriage, and few women would know anything about contraception. Single women would be even less likely to ask their medical practitioner about it. Even nurses' training contained little, if any, information about contraception.<sup>155</sup>

Oral contraception allowed more control of fertility when 'the pill' became available in the mid-1960s. The effect of a relatively reliable form of contraception, and changing attitudes to women's place in the workforce, began to erode the predominance of unmarried women in the permanent nursing workforce in hospitals. By the 1970s there were increasing numbers of married women in the nursing and midwifery workforce, but during the time-frame being described, from 1950 to 1970, there were very few married midwives and nurses caring for women having babies, and still fewer who had experienced childbirth.

Changes to social habits accelerated in the 1960s. Religion played less of a part in people's lives, communications improved with increased numbers of motor cars and telephones, and television, introduced in 1960, was in most households by 1970. With

---

<sup>152</sup>P. Mein Smith, *Maternity in dispute*, p.111.

<sup>153</sup> S. Kedgley, *Mum's the Word*, p.157.

<sup>154</sup> New Zealand Obstetric and Gynaecological Society, *The Expectant Mother*, Whitcombe and Tombs, Wellington, 1953, p. 2.

<sup>155</sup> S. Kedgley, *Mum's the Word*, p. 158.

the increase in air travel more people travelled and consequently brought new ideas back with them to New Zealand, including 'hippie' culture with its ideas of sexual freedom. Labour saving devices such as washing machines and refrigerators saved time for women, freeing them to work outside the home or pursue other interests. Many of the cultural constraints which had shaped women's lives were changing by 1970.

The influences on women's lives in the 1950s and 1960s are contextually important to our understanding of women's maternity experience in that era. They contextualize many of the women's responses to the maternity environment and the attitudes of the maternity practitioners.

### **The Women**

This section introduces each of the four women interviewed and relates their stories of giving birth in Wellington in the 1950s and 1960s. In this section I have tried to allow the women's voices to speak as they tell their stories. The issues which arise are considered in more depth in later chapters.

### **Ivanka**

The first woman interviewed was Ivanka Marta. She is of Ukrainian descent and came as a young woman to New Zealand, leaving her family in Australia. As a young woman working in Wellington, she became pregnant at a time when there was no financial support for unmarried mothers and to be an unmarried mother was socially unacceptable. In 1968 there were three options available. The first was to travel to Australia for a termination of pregnancy. This was morally unacceptable to Ivanka. The second was to live in the Salvation Army's Bethany Maternity Home, where pregnant single 'girls' were able to stay during their pregnancies, while they worked in the institution to pay their keep and were 'trained' in domestic skills. In Ivanka's words:

*...another option pointed out to me by my doctor then, in Wellington, was to go to Bethany Home, which I went and visited. And I thought, wow, this is not for me. Staying seven, eight months in this home and basically just being a servant and losing your identity totally.*

Ivanka chose the third option, finding a family in Porirua with whom she could live, in exchange for help in the house and help with the two children. She hid her pregnancy from friends and family, wore a gold ring bought at a second hand shop, went to antenatal classes pretending she was married and looking forward to the baby although she had decided to have the baby adopted. This method of maintaining herself during her pregnancy was not uncommon at a time when many young, unmarried women left home during their pregnancy so as not to 'shame' their families and there was no benefit that they could access for financial support. It certainly was a difficult way to live:

*My whole nine months. I felt like I was living under false pretences, totally. I suppose I had to divorce myself from being pregnant, as such, and from even allowing myself from having thoughts about the child, about the baby I was carrying.*

Ivanka finally went into labour and was taken to Kenepuru Hospital.

*Well, the birth of my baby ... I think I had a show, and I thought, oh, what's happening here. So I was taken to the hospital. Probably dumped, because, nobody was allowed to stay, and hang around and be supportive or anything like that.*

Her memories of being admitted to the hospital in labour were not happy ones:



*My recollections are of first coming to the hospital and just being dumped in this room on this very, very high bed. I can't remember being greeted with any compassion, with any love. With any sort of 'how are you dear?' or anything like that. It was like, 'Get up there, get up there and stay there.' And all I remember was this room. It was horrible.*

*It was big, and there were all these instruments everywhere. It was so big and just full of metal. I felt so ... what is the word ... like I had been such a bad girl.*

*And I wondered, what am I doing here? I deserve to be here. So, any outcome of this ... This is all my fault, kind of thing. I'll be punished. This is my punishment. So, you just stay on that bed and just wait for us. Y'know, we'll come to you when we're ready...I can't remember having anything told to me or explained to me. Or even shown any empathy or anything.*

*...So I remember really dying for a pee and thinking, gosh, I'm up here ten feet off the floor and I'm waiting and waiting for someone, and I really am bursting for a pee. What am I doing? So, I finally manage somehow to get down and found a toilet. Waddled off to the toilet, had a pee and of course I got spotted by a nurse.*

*I don't remember who it was, a short lady, and wow, she laid into me. Oh, she gave me such a hard time. "Get back on the bed! What do you think you're doing? You're killing your baby ... and da da da da ... Y'know, she was probably just being sensible. I thought okay. So I get back on that bed and I ... That's when I felt, oh, I'm at their mercy. I deserve this y'know. And, of course, being brought up to respect authority, I totally lost my identity, and I thought I was a strong woman until then. I thought, I just have to let go and be totally submissive. I think that day I was in labour for about ... it would have been way over twelve hours....*

*...Yeah, I felt like nothing.*

Ivanka expresses her fear and anxiety, unalloyed by any show of warmth or welcome from the staff, and her decision to do as she is told. She felt very alone during her labour, a loss of identity and a feeling of being punished. The societal attitudes of disapproval of single parenthood may have been reflected in the way she was treated by the hospital staff. Some of the upsetting factors may however, also have been due to the usual hospital routines of the time:

*And I remember they gave me a pan there one time. Which was the most uncomfortable thing in the world. Sitting up in this big, high bed with a pan underneath you, and trying to do something, which was quite bizarre. I feel like I was in labour quite a long time.*

Obviously there were some staff who were more understanding:

*I think I gave them a run for their money. Because I was in labour for quite a while, and pushing, and screaming, and I do remember, there was one wonderful midwife there, and I'm sure she must have carried bruises for many months afterwards. She was quite loving. She would talk to me and be nice and comforting.*

After the birth of a baby who was over five kilograms in weight, Ivanka decided not to have the baby adopted and informed the social worker of her decision.

*She was very angry. And I thought, wow, this is my baby and you're being angry with me because I've decided to keep my baby? She was angry because, she told me, that she'd already picked out parents for the child. She told me I couldn't do it because I'd already signed the adoption papers....*

*.....I said, I'm not doing it. I'm not giving my baby up. That I want to keep him. I don't know what ensued after that. It's quite a strange thing, I don't know who notified who, or whatever, because then I had my baby in the room with me. And, I don't know if that was before I notified 'Welfare' or whether it was after. But he was there in my room.*

Ivanka kept her baby. Because she had not prepared for him, he stayed as a 'boarder baby' in the hospital for a few days while Ivanka and her partner went to Wellington to organize accommodation and baby equipment:

*They said they wanted to monitor him, because he'd been so big and he was losing weight so quickly. So they suggested that I could go off for a few days and get things organized. And get myself organized. So I was very lucky.*

Because Ivanka left hospital fairly early to arrange for her new life with her baby and partner, it was arranged that she would go to the Karitane Hospital with her baby for a while.<sup>156</sup> This might have been because there seems to have been concern about baby's feeding, but the stay in Karitane was welcomed by Ivanka:

*I would like to know how I got ... who gave me leave to go and do these things, because, whoever did, obviously was working in my favour. And wanting to help me. So, someone must have been working on my behalf, which was really wonderful.*

After a week at Karitane Hospital she took baby home and began her new life. She did not breastfeed because she had been given an injection during labour to suppress her lactation. She believed that she would not, therefore, be able to feed and nobody ever

---

<sup>156</sup> The Karitane Hospitals helped mothers with babies who were having problems associated with infant feeding, and other problems related to mothercraft. They were initially established by Sir Frederic Truby King who also founded the Plunket Society.

suggested she should try. The staff were already having concerns about baby's lack of weight gain and possibly felt that he would be better formula feeding.

*So, someone organised for me to go to Karitane, for a week with the baby, so I could get some bonding together.*

*Which was magic. Absolute magic.*

*The place itself was beautiful. There were some wonderful people there....*

*...That was excellent. It just gave me that little bit of breathing space, because they were there to help me and it gave me that little bit of space to quietly bond with baby. And get used to the idea that, well, I've got a baby.*

Ivanka had her next baby in the early 1970s at the new St. Helens Hospital. It was a totally different experience, but not everything had changed:

*Yeah, and my whole life was different then too. I was legal! I was a legal mother! But I still felt, knowing now what I know, that you still had no rights, basically... You had to put your feet in stirrups.*

*There were no choices. No options. Of course I didn't go out looking for them either I mean, I didn't know there were any options. The doctor said, "This is what you do," but that was okay.*

## **Noeline**

The second interviewee, Noeline Ruston, was born in Christchurch in 1931. After marrying, Noeline bore five babies. They were all vaginal births and included one breech birth and one baby born prematurely.

The first baby was born in Alexandra Hospital, Wellington in 1951. Noeline's mother made the arrangements for her to have her first baby in that hospital.

*Well, in my day, having my children, I came from a very large family. I was helping to bring up brothers and sisters, then when I eventually got married, it was Mum; she decided I was going to Alexandra.*

Noeline's mother had babies at home tended by a midwife:

*When my Mother had her babies at home, we had a lovely elderly lady, Mrs Sullivan from Tawa, she came to the house and looked after the women when they had their babies. She was probably a midwife. It was her that taught me to... all sorts of things.*

The circumstance that stands out in Noeline's mind is her lack of knowledge about what was going to happen, and being left alone:

*Noeline: When I had my first baby, I knew nothing. Not a thing. I went in to the hospital, which happened to be Alexandra Maternity Home, in Hanson Street in Wellington.*

*I go in there and they lay me on the bed, get me all prepped up. I was so scared, I really was, I was terrified. One of the nurses came and checked me and she said to me, "Don't you know what's going on?" and I said, no. She said, "We're going to prepare you, we shave you and then we test to see how high the baby is." Then they left me all night. I was on my own all night. Early morning of the day Christine was born.*

Jane: So you hadn't had any antenatal classes and nobody had talked to you about it?

*Noeline: No, nothing what-so-ever. No, my Mum wouldn't even talk. My Mum was still having babies at the same time.*

Jane: Did you know about contraception?

*Noeline: No, none what-so-ever. We didn't have any at all. There was no pill in those days.*

Jane: So you just expected to have babies.

*Noeline: That's right.*

Noeline planned to have her second baby at 'Sister Ritchie's' Maternity Home but because the baby came early, there were no beds available. Sister Ritchie made arrangements for her to have her baby at the old St Helens Hospital.

*I was going into a kind of home to have her. Mum organised that again. It was Sister Ritchie, I think she might have been a midwife. In Wellington, up near the hospital, somewhere. She had all her bookings. She was full. So she rang St Helens and they were wonderful.*

Noeline had her baby without problems at the old St Helens hospital in 1953. The baby was premature and small and was taken away to a special nursery when she was born.

*But just after she was born – 'cause they took her out, straight away, in those days and put her straight into the nursery – so I never saw her. ... there were two nurseries, it was called the prem room. ... in those days I never saw her. I didn't see her for seven or eight days. One day the doctor came in to see me, again. He came and said, "You're not very happy, what's the matter?" And I told him, I haven't seen my baby. So the next thing, here's this big buxom woman with my tiny wee baby. And she said, "Sorry love, you haven't seen your baby. Well, here she is. We mustn't keep her out too long, because she's very tiny." So, I checked her over and made sure she was alright. I was quite happy after that. I was fine because I'd seen the baby and knew there was nothing wrong with her. I think she was about ten days old before I was allowed to feed her the breast. She was quite easy to feed: she was a little hungry baby. She never looked back. I was in the hospital for 16 days.*

Noeline's third baby was also born at the old St Helens Hospital, in Coromandel St, Newtown in 1955. Her last two babies were born in 1958 and 1959 at the Mana Maternity Home at Elsdon which served the Porirua area prior to the building of Kenepuru Hospital. Noeline lived just a few doors away and found that very convenient. Discussing being discharged from hospital she notes:

*What I liked about with Alexandra and St Helens, was the Matron, that used to bring your babies out, when you went home. Your husband would be there and he'd carry your cases with your stuff in it, but the Matron always carried the baby out. Always.*

*And you got in the car, and she handed the baby to you on your knee. Because in those days there was no such thing as seat belts. I used to think that was lovely. To think that it was that person that looked after you and then they'd come out with you.*

And because she lived so close to the maternity hospital in Elsdon

*...when Alison and Philip were born they used to walk me out to the house and put them in the bassinet.*

The last baby was born as a breech but the history Noeline gives suggests that the baby might have presented as a transverse lie and been delivered by podalic version.<sup>157</sup>

*Noeline: Yes, he was breech. He started coming front first. The doctor had to come and turn him.*

*Jane: So it sounded like he was coming actually lying across your tummy?*

*Noeline: Yes.*

---

<sup>157</sup> A 'transverse lie' means the baby is lying horizontally across the woman. It cannot be born from this position. The birth attendant puts one hand inside the uterus and pulls down the baby's feet thus turning the baby into a position that would enable a breech delivery. This is a very risky manoeuvre for both mother and baby.

Jane: The doctor had to put his hands up and get his feet and bring him down?

*Noeline: Yes, turn him and bring him down. That was embarrassing....  
... It was, it was very nasty. But, as I say, I had no pain. This is what amazed me, no pain what-so-ever. My waters hadn't even broken because he had to break my water. But they knew he was ready to come. After he was born somebody said to me, "Oh, you've got your son." And I did not believe them, because I had four daughters. I swore I was going to have another daughter. And they held him upside down.*

Noeline enjoyed breastfeeding all of her children.

## **Helen**

Helen Van Kampen emigrated as a young woman from Northern Ireland and married another immigrant, from the Netherlands. They had four children. Helen had her first baby in 1961 in the old St Helens Hospital. The first baby was about four weeks premature and Helen was quite ill at the time. She hadn't realized that she was unwell, attributing her symptoms to her pregnancy. She was on her own when she went into labour, her husband, Ari, having gone to work. Transport and communication were issues for her:

*Helen: I made a few telephone calls before I rang the hospital, to round up enough money for a taxi. Calling from a callbox. My girlfriend arranged to meet me, so we got to old St Helens.*

Jane: Where were you living?

*Helen: In Wilton. Quite a way to come in, to get a taxi.*

Her admission to St Helens in labour was not without humour:



*We got there and I was carrying a suitcase. The Sisters came to the door and took my girlfriend away by the hand, and left me standing at the door. That was a laugh. Eventually they came and got me and took me to the prep-room. That was an experience as well, you know, getting prepped. Getting shaved and all that.*

Helen had her four pound (1700gm) baby boy without incident after quite a short labour, and was put to bed in the postnatal ward. The baby was taken to the special nursery for small or weak babies:

*That was the thing, you see, then. They took him away to a little special room, and I don't think he was in an incubator. I think he was just behind glass but I never could handle him or see him. There was none of that bonding. I didn't see him. They'd take me up sometimes to look through the glass at him.*

Asked how he was fed, Helen explained that she expressed milk for him for a few days:

*I remember, I used to hate it when I was trying to express the milk to take to Eric. I didn't like that part....  
...yes, they had a pump. That's one thing. He did start on breast milk, for a while.*

Helen's medical condition became worse.

*Well, that didn't last for too long at St Helens because I was only in there... and the next week, my condition got worse, I was alright for a week. But my condition got worse and that's when the doctor... because I had bad diarrhoea. Very bad. He would just send big bottles of diarrhoea stuff up. And that made me really bad.*

*The poor Sisters were up with me all night. They had me cordoned off, I was vomiting and diarrhoea and all. And they left me. ...  
.....They kept ringing the doctor up. He never came over the weekend and he came on the Monday, and when he saw the condition I was in, I was straight to the stretcher and off to Wellington Hospital.*

Helen was transferred to Wellington Hospital and her little baby boy was taken to Karitane Hospital.

*I was very sick then, and they took me up to have a look at him, before they took me down to the other ward.... ...Eric went straight to the Karitane. And I never saw... I never had anything to do with Eric for over seven weeks. I was in the Public and he was in the Karitane.  
That was in 1961.*

*But the nurses, they were really good. They were trained for babies, not for what was wrong with me. They were really good. Good service.*

When Helen was ready to go home from hospital she was sent to the Karitane hospital for a week prior to her discharge home with her baby:

*I know I went to Karitane for a week or something and held him and bathed him and all that....  
...Then I went home with Eric. Ari went off to work the next morning and I was left there.  
I didn't know what to do and I lay in bed and I left Eric, afraid to go out and touch him. You know, I could have done with someone coming in and bathing him or something at home.*

Helen was grateful for the support she had from the Plunket Nurse.

She had her second baby in 1963 in Wellington Public Hospital. She was advised to go there by her medical specialist because of her condition:

*I had Frankie in a public hospital with a specialist. I was under them because of Eric and because of the colitis and stuff. He said to me, I had to go to the Public Hospital. It wasn't a maternity doctor: it was a specialist, a different doctor this time. A very good doctor.*

It was planned that she would be induced, but she went into spontaneous labour:

*Frankie was a bit late coming, 'cause the doctor had said, go in on Friday night and then I'll come and break your waters. And so I was all prepped up nicely. In bed and nice and warm and all, and then about 10 o'clock or sometime I started getting the pains and Frank was born at midnight.*

Frankie's birth was normal but much to her distress, once more, Helen was unable to breastfeed:

*I was looking forward to breastfeeding Frank. But because of my condition, that Medical Specialist – for my condition – he came charging into the ward, and I'll never forget it, he told them that I wasn't to breastfeed. And he gave me an injection to stop it.*

Jane: Because they thought it would take too much out of you?

*Helen: Yeah, but I was really feeling good then. It was a shame.*

Helen had her third baby in 1964 at Bethany Hospital. Her doctor advised her to go there so she would be able to rest:

*With Peter I went to Bethany. That was over in Newtown way, Rintoul Street, somewhere.... I think I was in a cubicle of my own there. And I did really need the rest, I'm sure. That was in August too, and now I remember it, I used to have to wear a mask every time they brought Peter to me.*

*I had to put a mask on because I was always coughing. They didn't know what it was. I think they called it an asthmatic cough, they didn't use anything for it, I just had to get over it. When the weather changed or whatever.*

Helen breast-fed her third and fourth babies without any problems. Her fourth baby was born in 1968 in the New St Helens Hospital which she enjoyed especially for its single rooms but was not as sure about having the baby in the room:

*Oh I loved it. Single rooms. I don't know about having the baby beside you all the time, because every time, you walk off... but then you can feed them.*

## **Mabs**

Mabs Le Page was suggested to me as a potential interviewee by her daughter, who is a midwife. She was pleased to help and willingly gave time from her busy life running a motel at Peka Peka, to help. Midwifery obviously runs in the family:

Jane: Your great-grandmother was a Midwife?

*Mabs: She was a midwife in Nelson in the early days and she used to travel by horse and cart.*

Jane: What year would that have been?

*Mabs: In the late 1800s.*

Mabs discussed her involvement with maternity:

*I was married at 18, had my first child at 19 and I suppose my whole life has been around babies and children.*

*At the time I was working. In those days we didn't really try to extend ourselves to varsity.*

*If you were a girl you were told that your life was going to be in an office, which mine was or you'd end up a mother, housewife, and that would be your vocation in life.*

Mabs was born in Wellington in 1940, married, and had her first child in the old Wellington Hospital in 1959, followed by two others in the Hutt Maternity Annex in 1961 and 1963, when she was living in Wainuiomata, a suburb enclosed in the hills beyond Lower Hutt. She accepted that once she was married she would have babies:

Jane: You didn't have any contraception or thoughts of holding off for a while?

*Mabs: Oh no, we were Doris Day era. It was the way it was.*

*And I had been working since I was fifteen and I was grown up! And we all could cook and sew, entertain and we had a social life and we were hard working. By three years out in the work-force you were grown up and you'd saved money and you were doing okay. So here we were, planning for a future, you know. A house, children...*

Jane: If the children came quicker, it didn't worry you?

*Mabs: It didn't matter because that was our aim in life.*

*We took on two or three jobs to get the money to buy that house.*

When Mabs had her first baby she attended the antenatal clinic which was run by midwives and was held in the basement to the right of the main entrance of the Wellington Public Hospital in Riddiford Street. There were antenatal classes held there as well. She also attended her doctor in his rooms. The usual timetable of visits to the doctor was monthly until 28 weeks, fortnightly until 36 weeks and then weekly until the birth although Mabs remembers visiting him every three weeks:

*There were antenatal classes at the Wellington Public Hospital in the basement. That's where we went once every three weeks, then it went to two weeks, and then it went to one week, the closer you came to child bearing.*

*Each time you visited the doctor you took a sample of urine, and he would take your blood pressure.*

*... it was a clinic but we did exercises of a sort and breathing. They took your blood pressure as well, because when it came to near time of our babies coming, I ended up with toxemia.*

After her last clinic appointment Mabs saw her doctor:

*The family physician was my doctor, through my entire birth, Doctor Segal. He was a Polish Jew, and a straight up man, a very, very good doctor from Miramar.*

When her doctor discovered her symptoms of toxemia of pregnancy at a routine visit he arranged for her admission to hospital and induction of labour:

*Then he rang the hospital and booked me in for that particular night.... I was to be in there within the next six hours. First baby, hospital emergency, what on earth was going on?! Toxemia, life and death, and it was life threatening and so the doctor said I was to be there. I had no car, I had to get on the bus and back I went. I didn't walk up the hill; I caught a taxi up from the shopping centre.*

Shocked and surprised, four weeks earlier than her due date, Mabs took herself in to Wellington Hospital:

*Mabs: So they took all the particulars and prepped me. We used to have shaves, baths etc. Absolutely as if I was going to have this baby, which I knew was there. Then they started filling me with castor oil and orange juice.*

Jane: Did they give you an enema?

*Mabs: Yes, and castor oil and orange juice and they put baking soda in it. Can you imagine that? A young girl's stomach, baby and all. They said, "Now try and keep it down." I remember spraying this, literally, all over the walls.*

Jane: How many weeks early were you?

*Mabs: About nearly a month.*

*...This dear lady, she was the only one that helped me really [another patient]. The nurses seemed to be so busy that you were just put into this cubicle and left to your own devices. I remember that they gave me an injection to help to bring it on: this was all within twenty-four hours. I remember getting out of bed and my water broke.*

Mabs remembers being in a bed in the corridor while she was waiting for the induction to work:

*There was a system. You went in - you clocked in and you were taken straight off to get prepped. Then you were put in a ward. I got an idea, ... that I was on the way, after they'd given me these injections to start my contractions, that I was out in a hallway/corridor and that's where I stayed. And I had asked for help but no one stopped, everyone was busy. Because that would be quite baby booming time then too. They were very busy; there were lots of babies.*

Jane: Was there a sitting room?

*Mabs: No, our ward was it.<sup>158</sup> I'm pretty sure I was in the corridor with Christine and waiting.*

Jane: On a bed?

*Mabs: Yes, on a bed, waiting. And you know, first baby, you think it's coming all the time don't you? Nobody tells you different.*

Mabs remembers the birth of her baby quite clearly:

---

<sup>158</sup> This corresponds to my experience in 1962 when the sitting room would be turned into a bedroom if needed.

*Overnight I went through all this trauma. In the morning I was such a centre of attention, I suppose, in the end, that they took me down to theatre and they strapped my legs,<sup>159</sup> of course. Terrible thing to do to anyone. They had me up there and in came, about, ten student doctors and all these nurses I'd never seen. It was quite traumatic. I suppose if I hadn't have been such a strong person it all would have fazed me right out. There was all these different student nurses and Doctor Segal, and he made it happen. There was this fantastic pain but I'm sure that he used an instrument or something. I wasn't unconscious, and these legs up...*

*.... and they were all watching. All these students, faces I had never seen before.*

Jane: Was there someone beside you, holding your hand?

*Mabs: No, we had the old iron beds. Marvellous, I don't think they should ever have been taken off the wards. You could... I had a great pain tolerance anyway, which was lucky for me.*

Jane: You remember you were holding on to the back of the bed?

*Mabs: I do, I was in control and they were quite happy with that, evidently.*

When asked if her husband had been able to be with her in labour, Mabs replied:

*No, they weren't allowed into... they had to wait until you had had the baby and were cleaned up and the baby was weighed and all the rest.*

Mabs remembers the baby being taken away after the birth:

*They were weighed, wrapped. I think they were taken away because they were taken away for certain things to be done, straight away.*

---

<sup>159</sup> Legs were lifted up into stirrups – the lithotomy position.



*And then I don't think they came back 'til later. ... Yes, and not only that but you used to have to ask to see your baby through the window.*

Mabs told an interesting story, however:

*We used to go down to the nursery though. In fact there was a couple of nights, like when you'd had your baby, where I was on a high, all adrenaline rushed, and I couldn't sleep and I'd go down and help the nurses to change the babies' nappies.*

Mabs had heard of the danger of 'H- Bug', (Staphylococcus aureus) bacteria which caused severe infections and a major scourge of hospitals in the 1950s:

*I forgot to mention to you that when I was in Wellington Hospital, it was almost the start of the H bug. That was a terrible thing. They didn't know how it was all happening. Mind you, I've been back to Wellington Hospital in this day and age and there's still cockroaches.*

Jane: So, you just remember being worried about the H bug?

*Mabs: Yes, everybody was.*

Jane: And had you known that some babies had died because of it?

*Mabs: Yes.*

Even knowing about the 'H Bug' Mabs still believed hospital was the safe option for birth.

Jane: What about homebirth, could you have a home birth?

*Mabs: No, it wasn't even discussed. Never mentioned. We went into hospital for safety reasons.*

Mabs told me about the postnatal care:

*Mabs: The first days you barely saw your child, you had to go down to the nursery.*

*...and then we had, at night-time, if the babies cried, they went down to the nursery, and were taken away from us.*

Jane: Were the babies with you during the day, or would they just come out for feeds?

*Mabs: They came out for feeds.*

Jane: They were brought out?

*Mabs: Yes. ...on a trolley,...then they'd be beside you for visiting hours.*

Jane: Were the husbands allowed to see the babies?

*Mabs: At the end there, they were. But that wasn't for the first days.*

Jane: When you first started breast-feeding, did your breasts get really hard and sore?

*Mabs: Yes, they did.*

Jane: Did they put anything on them?

*Mabs: We used to put hot towels on and a binder.*

*We had binders everywhere. We had binders around our stomachs<sup>160</sup> ... and what's more, we were in hospital for twelve days, so you would have thought that in twelve days they would have almost got us organised, wouldn't you? But it never happened like that because the nurses weren't over friendly, a bit starchy and they swung their uniforms around, their hats. Sisters were Sisters in those days. And they were in charge. They seemed as though they had a private war going. At the same time we really did appreciate having twelve days. We used to have to lie in our beds with our feet up the wall and do our 'tummy times' ...<sup>161</sup>*

---

<sup>160</sup> A firm cotton binder was wrapped around the abdomen immediately postpartum – pinned with safety pins. It stayed on for about twenty-four hours was supposed to help with the recovery of muscle tone in the abdominal muscles.

<sup>161</sup> Women were encouraged to lie on their stomachs for an hour or so every day to prevent retroversion of the uterus. The 'feet up the wall' would be to reduce varicose veins by helping the blood circulation.

Her postnatal stay in Wellington Hospital was marred by the attitude of some of the staff.

*... we had this particular Sister, who used to delight somehow, in leaving us all in tears in the night. Everyone would be crying because of this wretched woman. She never helped you.*

Mabs perceived that there was a lack of help with breastfeeding.

*We were left very much to our own devices, and at the same time we had the babies brought in and they were left... We didn't have feeding help.*

Mabs went home with her baby, breastfeeding but with very sore nipples:

*...being such a fair skinned, I was really quite unprepared for breast feeding, and my nipples split, I can remember that. And gentian violet and all this stuff going over it.<sup>162</sup>*

Mabs was keen to breastfeed and persevered for several months, before finally putting her baby on formula, but there was little encouragement to persevere. 'Bottle feeding' was quite acceptable.

Jane: Did you dry your milk up because your nipples were so sore?

Mabs: Yes. *We used to have a hand pump in those days, I tried that.*

*I tried nipple shields, everything. All these women around trying to feed these babies, with not a great success rate because it was said to us that, if we couldn't manage, they went on to the bottle.*

---

<sup>162</sup> J. Peel. *Materia Medica for Nurses*, N.M. Peryer, Wellington, 1959, p. 24. Gentian violet, also known as crystal violet was a strongly antiseptic dye used in a 1% solution for skin lesions. It was also used to paint the mouths and rashes of babies who had yeast infections.

Mabs appreciated having the support of Plunket at home following her discharge from hospital:

*When we came home from the Hospital, we had Plunket: the Plunket Nurse came around, virtually within the matter of a day. She was superb, Nurse Beverly, and she was a wonderful, stout little lady.*

*She had a little car and she'd come all the way down my steps carrying all her stuff, and have a cup of tea. Gosh she was good: she was so good to me, that she used to think I was the bee's knees.*

*She always commented on how nice and clean my baby was and how nice and tidy I kept my home. She used to wish all her mothers were like me... and of course that's all a girl needs, isn't it. She was the one that said to me, that "you're the mother, and that's the baby. You're in charge and you set the rules."*

Mabs did 'set the rules' and followed Plunket's guidelines:

*In my time, there was set times, like, four-hourly, [for feeding] and that was it. In between times, she'd be having rose-hip syrup or boiled water. If they cry, just change their nappy, change their side, and we lay them on their side. We cocooned them, and they slept beautifully. ...We'd have to alternate the side and they slept snugly, but she said, "If they keep crying, instead of going mad, put them in a room and let them have a cry, because a baby must have a cry." Of course we wouldn't even talk about that now, would you? So, we used to have a good night's sleep.*

Jane: So, you didn't get up to feed during the night?

Mabs: We wouldn't have to. She slept right through, she knew the rules, y'know?

Mabs was not lonely at home with her baby. She had moved to Wainuiomata.

*We looked after each other's children. The neighbours helped each other. It was totally different. And of course we bought our first house in Wainuiomata, and that was tough because we were all the same age, all having babies, no sewerage, no footpaths, no cars. It was hard work. I had three children and the eldest was four, and we didn't have the mod con's for a long time. Even a washing machine for goodness sake.*

Jane: You boiled your nappies?

*Mabs: Yes, and to wash those napkins and to dry those napkins, for goodness sake!*

Her other two children were born at the Hutt Maternity Annexe which was much more to her liking.<sup>163</sup> Both births were quick and easier than the first, with no toxemia to complicate matters:

*Mabs: We were living in Wainuiomata, when she was born, and so I had her in the Hutt Hospital in 1961 and that was quite traumatic but I was well prepared, mentally, because I knew what it was all about. I took my own castor oil, the day before her due date and she arrived right on time. We had to travel from Wainuiomata with the road under construction, so as you can imagine, I left it right 'til the very last, meaning that I got to the Hospital and within twenty minutes she was born.*

Jane: Why was it traumatic?

*Mabs: Well because, well the road, we were travelling at nought mph and I was in strong labour and there was no way that you could get through anyway. Thirteen months later, I had the third baby in the Hutt Hospital. Same procedure, not a bother.*

---

<sup>163</sup> It was called the maternity 'annexe' because it was built on to the existing hospital, rather than being built as a separate hospital. Wellington's maternity ward was also referred to as a maternity 'annexe'.

*But I quite liked the Hutt Hospital. Yes, but it was a happier stay.*

Issues emerged from the narrative of the women's interviews which required further exploration. These were clearly significant because of the emotion attached to them in both verbal and written communication, and also because they resurfaced during the analysis and comparison of each of the women's recollections about the child bearing process. The three main issues identified were 'lack of autonomy', 'being alone', and 'uncaring attitudes'. These will be discussed, and the process of 1950s and 1960s hospital childbirth will be examined using the information gathered from the women, the midwives and other primary and secondary sources in later chapters. Different themes are discussed in different chapters, depending on the aspect of maternity being discussed. Chapter 4 offers illustrations of 'uncaring attitudes' and 'lack of autonomy'. Chapter 5 considers 'lack of autonomy' and 'being alone'. Chapter 6 revisits and discusses all three themes.

### **The Midwives**

This section introduces the two midwives who participated in this study. Two midwives were asked to share their memories with me. Both women readily agreed to do so. Between them they had worked in Wellington Public Hospital, the old St Helens Hospital, the new St Helens Hospital and the Alexandra Maternity Hospital. These particular midwives were asked to participate because they had been suggested by other midwives as having worked in Wellington during the timeframe being studied, and they were geographically accessible. I am grateful that they made themselves and their memories available to me.

I found their testimony very interesting, generally reinforcing my own knowledge in some areas, clarifying points in others and introducing new information. They substantiated many of the statements made by the women but from the perspective of the professional.

This section will only briefly introduce the midwives. Most of their testimony will be included in the next chapters as issues emerging from the women's stories are

explored. The testimony of the midwives is more usefully documented in relation to the topics explored in other chapters.

The first midwife to be interviewed was Mrs Ruth Belton (nee Ffitch). Ruth was born at the Willis Street Obstetric Hospital in Wellington in 1917. She had always wanted to be a nurse and consequently trained as a general nurse at Christchurch Hospital and then as a maternity nurse at Gisborne Hospital.

Ruth went overseas for three or four years, and on her return undertook her training as a midwife at the Auckland St Helens Hospital. When her training was over she returned to Wellington. At the end of 1953, after about four months working in Ward 21 at Wellington Public Hospital, she transferred to St Helens and worked there, “on and off, ‘til the end of the sixties”. This time included two years when she was in England. She was the Matron of St Helens Hospital, Wellington from 1965 until she married in August, 1970.

### **Kathleen**

My second midwife interviewee was Miss Kathleen Brosnahan of Wellington. Kathleen had commenced training as a general nurse at Wellington Hospital in May 1951, registering in 1953 – 1954. She then went straight to Alexandra Hospital to train as a maternity nurse.

While she trained at Wellington Hospital and at Alexandra Hospital, Kathleen lived with her parents in Newtown. She was given special permission by the Hospital Board to do this, because she lived with her parents whose home was within walking distance from the hospital, and only for “as long as my behavior remained acceptable”. Kathleen states that she was the first student nurse to be allowed to live away from the hospital.<sup>164</sup>

---

<sup>164</sup> It was still mandatory for students to live in the nurses home until the end of my training in 1965.

Immediately after she registered as a maternity nurse, Kathleen was accepted for midwifery training at St Helens Hospital, Wellington. It was usual to work for six months before entering into further training but Kathleen did not do this, going straight from her maternity training to her midwifery. Kathleen discussed with me in depth her training in the old St Helens Hospital, and her experiences following that, as a midwife at Alexandra Hospital, where she remained for thirteen years, before it was closed. Following Alexandra's closing in 1971, Kathleen became a Charge Nurse in the maternity Annex at Wellington Public Hospital, and later worked in nursing administration.

This chapter has provided a brief, general description of the role of women in the 1950s and 1960s particularly in relation to being wives and mothers. The women and the midwives have been introduced and the women's stories have been told. The testimonies of both the women and the midwives will be used to explore the physical setting for childbirth in the next chapter and process of childbirth in Chapter 5.



## *Chapter 4*

### **WELLINGTON MATERNITY; BRICKS, MORTAR AND THE WORKFORCE**

This chapter traces the development of the maternity hospital system in Wellington and describes the working conditions for staff, with particular emphasis on nursing and midwifery students and midwives. It uses the testimonies of the two interviewed midwives, my memories and other primary and secondary sources to describe the hospital culture which framed the environment in which the women laboured and birthed.

The first section examines the physical environment of some of the maternity facilities that were available to the women of the time and discusses relations between the maternity practitioners.

#### **The Evolution of the Maternity Service in Wellington**

Maternity in New Zealand had changed from the 1900 environment of unregulated small private maternity homes and homebirth to medically controlled state subsidized hospital care for maternity ‘patients’ by 1950. This section examines the progression of these changes in Wellington. It explores the history of maternity in Wellington to establish an understanding of how the hospital system had evolved locally and what options for childbirth were available to women from 1950 to 1970.

Sir Fred Bowerbank gives a fascinating account of maternity in early Wellington. He discusses midwifery care, mentioning maternity nurses and midwives, stating that midwifery was “very primitive”.

*In Wellington only complicated maternity cases were admitted, and then only to the general wards at the Public Hospital. Not until 1932 was a decision reached to set aside small wards adjacent to Ward 6 for these cases; and it was not until 1939 that the board leased a private hospital in Lower Hutt for normal maternity cases.*<sup>165</sup>

The private hospital in the Hutt Valley is likely to have been the Te Marua Hospital which was noted to have been administered by the Wellington Hospital Board. Sonja Davies also recalls that Ward Six was “reserved for women with difficulties associated with pregnancy”.<sup>166</sup> Bowerbank mentions Upper Willis Street as being, in those days:

*... the Harley Street of Wellington because so many doctors practised there. During the first decade of the 1900s, or shortly afterwards, three private hospitals and two maternity homes opened in and about the area.*<sup>167</sup>

He elaborates by explaining that all the doctors, apart from three who were ear, nose and throat specialists, were in general practice which included maternity cases. Even the doctors with extra qualifications in surgery, some of whom were honorary visiting surgeons to the Wellington Public Hospital practised in this way. Bowerbank then explains that by the 1950s many doctors had rooms in Kelvin Chambers (on The Terrace), or in the suburbs. Kelvin Chambers was almost entirely populated by medical specialists in the 1950s and for many years thereafter, and Willis Street lost its primacy as the ‘medical’ street. Beaglehole, also mentions the many medical brass plates advertising the doctors who worked within the houses in Upper Willis Street, including that of Dr Agnes Bennet, who was appointed as the first woman medical superintendent of St Helens Hospital, Wellington, in 1908.<sup>168</sup>

---

<sup>165</sup>F. Bowerbank, *A Doctor's Story*, p.81.

<sup>166</sup> S. Davies, *Bread and Roses*, Australia and New Zealand Book Co, Auckland, 1984, p. 52.

<sup>167</sup>F. Bowerbank, *A Doctor's Story*, p. 75.

<sup>168</sup> C. Manson and C. Manson, *Doctor Agnes Bennet*, p. 53.

Willis Street was still home to several maternity homes until the early 1950s, notably the white, two storeyed Harris Hospital and the Willis St. Obstetric Hospital pictured below.

There were other small maternity homes in various suburbs similar to the four-bed Ranui Maternity Home in Frazer Avenue, Johnsonville. The woman who set up and managed Ranui was a Mrs Mikozi, who had separated from her husband after having two sons. She had been a District Nurse. She had to temporarily put her sons into an orphanage so that she could train in maternity, but opening her own maternity hospital gave her an income so that she could continue to support herself and her two sons.<sup>169</sup>



Figure 2. The Willis St. Obstetric Hospital. Circa 1947.

The *Evening Post* and *Dominion Newspapers*' birth columns of 1943 show that numerous small maternity or "obstetric" hospitals existed in the greater Wellington region. These included Bethany (Rintoul St), Alexandra (Hansen St, Willis St Obstetric Hospital, Harris Hospital, Avon, Waimarie, Ranui (Johnsonville), Knights Rd Hospital (Lower Hutt), Hopwood Obstetric Hospital, Hataitai Obstetric Hospital, Te Marua, Braeburn, and Trescol Private Hospital. Some of these were to close between 1945 and 1955. For example, Ranui closed its doors in 1945 soon after I was born there. This closure of private hospitals has been discussed in the previous chapter.

All of the hospitals enjoyed the services of their local obstetricians and general practitioners but some doctors did have preferences. For instance Dr T.F. Corkill disliked caring for women at St. Helens:

*Ruth: ...some of the doctors had to send their patients to us. And some of them, especially Mr Corkill, deeply resented having midwives interfering with their patients.*

Jane: Was that the old Mr Corkill?

*Ruth: Yes, he deeply resented it. Absolutely hated it. So that, before that, Miss Hamilton had complete sway, if you had any problems you went to her and she'd deal with it or she'd get one of the medical staff to deal with it.<sup>170</sup>*

Generally, however, the doctors were respected and relations between midwives and doctors at that time were good. This was probably due in no small part to the fact that midwifery had become nursified and hospitalised and consequently controlled by medicine.

*Kathleen: The Matron ...lived up stairs and there was a bell if you needed her, but the doctors always came, they were extremely good.*

---

<sup>169</sup> A Mikoz, Personal Communication, April, 2000.

<sup>170</sup> There were two doctors with the name Corkill, a father and son who both practised obstetrics.

Training in maternity was not always as comprehensive for doctors as midwives and some doctors (and midwives) recognised this:

*Ruth: Some of them, I felt, didn't know much about delivery at all...  
I was talking to Doctor Farrow who we used when one of the staff  
members was incapacitated and he said he was terrified. He felt we all  
knew so much more than he did.*

Some of the doctors working in Wellington would have received their training in the 1930s, the time that Parkes was commenting on when she said:

*Although the midwife's status was defined in every way as inferior to  
the doctor with whom she worked, obstetrical training for graduates  
from the Otago School of Medicine was far from adequate.*<sup>171</sup>

### **Bethany and Alexandra**

Bethany and Alexandra Maternity Homes were charitable institutions which catered for unmarried mothers, providing accommodation for the pregnancy and postpartum period as well as for the birth of the baby. This care was subsidized by the hospitals' private patients, although after 1938 the hospital would have received a government subsidy.

*Jane: Was Bethany private as well?*

Helen: Yes, it was private.

*Jane: Did you have to pay?*

Jane: Yes, actually twelve pounds comes to mind.

---

<sup>171</sup> C. Parkes, *The impact of medicalisation*, p. 171.

Bethany was owned by the Salvation Army, Alexandra by a local charitable trust. Alexandra was also a training hospital for maternity nurses. These two hospitals did not close until the 1970s. Alexandra Maternity Home, which was on the corner of Hansen Street and John Street, was particularly mentioned by Bowerbank. He states that it had originally opened as:

*...a voluntary hospital for unmarried woman patients. It was administrated under great difficulties because of a shortage of funds, but was ably conducted by Miss Morgan, the Matron....*<sup>172</sup>

Alexandra hospital was a training school for maternity nurses, both direct entry and registered general nurses who trained prior to 1958. Kathleen Brosnahan trained there and some years later, after completing her midwifery training at St Helens, worked there as a midwife. She remembers:

*Miss Burdett, who was the Matron of the hospital, she was a very fine woman – fine looking woman who wore a pretty little lace hat, tied under the chin, with lace around it like a bonnet – and she administered the hospital from – what we used to call – the administration trolley, which was a flower trolley. She did the flowers all day, it would appear to us as students, and the hospital ran around this flower trolley, and there wasn't anything that went on that Miss Burdett didn't know about. As a student, we worked hard, but I had a wonderful training. Then, Alexandra Hospital had the services of the best obstetricians, specialists, in Wellington. That was Mr. Findlay, T.F.Corkill, the 'founder of Obstetrics', and these gentlemen came to the hospital and gave their care and they were actually the Medical Superintendents of the hospital as well. The one who was the Medical Superintendent, when I was there, was T.F.Corkill, and later Mr. Brian Corkill and later on from that, Dr Diana Mason.*

---

<sup>172</sup> F. Bowerbank, *A Doctor's Story*, p. 81.

*The hospital was divided into two parts, with the ‘Girl’s Home’ attached, which had about 24 girls residing in it. These were the unmarried mothers. The other mothers were in the actual private rooms. Every room had a Maori name: Rangatira, Te Awatea, one of them was translated that was attached to the labour unit and we had it related to ‘stout hearted’, which we thought was very applicable. However, the hospital ran very well but, when I look back on it, it was very frugal and it was administered by a bevy of christian women, who founded it at the turn of the century, as a home for single girls, with a back up for the financial support of the married mothers. It was an extremely efficient area of social service and it worked very well.*

### **Karitane Hospital**

A hospital which features in the women’s testimonies is the Karitane Hospital in Melrose. Here it is described by a contemporary writer:

*On the town belt, adjoining the Melrose Heights is to be found one of the most interesting institutions in New Zealand – the Karitane Babies’ Hospital opened by our present Queen, when visiting the Dominion in 1927.*

*“It is the loveliest thing I have seen since I came to New Zealand,” was the enthusiastic comment of Lady Freyburg on the occasion of her first visit. Building, contents and site are alike, lovely and inspiring. The exquisite harbour view, the many windowed building adorned internally with beds of beautiful babies and externally with beds of beautiful flowers are a lasting city memorial to the “World’s greatest friend of little children,” the tribute to which by common consent posterity has bestowed upon the Dominion’s greatest benefactor to humanity, Sir Frederic Truby King.<sup>173</sup>*

---

<sup>173</sup> F.L. Irvine Smith, *The Streets of My City*, A. H. & A.W. Reed, Wellington, 1949, p. 249.

The florid terms in which this author describes 'Karitane' and the founder of the Plunket Society, reflects the culture of 1949 and the high regard in which Truby King and his theories, the Plunket Society and the Karitane hospitals were held at that time, the beginning of the era which is the subject of this thesis.

The Karitane Hospital was not a maternity facility but was a hospital for babies and a teaching hospital for Karitane Nurses. These were nurses specialising in infant care and nutrition. They were trained only for that purpose and were not registered nurses. They were often employed as nannies and also worked in hospitals caring for sick infants. The Karitane Hospital was moved to Featherston during the the war years but after the war was returned to its original site.<sup>174</sup> It was closed in the early 1970s. The hospital earned high praise from some of the women who used it.

*Ivanka: So, someone organised for me to go to Karitane, for a week with the baby, so I could get some bonding together. Which was magic. Absolute magic. The place itself was beautiful. There were some wonderful people there.*

Helen was a little more non-committal.

*Helen: I know I went to Karitane for a week or something and held him and bathed him and all that.*

Jane: Because he was premature.

*Helen: Yes, and I stayed there.*

Jane: Was that alright?

*Helen: Yeah, I came out of the hospital and I went straight there, for a week. Then I went home with Eric.*

---

<sup>174</sup> J.F. Jackson, oral history tape. 2000.



## St Helens Hospital

The first of Grace Neill's St Helens Hospitals had been hurriedly set up in a rented house in Rintoul St. which was finally purchased in 1909.<sup>175</sup> It had proved unsuitable by 1912 and by the 1950s had been "long since abandoned"<sup>176</sup> and replaced. Noeline describes the St Helens Hospital of the 1950s as "a big two-storey house in Coromandel Street, Newtown".

*Ruth: Yes, it was a Department of Health hospital and it was an old hospital and inconvenient according to today's standards.*

Miss Hamilton had been the Matron in the 1950s and was replaced in 1965, on her retirement, by Miss Ffitch (Mrs Ruth Belton), who remained as Matron until 1970.

*Kathleen: It was run by the Health Department at that time.... I think the main thing about it was, the conditions were very primitive, and the place was rundown and unsafe, as I look at it now. At the time we, as a group, made a deputation to the Health Department, saying it was unsafe and we were very unhappy there, but it didn't do us any good at all, except to put us in, what we thought of, as the black book....*

*That was the late fifties, '58 to '60, something like that. ...The lino was all worn with big holes and we were petrified that we would catch a cot in it and the baby would tip out and things like that. It was extraordinarily run down, probably because they were on the verge of closing it or planning the new hospital, and so that was what was left up there.*

Jane: How many beds did they have?

*Kathleen: I wouldn't really know, maybe 50 beds up there, but I really don't know.*

---

<sup>175</sup> H. Maclean, *Nursing in New Zealand*, H.W.Tolan, Wellington, 1932, p. 55.

<sup>176</sup> H. Maclean, *Nursing in New Zealand*, p. 58.

*The Matron at that time was Miss Hamilton, who was a very nice person, and she saw that we had good food, the food was extremely good. The milk rooms and the boiling up of all the teats and things were very antiquated, old and quite horrible.*

The old hospital was obviously very run down by the late 1950s but was replaced by a modern 60 bed 'rooming-in' hospital in 1965. Ruth Belton was Matron at the time.

*But while I was there, before I became Matron, they built the new hospital. They finished it after I became Matron and we moved across... ...it was very convenient. Lovely hospital.*

The new hospital was very popular with women and the midwives. They liked the single rooms and the pleasant, clean and new surroundings.



Figure 3. A postnatal room in the 'new' St Helens Hospital which opened in 1965.

The rooms in the hospital were welcoming with floral curtains and large windows. The delivery rooms, while still very clinical, had been enlivened with washable wallpaper

and pictures, very different from the painted, plain walls of Wellington Public Hospital at the time. The hospital had new modern beds and new perspex cots for the babies. Along with the four delivery ‘theatres’, there was an up to date operating theatre for Caesarian Sections which would have been very welcome after the poor conditions in the old hospital described by Kathleen.

### **Wellington Hospital Board Hospitals**

The Wellington Public Hospital had been opened on 15 September, 1847 in Pipitea Street as the ‘Wellington Colonial Hospital’ on land presented by the local Maori. In 1855 expansion became necessary and a new building was erected, also in Pipitea Street, where the Wellington Girls College was later built. A new and larger hospital was erected, using prison labour,<sup>177</sup> in 1878 on a government reserve of eight acres of land in Adelaide Rd, Newtown.<sup>178</sup> This building was opened in 1881 and formed the earliest part of the cluster of buildings at the present Riddiford Street, Newtown site, forming the main corridor and Wards 1 to 4, which were still in use in the 1960s. It was known then as the largest hospital under one roof in the Southern Hemisphere.<sup>179</sup> The hospital had developed into a proud institution with a good reputation. This is reflected in this rather idealistic description:

*Wellington Hospital is far more than bricks and mortar. It is a symbol of sympathy, sacrifice and love of one’s fellow men, of trusteeship of possessions for the common weal, “ the spirit and service of a noble band of men and women bound together by indestructible ties of kinship and common citizenship,” a spot where doctors, nurses and public alike meet on a shining plane of service.*<sup>180</sup>

The ‘soldiers ward’ which had been built in 1941 beside Wellington Public Hospital

---

<sup>177</sup> L. Barber, and R. Towers, *Wellington Hospital*, p. 21.

<sup>178</sup> F. Irvine Smith, *The Streets of My City*, p. 245.

<sup>179</sup> Personal communication from nursing tutors during student days.

<sup>180</sup> F. Irvine Smith, *The Streets of My City*, p. 247.

was converted for use as the Wellington Hospital Maternity Annex and opened in 1947.<sup>181</sup> Doris Gordon discussed the urgent need for maternity beds which was then acute because of the post war baby boom and tells the story of how she expedited alterations to the military hospital for its new use while in her Department of Health role as Director of Maternity Welfare:

*By the time I took up office in Wellington, the buoyant birthrate had given politicians a headache and reactionaries were hoping a baby would be born on the steps of Parliament itself to spotlight the utopian debacle. So it was easy for me to arrange for the empty ward twenty-one at Wellington Hospital to be ceded for maternity.*<sup>182</sup>

However, difficulties, mainly in the form of bureaucratic slowness, impeded progress and it was another seven months until the unit was opened.<sup>183</sup>

The early 1950s were a time of relative prosperity, and the Wellington Hospital Board reflected this in an increased building programme:

*In times of prosperity the welfare state's hospitals are one of the first avenues for absorbing increased economic wealth. Prosperity did come to New Zealand at the beginning of this period. Between 1954 and 1964 the Dominion's Hospitals increased their expenditure on land, building and equipment, from £2,750,000 to £6,840,000. Of the 2,683 Maternity beds in use in 1964 one thousand and eighty were new or replacements.*<sup>184</sup>

The new Hutt Hospital admitted its first patients in 1944.<sup>185</sup> It was designed and built

---

<sup>181</sup> L. Barber and R. Towers, *Wellington Hospital*, p. 96.

<sup>182</sup> D. Gordon, *Doctor Down Under*, p. 120.

<sup>183</sup> D. Gordon, *Doctor Down Under*, p. 122.

<sup>184</sup> L. Barber and R. Towers, *Wellington Hospital*, p. 106.

<sup>185</sup> L. Barber and R. Towers, *Wellington Hospital*, p. 82.

with its own Maternity Annexe. The annexe was replaced by a new maternity block in 1966. In Knight's Road, Lower Hutt, also under the control of the Hospital Board was the nine-bed Te Marua Maternity Hospital which closed in 1966. Elderslea Hospital in Upper Hutt opened in 1961, with 40 beds with rooming 'in' facilities.<sup>186</sup>



Figure 4. Wellington Public Hospital. Circa 1968.

Key.

- |   |                                |   |   |
|---|--------------------------------|---|---|
| 1 | Medical Superintendant's House | 6 | Victoria Ward                                     |
| 2 | No. 1 Nurse's Home             | 7 | 210 Block   |
| 3 | Maternity Annexe               | 8 | Main Corridor and demolished 'Nightingale' wards. |
| 4 | Children's Hospital            | 9 | Riddiford St. Entrance and Casualty Department.   |
| 5 | Seddon Block                   |   |   |

The Kapiti Coast, north of Wellington, was served by the Otaki Maternity Hospital<sup>187</sup> (built as a cottage hospital in 1898) until the fifteen bed Paraparaumu Maternity Hospital opened in 1958. Kenepuru Maternity Hospital opened in 1965 replacing the

<sup>186</sup>L. Barber and R. Towers, *Wellington Hospital*, p.100.

<sup>187</sup> This had opened in 1898 as the Otaki Cottage Hospital and later been converted for maternity use.

temporary six bed Elsdon Maternity Hospital catering for the Porirua and Titahi Bay population.<sup>188</sup> The 'Mana' Maternity hospital in Elsdon, Porirua, described by Noeline was likely to have been the 'Elsdon' Maternity Hospital. All of these hospitals were owned and administered by the Wellington Hospital Board, except Otaki which had passed to the Palmerston North Hospital Board in the 1930s.<sup>189</sup>

### **Student recollections of Wellington Hospital**

This section will be written from my own recollections of maternity services at Wellington Hospital as a student nurse from 1962 to 1965, and later as a Staff Nurse until 1970. The purpose of this is to present the details of the day-to-day work of the staff in a maternity hospital of the time, to add to the contextual detail for the testimonies of the women and the midwives, and to illustrate the conditions for the majority of the workforce, for both the general and maternity hospital, who were the students. Recording these details here will also ensure that they are captured before passing beyond the memory of midwives.

I began my nursing training at Wellington Hospital in 1962. The training school for nurses was, during the 1950s and 1960s, using textbooks specifically written for New Zealand student nurses by the doctors who lectured in those disciplines.<sup>190</sup> The Nurses' Regulations 1958 had incorporated the six-month maternity nurse training into the three-year nursing course so that we were training as 'General and Obstetric Nurses'. For 'obstetrics' we used texts written by Dr. Herbert Green from Auckland and by T. F. Corkill, the well known and influential Wellington obstetrician and gynaecologist of the 1930s, 1940s and 1950s, who was the father of Brian Corkill, also an obstetrician and lecturer.<sup>191</sup> Other obstetricians lecturing student nurses included Gordon Findlay, a very large, tall man who was fond of explaining reassuringly to

---

<sup>188</sup> L. Barber and R. Towers, *Wellington Hospital*, p.109.

<sup>189</sup> L. Barber and R. Towers, *Wellington Hospital*. p.53

<sup>190</sup> A. L McDonald, and C. P. Tulloch, *Wellington Hospital: Educating Nurses*, p. 23.

<sup>191</sup> Wellington Women's Hospital opened in 1980 and was known colloquially amongst local midwives as 'Corkill's Castle'. It is now officially known as the 'Grace Neill Block'.

mothers of premature babies, that he too had been premature and had weighed only three pounds at birth. Another obstetrician lecturer was Dr. Graeme Duncan. Dr. Kenneth Pacey was also still practicing in the hospital.

Being a student nurse was physically, mentally and emotionally draining, but it was also interesting, challenging and fulfilling. My third six-week ward placement, as a student in 1962, was in the maternity ward. I was very nervous as I had very little experience of babies, and had never seen a newborn. I was reassured by one of the older students that I would soon learn. On my first day I was shown how to wash and change a baby. I then spent all day, for the next week, doing just that. There were forty babies to change before and after each four-hourly 'feed'. I was very expert when I finished my spell in the nursery.

The maternity annexe was a rather temporary looking, draughty, two-storeyed long wooden building. It had mostly four-bed, pale yellow or blue curtained cubicles and a few two-bed rooms that were sometimes used for sick women or women who had lost babies. For ten to fourteen days the new mothers lived in their rooms, in bed most of the time. There was a small sitting room but if there were too many patients the sitting room would be sacrificed and extra beds would be put into it. Sometimes five beds were squeezed into the four-bed cubicles to accommodate patients. At least twelve to fourteen days hospitalisation was considered essential for a woman to recover after the birth of a first baby. This reduced to a minimum of ten days for subsequent babies. The student nurses carried out most of the routine nursing of the women and their babies. They were the largest group of staff in the hospital. Staff Nurses (including midwives), Ward Sisters and Miss MacGregor, who was in charge of the Maternity Annexe, supervised them. There were several Sisters, one in charge of each of the two wards<sup>192</sup>

Ward 22 was upstairs and dealt with complicated obstetrics including caesarean sections, pre-eclampsia, and other antenatal admissions including miscarriages. Ward

---

<sup>192</sup> The ward numbers were changed later to Wards 12 & 14, then again to Wards 11 & 12.

21 was downstairs and included the main ward which was the postnatal ward. The delivery area had its own 'Sister' and included two delivery 'theatres', 'Prep' or preparation rooms where the women were assessed, given shaves, enemas and baths, and labour rooms equipped with nitrous oxide and oxygen gas, where the women laboured until transferring to the 'theatre'. The delivery rooms were well labelled 'theatre' as they had all the appearance of stark surgical operating theatres.

The nursery was another area which had its own Ward Sister. There were two separate nurseries called the 'pink' and the 'blue' nurseries. The cream woven metal bassinets were partitioned off from one another and had pink or blue cot-covers and drapes depending on which nursery the baby was in. Boys and girls went to either nursery.<sup>193</sup> One of the nurseries belonged to the 'hospital team' babies. The other nursery catered for babies whose mothers were under the care of general practitioners or specialists. One nursery had the 'twenty-four hour' room attached to it where the newborns were kept for the first twenty-four hours under observation. The other nursery had the 'weakling room' attached to it where small or sick babies were cared for. It was generally accepted that no babies under twenty-eight weeks would survive and that was the legal definition of the gestation of a viable baby. There was no neonatal intensive care unit at that time.

These first two sections have given an overview of the maternity hospitals in Wellington and an idea of how they were run. The next section will examine the culture of the hospitals of the time based on the midwives' and women's accounts.

### **The Culture of Hospital**

The hospitals were staffed mainly by single women, and students were a large part of the workforce. 'Task nursing' was the way care was delivered and helped to create the regimented environment in which the women birthed and were accommodated for the following twelve to fourteen days.

---

<sup>193</sup> Confirmed by Kathleen Brosnahan in her interview.



The normal working week, at least until 1965, was 44 – 46 hours,<sup>194</sup> but from Kathleen's evidence it seems that at least the student midwives in the 1950s were working well in excess of this:

*We had very long hours. We had to do all our own packing; we bought our own equipment, making swabs and things like that, which we stayed until 2 or 3 in the morning to do. We were on call for days and days and days. Our conditions were very poor indeed and we worked extremely hard.*

This account of long hours of probably unofficial and unpaid overtime is in agreement with Stevenson's findings:

*Daily informal overtime in order to get the work done was the norm throughout the 1940s and 1950s and persisted through into the early 1960s.*<sup>195</sup>

Kathleen also describes incidents of unkindness toward student midwives at the old St Helens hospital:

*The other factor that was there, was that the midwives that were in charge of St Helens were mostly, English trained midwives and they were very harsh and they were almost cruel to us.*

*We were registered nurses at the time, but they really treated us very badly indeed. Our time at St Helens was very unhappy, as students*

This unkindness may have been due to cultural differences, but it is quite likely to be an expression of the hospital culture as described by Stevenson:

---

<sup>194</sup> A. Stevenson, 'Realities and rhetoric', p. 102.

<sup>195</sup> A. Stevenson, 'Realities and rhetoric', p. 101.

*...rather than being focused on values such as honesty and integrity the oversight of nurses was one of control and compliance.*<sup>196</sup>

She adds that each 'layer' of the hierarchy had the duty of inspecting and disciplining the 'layer' below but that even the Ward Sisters who may have had:

*...reputations for being harsh and unreasonable ... were subject to many of the petty rules and bureaucracy they enforced.*<sup>197</sup>

Stevenson points out that the authoritarian control and discipline of nurses in Wellington hospital was "central to nursing practice throughout the 1940s and 1950s",<sup>198</sup> in my experience it was still a factor also in the 1960s. There is no reason to suppose that this culture was only local to Wellington Public Hospital, because nurses and midwives moved freely between the hospitals once qualified, bringing their socialization with them. There is also no reason to suppose that this controlling behaviour would be limited only to student nurses. The experiences of the women illustrate that women were also sometimes subjected to unkindness or indifference. The following discussion relates to the theme of 'uncaring attitudes' identified in Chapter 3 as one of the major issues arising from the women's stories. The previous chapter alludes to Mab's perception of "a private war" between nurses and Sisters.

She added:

*Why they were like that? I think that it might be that they all knew their position. Because a Sister was the boss, and a nurse was to take orders from the Sister and the junior... and even down to the tea lady and everything, they were lovely the tea ladies. I think those ladies were in pink even in those days. But they were all humane, but the others were very regimented.*

---

<sup>196</sup> A. Stevenson, 'Realities and Rhetoric', p. 80.

<sup>197</sup> A. Stevenson, 'Realities and Rhetoric', p. 80.

<sup>198</sup> A. Stevenson, 'Realities and Rhetoric', p. 80.

It was not only the relations between staff that the women remembered, It was also the staff's attitude to them. Ivanka also felt subjected to uncaring attitudes:

Jane: So if you actually had to say one word to describe your feelings about the hospital and the staff there. Not necessarily one word but any sort of impressions?

*Ivanka: Sad. Really sad. Sad, in a sense that I didn't feel that there was any compassion towards me as a human being, y'know, let alone a woman in disgrace. And it wasn't an experience that I would want to go through again. But, on saying that too, like I said, my whole thoughts are distorted. There must have been some really good people there too, who cared.*

Sometimes the negative attitudes a few people leave a lasting memory, but the women also had positive comments about the hospital's staff:

*Helen: ...but the nurses, they were really good. They were really good. Good service.*

*Ivanka: I do remember, there was one wonderful midwife there, and I'm sure she must have carried bruises for many months afterwards. She was quite loving. She would talk to me and be nice and comforting.*

*Noeline: The Matron, she was lovely, she really was. I did feel welcome but as I said I was very nervous and a bit tearful.*

Not all staff were unfriendly:

*Noeline: But when I was at St Helens, I did knitting for all the nurses, we had one particular pattern, because I was knitting myself a cardigan and the nurses liked it so much, that in the end they all came in with their wool and I had to knit all these jerseys, in fourteen days.*

Jane: You sound as though you quite enjoyed the nursing staff; it sounds as though they were very friendly to you.

*Noeline: Yes, yes, they were.*

Another issue which emerged from the women's testimonies was that of the 'loss of autonomy' experienced by the women. This issue is addressed in the remainder of this section. The women's care was dictated by hospital protocols, and even their normal bodily functions such as breastfeeding and elimination needed to fit hospital timetables. Choices regarding breastfeeding, as in Helen's case, or the ability to see and hold one's baby after the birth, were denied to the women by the maternity system.

*Helen: I'll never forget it, he told them that I wasn't to breastfeed. And he gave me an injection to stop it.*

Jane: Because they thought it would take too much out of you?

*Helen: Yeah, but I was really feeling good then. It was a shame.*

Jane: Did you have any choice, did you have any discussion with them?

*Helen: No. There was no discussion. Nothing. In those days you're only in your twenties and you think oh you know, it's their world, and you do what they say.*

Mabs commented on the regimented care:

Jane: So, from being a married woman, in charge of your own home, you're suddenly in a situation where you had to do as you were told and fit in with the Hospital?

*Mabs: Yes, and you believed everything they said and there was no questioning anything.*

Jane: And if you didn't believe them you wouldn't let them know that?

*Mabs: No, no because you'd be breaking the rules. You had so many nappies; you had so many everything. You never asked for any more.*

There were also some differences likely between qualified staff members. Wassner

reports that as a response to the 1957 curriculum changes those maternity trained midwives who were not registered nurses:

*...felt very threatened, indeed were very defensive and resistant. ...latent antagonism existed between general nurses and midwives for decades. The difference in remuneration, despite the same duties and responsibilities ...The newly developed nursing education, upset the status quo between the two groups and heralded the end of maternity nursing.*<sup>199</sup>

This chapter has explored the physical environment of the maternity system in Wellington in the 1950s and 1960s. There were a variety of facilities open to women for childbearing. At the start of the era homebirth was still available but became increasingly unavailable as an option because of the growing medicalisation of birth and the establishment of doctors as ‘gatekeepers’ to the maternity service.

The two most important maternity hospitals in Wellington were the Wellington Public Hospital, which was a teaching hospital for medical and nursing students, and St Helens Hospital which was a teaching hospital for student midwives and maternity nurses. The Wellington Hospital Board was charged by government to provide sufficient maternity beds for the population and this saw a proliferation of maternity beds with the opening of the Wellington Maternity Annexe and then other smaller local hospitals. These were opened between the late 1940s and the early 1950s to cater for the bed shortage due to the increase in hospital birth and the closure of the private hospitals. Bethany and Alexandra were two hospitals that survived until the 1970s due to their accommodation of single mothers which was subsidised by the intake of ‘private’ patients. Alexandra was also a teaching hospital for maternity nurses until that was phased out nationally. Other private hospitals, including Harris Hospital and the Willis St. Obstetric Hospital, closed their doors so that by at least 1960 the choices for childbirth were very different from those in the 1940s. The private hospitals and

---

<sup>199</sup>A. Wassner, *Labour of Love*, p.73.

homebirth vanished, and state or hospital board run hospitals were opening or being built. The Karitane Hospital persisted a little longer, catering for small or sick or convalescing babies and their mothers, and was a teaching hospital for Karitane Nurses.

The workforce was a busy and regimented hierarchy of mostly single women with a large cohort of students. The childbearing women were expected to fit into the institutional culture and conform to the needs of the hospital and its workers. This chapter is important to this study as it describes both the facilities in which the women were accommodated, and the culture and regimentation of the workforce, which are central components of the perceptions of the women in regard to their maternity experience. The next chapter will outline and explain the childbearing process and the women's and midwives' response to it.

## *Chapter 5*

### **THE CHILDBEARING PROCESS**

This chapter will examine the experience of childbearing in the 1950s and 1960s. The process of childbirth will be outlined and explained and issues which are identified in the women's stories will be explored. The explanation will usually be from the perspective of the women, using their narratives as the primary source of information. The midwives' interviews, my own experience and other primary and secondary sources will be used to substantiate and enlarge on each phase.

With some reluctance, I have paralleled the hospital system and used the device of separating the whole childbearing process into the artificial divisions of pregnancy, labour and birth, postnatal and infant care, simply to facilitate discussion of the topics which evolved from the interviews. For the woman the continuum of childbearing is a whole experience and I do not lightly dissect it.

#### **Pregnancy**

In this section I trace the women's experience of pregnancy including their expectations and knowledge of sex, contraception, pregnancy and birth. This section will also cover antenatal care and education, using primary sources from contemporary texts, my own experience, information from the midwife participants and comments from the women interviewees.

The women interviewed displayed pragmatic attitudes toward pregnancy. It was the expected outcome of marriage. They expected to have children and work in the home. Society fostered the idea that marriage and the consequent bearing and nurturing of

children was the most desirable and fulfilling role a woman could attain. The acceptance of this role is shown, for example, by Mab's comments.

*Mabs: I was only 19 years of age. I was married at 18, had my first child at 19 and I suppose my whole life has been around babies and children. At the time I was working. In those days we didn't really try to extend ourselves to varsity. If you were a girl you were told that your life was going to be in an office, which mine was or you'd end up a mother, housewife, and that would be your vocation in life. Here I was, at about eighteen and a half, expecting my first baby.*

Jane: You expected to have a baby when you got married?

*Mabs: Yes, that was the thing.*

*... So here we were, planning for a future, you know. A house, children...*

Jane: If the children came quicker, it didn't worry you?

*Mabs: It didn't matter because that was our aim in life....*

*... the wife stayed home and the man went to work and that was it.*

The women who gave birth in the 1950s particularly commented on their lack of knowledge of women's sexual functions. Noeline's mother would not discuss any topic to do with women's sexual functions but Noeline did manage to get some information, possibly from a domiciliary midwife.

*Noeline: As I say my Mum never ever sat us down even when I got my period. I thought I had cut myself or something. I didn't know what it was all about.*

*...When my Mother had her babies at home, we had a lovely elderly lady, Mrs Sullivan from Tawa, she came to the house and looked after the women when they had their babies. She was probably a midwife. It was her that taught me to... all sorts of things.*

Jane: About periods?

*Noeline: Yes, all sorts of things.*



*... She was very good. But she didn't come along until later, I think I was married to Bert when she started coming.*  
*I used to be able to go over and talk to her like she was a mother. She was lovely she really was.*

Helen also expressed a lack of knowledge about sexual issues:

Jane: Did you know, as a young woman, about contraception?  
*Helen: I vaguely knew. We weren't told anything. You just weren't told anything.*  
Jane: Were you told about sex?  
*Helen: No, it wasn't 'til we had sex, y'know, we weren't told about sex. You picked up little bits here and there, when your mother would talk about something like that.*  
Jane: Your ears would flap?  
*Helen: Yeah. My sister or somebody else would tell you. But nobody ever sat down and told you. Or my uncle, when I was going to a dance at night, he said, "make sure you sit with your legs crossed".*  
Jane: So how old were you when you came to New Zealand?  
*Helen: Twenty-two, as green as grass.*

Even for those women who had some knowledge, contraception was not commonly used.

Jane: You didn't have any contraception or thoughts of holding off for a while  
*Mabs: Oh no, we were Doris Day era. It was the way it was.*

In 1969 Ivanka was not in a hurry to marry and have children:

*I didn't want to get into a relationship. I didn't want to get married. I didn't want to start a family, as yet. Because I was not yet twenty.*

By the end of the 1960s women's role in society was changing. There were more opportunities for other careers and it was increasingly acceptable to be married and also a member of the workforce. An example of this was the ability of married registered nurses to work part-time in the hospitals. In 1967 I worked from 6pm until 11pm three evenings a week in Wellington Public Hospital. I was the second staff nurse there to be allowed to work such hours. It was the beginning of hospital workforce changes and an illustration of the changes affecting the role of women in society.

The first step a woman in the 1950s and 1960s took when she thought she might be pregnant was to visit her family doctor. Pregnancy was usually diagnosed on the signs and symptoms presented by the woman, and included a vaginal examination during which a bimanual assessment of the size of the uterus would be performed to help in deciding when the baby would be likely to be born. During the vaginal examination the woman's pelvic measurements would also be assessed for adequacy. The woman's height and foot size would also be noted as an indication of her chances of having a normal birth. Women of recent Scottish ancestry, who were less than five feet tall and had small feet, were regarded with suspicion as it was believed that they were more liable to need caesarean sections. There were urine tests that would confirm the pregnancy. The woman's urine would be injected into a laboratory animal, mouse, rabbit or South African clawed toad and if pregnancy hormones were present physical changes would occur in the animal. Results could take between twenty-four hours and five days to obtain depending which test was used.<sup>200</sup>

Once pregnancy was confirmed the options for childbirth would be discussed by the doctor with the woman. The main choice was between having a general practitioner who took maternity 'cases' or a private obstetrician for whose services an extra charge would be made. In cases where the woman did not wish to pay for an obstetrician but for medical or other reasons specialist care was deemed necessary, she would be referred to Wellington Public Hospital as a 'staff' patient and be cared for by the

---

<sup>200</sup> T.F. Corkill, *Lectures on Midwifery and Infant Care*, Whitcombe and Tombs, 1960, p. 29.

hospital obstetric team, as Helen did in her second pregnancy. The woman could also elect to have purely midwifery care. The two midwives interviewed both confirm that this care was still available at St Helens, although with some medical input.

*Kathleen: the mothers got extremely good care, but they were mostly looked after by midwives, by us. There weren't many private patients there; they were mostly staff patients, so they called them.*

*They had a very good antenatal service, very good ante-natal Sisters and that sort of thing. The doctors only came in if there was a problem.*

*Ruth: ...we also had staff patients, who hadn't consulted with a doctor, so our medical staff used to see them. If we had any problems with their delivery they would come to see them.*

Jane: So, you still could go to St Helens and be looked after, totally by midwives and a doctor would only be called in if there was a problem.

*Ruth: That's right, but there was a doctor, I think it was Doctor Price, who would see the patients at antenatal clinic and check up on them.*

Jane: Would he see them regularly or just once or twice?

*Ruth: I think only once or twice. I think they'd regularly come to the clinic but I don't know that he'd see them every time. We didn't have very many private patients.*

St Helens had provided domiciliary midwifery care including homebirth from its inception, but this had stopped by the 1950s:

Jane: Was there any 'outdoor' [domiciliary] midwifery being done then?

*Ruth: No.*

Jane: That had stopped?

*Ruth: Yes. The Clinic Sister used to go out to some of the antenatal patients that couldn't come in, sometimes. There were some out in the Porirua area, and she used to go and visit them, but the other ones, they didn't.*

Domiciliary midwifery was still being practised in Wellington in the 1950s, however, as Noeline mentioned “Mrs Sullivan from Tawa” who looked after women in their homes during birth.

Midwives were able to claim from the Health Department for their services. Because women attended doctors to confirm pregnancy, the doctors had become the ‘gate-keepers’ for birth.<sup>201</sup> This would have been a strong influencing factor in the demise of midwifery led maternity care. By the 1960s midwifery care and homebirth were to all intents and purposes not an option. When, during my first pregnancy in 1966, I asked the specialist if it was possible to have my baby at home, I was told:

*There are no midwives doing it any more. You would be much safer and more comfortable in hospital.*

By the mid 1960s there were more private patients than staff patients attending St Helens antenatal clinics. This is reflected in the apparent conflict in the statements made by the two midwives who were each discussing different decades.

*Kathleen (1950s): There weren't many private patients there; they were mostly staff patients...*

*Ruth (1960s): Most of our patients were private doctors' patients, but we also had staff patients...*

The increase in private patients might also have been due to the new St Helens

---

<sup>201</sup> J.F. Jackson, oral history tape, 2000.

hospital, with its single rooms and rooming-in becoming very popular. It was well-known among pregnant women that if you wanted to birth there, it was necessary to book-in as early as possible.

Women were expected both at St Helens and Wellington Hospital to attend antenatal clinic several times, even if they were under the care of a doctor. This was my experience at St Helens and Mabs also attested to this regarding her experience at Wellington Hospital as noted in the previous chapter.

The pregnant woman had the choice of a number of hospitals in which to have her baby. Sometimes the doctor would make a recommendation, as Helen found when her doctor said:

*I think it would be good for you to go to Bethany, so you get a good rest.*

The antenatal visits the woman made to her doctor, or to a clinic, followed a routine pattern for a normal pregnancy. After the initial visit and the taking of the woman's general and obstetric history, monthly visits were made until thirty weeks, fortnightly until thirty-six weeks, and weekly thereafter.<sup>202</sup>

At each visit the urine was tested, particularly for protein to detect signs of urinary tract infection, kidney disease or pre-eclampsia (toxaemia of pregnancy). The urine was boiled in a test-tube over a Bunsen burner for this test. Any protein would solidify with the heat and become visible. There were other tests using a reagent to quantify the protein if it was present. The woman was weighed to assess the baby's growth, and to detect occult fluid retention, indicative of pre-eclampsia. The blood pressure was taken also to check for pre-eclampsia. The uterus was palpated to check baby's growth and position, and inquiry was made regarding the woman's general well-being and whether any danger signs such as reduction in baby's movements, vaginal bleeding or swollen

---

<sup>202</sup> T. F. Corkill, *Lectures on Midwifery and Infant Care*, p.54.

ankles had occurred. Blood tests for blood grouping and to detect anaemia were done routinely at least from 1960 onward, and iron tablets were also given routinely by most doctors to pregnant women. Blood tests to establish the woman's blood group, to detect antibodies and to detect syphilis, and a complete blood count including haemoglobin to check for anaemia, were done. X-ray examination was the only diagnostic imaging technique available and because of the potential complications it was done only if there were clinical indications such as suspected small pelvis, twins, placenta praevia, and foetal deformity such as hydrocephalus.

Antenatal education was not available to Helen and Noeline when they had their first babies in the 1950s but was utilised by Ivanka and Mabs in 1959 and 1969 respectively.

Jane: And you never had antenatal classes?

*Noeline: No, no antenatal classes at all.*

Jane: Did you go to antenatal classes?

*Helen: I can't remember anything like that.*

Jane: So, those were classes?

*Mabs (1959): There were antenatal classes at the Wellington Public Hospital in the basement....*

*...Yes, it was a clinic but we did exercises of a sort and breathing.*

*Ivanka (1969): I went to antenatal classes, and met lots of wonderful women there.*

The antenatal classes at St Helens that I attended in 1966 were taken by a physiotherapist who taught self-care in pregnancy, the physiology of pregnancy and birth using a birth atlas, infant care and breastfeeding. She also taught breathing exercises for labour, and relaxation techniques.

Antenatal classes were organised and run by Parents' Centre. This group had arisen in Wellington in 1951, led by Helen Brew, as a pressure group for more natural birthing and better conditions for women in childbirth. They were called the Natural Childbirth Association but changed the name to Parents' Centre partly to encourage fathers as well as mothers to join. They started by teaching natural childbirth in antenatal classes. They became a national lobby group for rooming in, breastfeeding and more autonomy for women in childbirth. After initial opposition they were approved by the British Medical Association (in New Zealand) and doctors started referring patients to their classes.<sup>203</sup> They obviously also encountered some difficulties being accepted, as Ruth Belton mentioned the opposition of the Matron, Miss Hamilton, to Parents Centre at St Helens:

*Ruth: Yes, Miss Hamilton was very 'anti' the Parent's Centre, I think she felt they were taking over the job of the midwives. So we didn't have much to do with them in the fifties, but later, they came in. And eventually we used to have classes for the fathers, beforehand, antenatal classes. We did have an antenatal clinic and a very good ante natal clinic system. I think they had an antenatal clinic for some time and we also had a physiotherapist as well.*

Jane: It was a physiotherapist who taking antenatal classes in 1966, because I went to the classes as a patient. She was very good, I remember it being quite comprehensive, and it was a course of classes, you went every week for about six weeks....

*Ruth: I think that was influenced quite a bit by the Parent's Centre. We had to keep up with the things they were doing.*

Jane: So there was definitely antenatal education happening at St Helen's from about the mid-sixties.

*Ruth: Probably early sixties.*

The medicalisation of maternity including the medical 'take-over' of antenatal care is

---

<sup>203</sup> S. Kedgley, *Mum's the Word*, p. 167.

captured in the words of T.F Corkill in his 1960 textbook:

*...antenatal care is now regarded as one of the most important measures in preventative medicine and an integral part of the service which should be given to every maternity patient.*<sup>204</sup>

*There is general agreement that, since there are many aspects of antenatal care which are essentially matters for the doctor, the primary responsibility should always rest with a medical practitioner .... [my emphasis].*<sup>205</sup>

The medicalisation of the obstetric part of the curriculum for nursing students is very apparent when reading Green's text for nurses. The book is almost totally focused on the physiology and medical management of childbirth. The woman as an individual is invisible. The only places in the book where some psychological aspects are considered is in the paragraph discussing the option of rooming-in and during labour – but only as the women's attitude and feelings affect her progress in labour. For the purpose of teaching nurses, the woman had been reduced to a group of organs, an organism which produced a baby.

Books have always been available to pregnant women with information on self-care during pregnancy. Two contemporary examples were examined for this study. The first book, by the New Zealand Obstetrical and Gynaecological Society, (mentioned in earlier chapters) dates from 1953. The second, by Liley and Day, dates from 1968. Both books were written for New Zealand women by medical practitioners. The first book begins with an introduction by Professor Dawson of the Otago Medical School, which lauds the Obstetrical and Gynaecological Society. The emphasis on the possibility of the abnormal reinforces the need for medical care.

---

<sup>204</sup> T.F. Corkill, *Lectures on Midwifery*, p. 37.

<sup>205</sup> T.F. Corkill, *Lectures in Midwifery*, p. 42.



*The aim of the Society has always been to ensure the best of care and attention for the childbearing women of the Dominion and for their children. Recently the Society has been convinced of the need for reliable information which would explain in simple terms the possible problems and complications of pregnancy and parturition....*

*...this handbook, whilst very properly emphasising the essential naturalness of the function of procreation, also points out the need for careful supervision of pregnancy that the earliest deviations from the normal which must herald the genesis of complications may be promptly detected; for such detection and adequate treatment can usually prevent the later and graver consequences.*<sup>206</sup>

The book discusses sexual intercourse and contraception then concentrates on the woman's self care, hygiene and diet and the signs and symptoms of pregnancy as they affect the woman. There is no information on labour other than methods of pain relief. There is a preponderance of advice regarding discomforts and complications of pregnancy and the puerperium. On 'natural childbirth' there is a rather disapproving paragraph which reflects the medical thought of the time.

*Within recent years, following the ideas put forward by Grantly Dick Reid, there has been some tendency to favour 'natural childbirth' in which no drugs or anaesthetic agents are used at all. To achieve this ideal requires much training and co-operation between the patient, the doctor, and the nurses who are to be present at the confinement, under conditions which are difficult, if not impossible, to obtain in this country.*

*Relatively few patients desire this method and it has not been accepted by many obstetricians as suitable for our conditions.*<sup>207</sup>

---

<sup>206</sup> N. Z. O. and G. Society, *The Expectant Mother*, p.11.

<sup>207</sup> N. Z. O. and G. Society. *The Expectant Mother*, p. 58.

It is interesting to note how normal birth had become so abnormal that it could no longer be left to nature because the conditions required for it, which had once been so simple, were now unachievable.

The second book is written more from the point of view of the baby and its experiences. Although sexual matters and contraception are touched on and pregnancy is described, much of the book discussed antenatal education, classes and exercises and a detailed description of labour with advice about the importance of maintaining a relaxed attitude. Natural birth, once again, is warned against with the suggestion that the mother is being selfish and could stress her baby by not conforming to a medically managed birth.

*Nature is notoriously wasteful, and though the mother may receive a thrill to the point of ecstasy in delivering her child, her baby may actually suffer considerably more trauma during natural birth than he would experience with a carefully managed confinement.*<sup>208</sup>

The focus is on hospital-based care, with homebirth or 'nursing home' care not mentioned. Much of the book covers the care of the baby and there is much more focus on the woman's and the baby's psychological well-being. The topics and how they are approached portray some of the changes taking place over the two decades of this study in pregnancy care.

Neither book mentions midwives. Doctors and nurses are the only practitioners discussed and nurses figure only as doctors' helpers. Liley does utilize a paragraph in the introduction to explain to his readers that women are lucky to have medical help, and quotes some rather doubtful and misleading figures.

---

<sup>208</sup> H.M.I. Liley and B. Day, *Modern Motherhood*, Heinemann, London, 1968, p. xi.

*Medically the purpose of obstetrics is to obtain a safe delivery for the mother, and a live child, to counteract the staggering infant-mother mortality rates of the past. In our grandmothers' day, for example, a woman had to resign herself to the fact that out of the ten or twelve pregnancies she would experience in her fertile years, she could hope to raise no more than five children. Today, thanks to adequate medical care for women and babies, better than 96 per cent of babies are born alive and healthy.*<sup>209</sup>

With this sort of information being disseminated to pregnant woman it is not surprising that doctors were successful in medicalizing childbirth.

In this section pregnancy, antenatal care and the development of antenatal education have been traced. The most important changes are the expansion in the medicalisation of antenatal care and the introduction of medically endorsed antenatal education. The necessity for Parents Centre, a lobbying group for women, to succumb to medical supervision in return for approval to provide education to pregnant women and their partners exemplifies the power held by the medical fraternity in the 1950s and 1960s. Midwives in both the textbooks and parent education books are referred to as 'nursing staff' and nurses, another indication of the nursification and consequent invisibility of midwives. The general tone of the interviews suggests that the women were generally happy with their ante-natal care and highlights the way doctors had become gate-keepers for maternity with midwives working increasingly as nurses working under medical supervision. This is particularly noticeable in the disappearance of midwifery care as an option for birth, as illustrated by the gradual decline in staff patient numbers at St Helens and the unavailability of homebirth as an option.

---

<sup>209</sup> H.M.I. Liley and B.Day, *Modern Motherhood*, p. xi.

## Admission, Labour and Birth Care

This section describes the progress of the labouring woman as she is admitted to the hospital. The routine processes for what was regarded as ‘normal birth’ in the 1950s and 1960s, are described, with some discussion on aspects of the medical pain relief that was offered and of the women’s feelings.

A problem with hospital birth was often the simple difficulty of getting to the hospital in an era where transport and telecommunications were not as available as today:

Jane: Where were you living?

*Helen: In Wilton. Quite a way to come in, to get a taxi. .*

*... I made a few telephone calls before I rang the hospital, to round up enough money for a taxi.*

*...he didn’t even drop me at the hospital. I went by taxi.*

*He was at work, and it all happened during the daytime. I had to try and find him, ‘cause we didn’t have a telephone. So I think I left it up to the hospital to ring or my girlfriend.*

Jane: If you didn’t have a telephone, how did you manage to get there?

*Helen: Well, there was a telephone box and I had a little bit of money so, first of all I rang my girlfriend and told her I was having these pains in my back and all. She said to me, “Oh Helen, you should ring the doctor”. So then, I got around to ringing him and he told me to get a taxi to the hospital.*

*...Then I had to go away and get money, and I think I had to walk home again. Then I had to go and ring the taxi...*

*... and then with Frank, Ari took me in with Frank, I think we had a car then.*

*Mabs: I was to be in there within the next six hours. First baby, hospital emergency, what on earth was going on?! Toxemia, life and death, and it was life threatening and so the doctor said I was to be there. I had no car, I had to get on the bus and back I went. I didn't walk up the hill; I caught a taxi up from the shopping centre. I rang my husband and told him and he came straight home from work. We packed a bag and I was in the hospital within about four hours.*

The midwives also remember this as a problem:

*Ruth: Because it was a real problem for people with transport then. People had to get taxis, often, to come in to the hospital. Yes, I remember one patient came in to St Helens and she lived in Paekakariki. She came in by train and then I think she caught a taxi up to St Helens and instead of having one baby she was having twins, and she had no idea. She had been to a doctor out this way but he didn't know she was having twins.*

Sometimes the problem was compounded by having to make arrangements for children, especially in the case of Helen and her husband as they had no family in New Zealand.

*Helen: Yes, Ari took me into the hospital for David. I had to put the other kids into the Salvation Army Home. I sort of had to get them together so to look after them, 'cause they had to keep them for that long.*

Jane: So, had that been organised during the pregnancy?

*Helen: That was organised during the last few weeks of my pregnancy, 'cause there wasn't really anyone suitable around.*

Kathleen's memories were of the Alexandra Maternity Hospital phone system.

*There were aprons that we used, when we were in what we called the 'pan-room duty', and these big sack aprons were made from sacks, and we wore them while we were cleaning, but our duties were to answer the telephone.*

*So, we were not allowed out of the 'pan-room', with our aprons on, so it was really a question of taking off and putting on these very heavy and unattractive aprons and getting out into the corridor and then going into a telephone room and pushing the right buttons, and cutting people off and things. It was a telephone system that served the whole hospital and then you would have to find the person.*

The signs of labour were explained to the woman during her antenatal care and she was advised to phone the nursing home or her own doctor:

*If a patient is in doubt or confused she should seek advice, either from her own doctor, or if he cannot be located at the time, from the Sister on duty at the nursing home.* <sup>210</sup>

On arrival the woman would be greeted at the door by the midwife or nurse. She was then taken to the preparation room (prep-room) to be assessed and if she was labour she would be prepared for the birth. Her husband would be sent home or to the fathers' room to wait. Her temperature, blood pressure, pulse and the foetal heartbeat were recorded. She was checked as for a normal antenatal clinic check and it was established by palpation and observation whether or not she was in labour. She would usually have an internal examination to assess how far on she was in labour. This could be a rectal examination or a vaginal examination depending on the circumstances and the hospital policies. She would then be shaved with a razor using liquid (green) soap.

---

<sup>210</sup> The N. Z. O. and G. Society, *The Expectant Mother*, p. 53.

The area shaved was from the 'bikini-line' and included all pubic hair through the labial and perineal areas and including the perianal area. The explanation given to the women usually included the words 'cleanliness' and 'stitches'. Following the shave a rubber tube was inserted about eight inches into the rectum and an enema consisting of about half a litre of warm soapy water was then administered. Rarely a suppository to stimulate bowel action was given instead. After using the toilet the woman was given a bath or a shower.

The enema was expected to empty the bowel so that when the woman gave birth faeces would not contaminate the sterile linen and, potentially, the mother and the baby. The shaved skin would be subject to itching for the next six weeks while the hair grew back and having an enema was dreadful for women who were already in strong labour. It always surprised me that more babies were not born in the hospital toilets.

This process had changed little since its inception in 1923 in the fight against puerperal sepsis. It had little to do with the woman's comfort and a lot to do with the recommendations included in Paget's H-Mt.20, 'The General Principles of Maternity Nursing'. The routines and rituals prescribed in this publication remained in place until The Nurses and Midwives Board determined in 1970 that it was no longer necessary to have such rigid procedures taught.<sup>211</sup> The procedures were reluctantly tolerated by most women because of the general belief amongst both the midwives and the recipients that it was safer for the baby and the mother to have it done.

*Noeline: When they gave me the enema I had never been so embarrassed in my life, And then the shaving was worse.*

*Helen: Eventually they came and got me and took me to the prep-room. That was an experience as well, you know, getting prepped, getting shaved and all that.*

---

<sup>211</sup> E. Papps and M. Olssen, *Doctoring Childbirth*, 1997, p. 111.

*Ivanka: I found that distasteful. I mean, you could accept stuff like that, if it's done in a nice way, but, I don't know, maybe they were, but, it wasn't pleasant at all. Just sitting there with your legs apart, up on this tall bed. Like, helloo, what are you doing?*

Jane: Did they explain why they were doing that?

*Ivanka: I'm sure they would have done. I mean, maybe I even had an idea about it. Anyway, I mean, that was the normal rigmarole.*

It was in discussion with women during 'prepping' that I first heard women say, "My mother [friend, sister, aunt] told me that when I went to hospital I would need to leave my dignity at the door." Over the years I heard it said so often that it came to symbolise to me the ritual and out-dated deprivation of modesty and dignity that these women endured.

*Noeline: That's what this lady who had had her baby, said to me, she said, "You lose your dignity when you have your baby."*

*Helen: ... I just accepted it, because you didn't know any different. It's just, this is it, you know.... I knew I was going to get shaved. Someone told me I was gonna get shaved.*

Jane; How did you feel about it?

*Helen: Well I think I didn't sort of, I just thought it was part and parcel of the thing. I just did everything I was told to do. To get it over with, you know.*

They did endure it, and usually kept their dignity although that may not have been their perception. The women usually accepted our ministrations as a 'necessary evil' and although some argued against them they were usually told that they had to have them. The midwives also had mixed feelings about the processes that were required.

*Ruth: I used to feel like a Gestapo woman when I was giving a patient an enema sometimes: You've just got to have it. And they'd be arguing.*



Kathleen had a different view. When asked whether she felt the same she replied:

*No, I always enjoyed that because you got to know them and you knew... you looked after them and encouraged them and that sort of thing.*

After being ‘prepped’ the labouring woman would be put into a room which could have one or two beds in it. Usually she was on her own as privacy in labour was considered important. If she did start labour in a room with another woman she would usually be moved into a single room later in the labour. Gordon tells us that in Europe women laboured and birthed in open wards, and tells the story of how a deputation of four women from the National Council of Women pressured the government for single rooms for labouring woman.

*That deputation did not mince matters. A conservative minister sat blinking at the notion that the humblest “char” had a right to strain and bulge in private... Like a wise man he saw the writing on the wall and promised. That promise has been honoured ever since.<sup>212</sup>*

Kedgley, discussing accommodation in labour, gives a different view and reports that:

*Because maternity wards had become so overcrowded as a result of the baby boom, women often laboured in tiny, darkened rooms that resembled cells, sometimes on a bare board without a pillow or blanket. Alternatively, they were put into communal labouring rooms with up to six beds separated only by curtains, where they could hear the screams of other women in advanced labour.<sup>213</sup>*

This disturbing picture deserves comment. In Ward 21 there were rooms without

---

<sup>212</sup> D. Gordon. *Backblocks Baby Doctor*, p.170.

<sup>213</sup> Sue Kedgley, *Mum’s the Word*, p. 160.

windows in the delivery area. The 'prep' room was sometimes used as an extra, temporary room in an emergency. The bath had a board which was lowered onto the bath to serve as an examination couch.<sup>214</sup>

Jane: Do you remember the wooden board over the bath?

*Kathleen: Yes, and you lifted it up and you had a little hook came over to make sure it didn't come down...*

A thin mattress covered it and sheets, a pillow and 'cuddly rugs', which were thick flannelette sheets, were usually adequate for warmth. None of the interviewees in this study have mentioned any experience similar to that of six women labouring together. Kathleen deplored the conditions in the old St Helens Hospital but she mentions only two women in the room.

Jane: What about at the old St Helens, did they do Caesars there?

*Kathleen: Yes, they did them there, oh terrible, in the fact that you'd be delivering normally at one end and you'd put a curtain up and there'd be a Caesar at the other, would you believe it!*

*It was dreadful. I remember one night duty we were so exhausted, that I slid down the walls: I went to lean across the thing and I just slid down, and that was during a Caesar, because it was so hot. We had a woman delivering at the other end and a Caesar at the other. The most primitive conditions you ever dreamt of!*

Certainly in the 1940s it was not uncommon for offices and even matrons' rooms to become temporary bedrooms (usually for postnatal women) when necessary.<sup>215</sup> It could be expected that in the baby boom days of the 1950s that would still be the case.

---

<sup>214</sup>Otaki Hospital had a similar system. It was quite common in the older maternity homes before baths were taken out and replaced with showers which were thought to be more hygienic.

<sup>215</sup> J. Jackson, oral history tape, 2000.

*Kathleen: [Wellington Public Hospital]... from the time they came out of theatre... the beds we moved, remember the moving of the beds? We had a system, where, the first night they stayed in the room nearest the office, the four-bedded room, and then they were shifted down wherever there were beds.*

Jane: I remember there was a sitting room, but it wasn't very often used as a sitting room because it was always ending up with beds in it.

*Kathleen: We had five beds in some of the cubicles; we were moving beds all the time.*

It seems that women were able to ambulate during early labour in some circumstances but the women and the midwives interviewed noted that women were often kept in bed during labour and were often left on their own. This relates strongly to the theme of 'being alone', identified as an issue in the women's interviews. The next part of this section illustrates this theme.

*Kathleen [Alexandra Hospital]: Yes, they were allowed to walk around, in the early stages. Because we had one labouring room only, with two beds in it and then the theatre....*

*We had two theatres only and a room with two beds in it plus the preparation rooms, that's all we had in Alexandra. If we had three deliveries, we were really in trouble. But we really did deliver in the 'Stout' half of the room as it was, very often, because we had the two theatres full and that sort of thing. We earned our money, I can tell you that in those days. We surely did.<sup>216</sup>*

Noeline remembers being admitted in labour with her first baby, being 'prepped' and then put to bed.

---

<sup>216</sup> The 'stout' room was a nickname for the room attached to the labour room as Kathleen said "Every room had a Maori name: Rangatira, Te Awatea, one of them was translated that was attached to the labour unit and we had it related to stout hearted, which we thought was very applicable."

*Noeline: Then they left me all night. I was on my own all night...*

Jane: Were you able to walk around when you were having your baby?

*Noeline: We weren't allowed out of bed for eight days.*

Jane: So, even when you were in labour you had to stay in bed?

*Noeline: Yes.*

Mabs and Ivanka also remember being unsupported:

*Mabs: [Wellington Public Hospital] The nurses seemed to be so busy that you were just put into this cubicle and left to your own devices.*

*Ivanka: [Kenepuru]...nobody was allowed to stay, and hang around and be supportive or anything like that. Because, they obviously must have known that I was a solo mum.*

*...I remember at one point there that, they came to sort of check me, and then at one point I was laying there for what must have been ages and ages... and I did ring and nobody was coming. But I don't even know if I had a bell to ring or anything.*

By 1966 when I had my first baby in St. Helens this was changing. My husband was encouraged to stay with me during the first stage of labour, but I was left alone in the early stages of the induction because it was felt (not by me) that he was not needed and the nurse would not telephone him for me. It was, however, still common for women not to have support, partly because some men did not wish to 'see their wives in pain'. Maternity had always been the business of women. When my husband was not there the student midwife was there for part of the time but her presence was dependent on the busyness of the staff.

*Kathleen: It was very busy. Night duty and there was only one Sister and a nurse on, that's all there was.*

*The Matron lived on the premises, because she held the license and that was the law. She lived up stairs and there was a bell if you needed her...*

Women may have been left alone because of the workload but it was also part of the hospital culture to keep busy. There was always cleaning, restocking and other work to be done and it could well have been considered by both peers and superiors that sitting with a labouring woman was 'shirking' the routine work that had to be done – and there was plenty.

*Kathleen: I went over to Alexandra Hospital... that was a very interesting experience, but it was a very hard studentship, at that time. It was hard because we worked 6:30 am start and a six-day week. The work was quite hard as a student, physically hard, because the sterilisers were extremely large and you could never see the bottom of them. It was a mammoth task to hook in the hook for the bedpans and try to find the bedpans at the bottom, and you got scalded on the way out.*

*Kathleen: [St Helens] Our conditions were very poor indeed and we worked extremely hard. We did all the cleaning for St Helen's.*

*We had tea leaves to spread to keep the dust down and we had little baskets with whiskbrooms and things like that, to whisk all the bottoms of the furniture. It was extremely hard.*

*Ivanka: I think I was in the labour for quite a long time and I think they had to be at hand quite a lot, off and on. But I'm sure they had other women there too, that they were dealing with as well. I vaguely remember one or two women coming in, distantly.*

*I remember thinking, oh, when are they going to come and see me, cause this is really painful.*

*It was awful.*

Twilight sleep was little used in the 1950s and 1960s because of the complications associated with it although Corkill in his 1960 text discussed the use of morphine and hyoscine (twilight sleep) for amnesia and analgesia. He mentioned the complications of sedation and respiratory depression for the baby and the increased rate of forcep deliveries but commented:

*Those who use the method, however, are satisfied that any disadvantages associated with low forceps delivery are outweighed by the benefit to the patients in other directions.*<sup>217</sup>

He recommended drugs of the barbiturate group, e.g. nembutal and Seconal, as a way of relaxing women and inducing amnesia, which was considered a very desirable state. But he recommended pethidine as a “valuable addition” to the drugs because of its sedative, analgesic and relaxant properties. He suggested that it be combined with hyoscine which would mimic twilight sleep.

The women in this study do not seem to have had narcotic pain relief in labour but that might be because the amnesic effect of the drugs in use and also the amnesic effect of the natural labour hormones had affected their memory. However according to the midwives analgesia in the earlier stage of labour seems to have been limited to pethidine, with some use of inhalational analgesia.

Jane: Were you actually having pains when you went in?

Noeline: Yes.

Jane: So it was quite a long labour?

Noeline: Yes.

Jane: Did you have pain relief?

Noeline: *Not to start with but then they did as time went on, as it got stronger and stronger they did. It was a mask. ... it was a rubber mask, and they held it on.*

---

<sup>217</sup> T. F. Corkill, *Lectures on Midwifery*, pp. 168 – 169.

Jane: Was that when you were actually pushing the baby out?

Noeline: Yes.

Inhalational analgesia was used frequently in labour, usually during or close to the actual birth. These vapours or gases were breathed in by the women as anaesthesia or analgesia depending on the amount used. The ideal in maternity was to use enough to take away pain without rendering the woman unconscious. Corkill describes the use of several liquid forms including chloroform and ether both of which used a simple apparatus called a Murphy's inhaler which looked like a sieve holding a sponge or fabric on which was dropped the anaesthetic liquid. Trilene vapour which was given through a rubber mask could be self administered but was inadequate for any operative procedure. Nitrous oxide was combined with oxygen through a machine which delivered the mixture through a rubber mask and was a helpful form of analgesia, the only one of these still used today for pain relief in labour.

Jane: What about pain relief for the women in St Helens?

Ruth: *Only pethidine, as far as I can remember.*

Jane: Just pethidine? What about the gases, did you ever use trilene?

Ruth: *No, we used ether.*

Jane: What sort of pain relief did they use at Alex?

Kathleen: *Pethidine, just pethidine. We used nembutal, they all had a sedation book and they all wrote out their pre-set dose and what they wanted: at how many fingers dilated did they want....*<sup>218</sup>

Jane: Standing orders?

Kathleen: *Standing orders, that's right. They all had those and we as midwives administered them as per that.*

---

<sup>218</sup> Cervical dilation was measured by how many fingers the examiner could insert into the opening cervix. The descent through the pelvis was also measured by finger length, e.g. 'The presenting part [of the baby] is half a finger length away'.

*Kathleen: We, actually also, in the line of anaesthetics: as a student, we had to give fourteen anaesthetics and when I look back on it now, it was extremely dangerous because we were using chloroform on the mask: the drip method.*

Jane: Like a sieve, with lint on it?

*Kathleen: Yes, one of those. And we didn't have enough... I mean, chloroform is extremely dangerous for the liver, as you know, but we didn't have enough tuition, or perhaps I didn't.*

*...I think it was just the liver damage and the level of anaesthesia. We used ether or chloroform. Chloroform was going out then and ether wasn't so bad and we just dripped the ether on. But it was very primitive.*

Jane: So that was in the fifties you were using that?

*Kathleen: Oh yes.*

Jane: What about nitrous oxide?

*No, that came in towards...that didn't come in my student days, that came in... it was later than that when we got the nitrous oxide.*

Jane: It was there in the sixties.

*That's right, there was nitrous oxide then, and that was wonderful. And the self-administered ones came in then, and they were great. I can still hear the clicking....*

When the birth was imminent the woman would be taken into the delivery room which often was called the 'theatre' and was very similar to an operating theatre of that time. She would be put onto the bed, flat on her back with one or possibly two pillows for her head. Her legs would be lifted into 'stirrups' which hung from poles at the sides of the bed. This was known as the lithotomy position. This position was used because by immobilizing the woman it was easier to try to maintain a sterile 'field' to work in and it also exposed the genitalia increasing accessibility for the birth attendant. Women had no choice in regard to birthing position and the practice of using the lithotomy position added to their lack of autonomy and to their sense of being alone.



Figure 5 is a photograph of a birthing woman in the usual lithotomy position while the doctor suctions mucus from baby and the midwife (or student) cuts the umbilical cord. It gives a sense of the woman's separation from what is occurring, and demonstrates how the clothing of the attendants (to maintain asepsis) could mask facial expression and inhibit communication. The woman was looking away from the area of activity and the photo conveyed a real feeling that the woman had been deprived of involvement in what was happening to her. Her position prevents her from seeing her baby and participating in the event. Indeed, we could speculate as to whether she had a choice whether the photo was taken or not, and for what purpose it was taken in 1969. It may be another example of the lack of autonomy which has been identified. With no support person near it certainly portrays 'aloneness' for the woman.



Figure 5. Birthing woman at St Helens Hospital, 1969.<sup>219</sup>  
An attendant suctions mucus from the newly born baby's airways.

<sup>219</sup> The unknown woman's eyes have been masked to protect her anonymity.

The lithotomy position was usually uncomfortable, sometimes painful, as many women experience severe backache at this stage of labour, but even more upsetting for the woman was the embarrassment at being exposed to view, often not only to her baby's 'deliverer' but to whoever else was in the delivery room. This could include quite a large number of people, especially if the birth was considered unusual. The birth of twins for instance, would often be used for teaching and all of the medical, nursing and midwifery students available would be encouraged to attend. This exposure was difficult for women to cope with especially when it is remembered that in the 1950s quite a prudish culture prevailed, particularly to do with body part exposure.

*Mabs: We didn't flounce ourselves around or anything. We didn't breast-feed, we didn't breast-feed in company, we went into the bedroom, and sat there.*

*...because your parents didn't even bath in front of you, they never got undressed... I had never seen my Father's legs! Never! Never ever.*

The lithotomy position was often very traumatic for women as it also made them feel very vulnerable and powerless.

*Mabs: Overnight I went through all this trauma. In the morning I was such a centre of attention, I suppose, in the end, that they took me down to theatre and they strapped my legs, of course.*

*Terrible thing to do to anyone. They had me up there and in came, about, ten student doctors and all these nurses I'd never seen. It was quite traumatic. I suppose if I hadn't have been such a strong person it all would have fazed me right out. There was all these different student nurses and Doctor Segal, and he made it happen. There was this fantastic pain but I'm sure that he used an instrument or something. I wasn't unconscious, and these legs up...*

Jane: Did you find that you got a lot of support when you were actually pushing the baby out, did they encourage you and help you?

*Noeline: Yes, but they would tell you not to push when you wanted to push. I found that hard.*

Jane: Stop pushing while you wait for the doctor or was that just - stop pushing?

*Noeline: Yes it was, the doctor had to be there. I didn't say that, but I think in those days I think the doctor didn't like to miss out.*

Only Noeline reported being made to wait for the doctor to arrive for the birth.

*Helen: I think I had my legs up for them all. They didn't do it any other way.*

Jane: And did everyone wear gowns and masks and all that?

*Helen: Yes, I never ever had a doctor actually at my birth. The Sisters said, Oh, they're experienced enough in their way. Even when Frankie, the one that came early, they delivered him and then rang the doctor. With David, the doctor was with me a lot with him. He was the only one that wasn't quick,*

Listening to the voices of the women describing their births there is an overwhelming sense of their aloneness in the hospital and of their inability to feel in control of what happened to them. Even when they were surrounded by people they still felt alone and unsupported. This sense of isolation or 'being alone' would have been exacerbated by the fact that at the birth the attendants, nurses and students all wore gowns and masks as if in an operating theatre. Not only could the women scarcely recognise people but they also could not easily read facial expressions making it difficult to interpret the nuances of dialogue. This is demonstrated in Figure 5. where the attendants are clustered around the newborn baby and there is a sense of the isolation of the mother from her baby, the attendants and what is happening. There was no consultation about what the women wanted, as demonstrated by having students present at the birth without the women's permission adding to their 'lack of autonomy'. Maternity care

was regimented, following policies which obeyed the dictates of 'H-Mt.20'. There was little consideration of the women's fear of the unknown or of their modesty or of their rights as people. Many practitioners did their jobs well, and many were sympathetic and kind but they could not change the system in which they worked.

Management of labour became increasingly technical and intrusive during the time of the study. Monitoring the foetal heartbeat was done using a Pinard's foetal stethoscope. This is basically a hollow tube with a small opening for the attendant's ear and a wider opening at the other end which rests on the mother's abdomen. The hospital variety was usually made of metal which was cold to the touch and was warmed by rubbing with the hand prior to placing on the mother. The heartbeat in earlier times (1939) had only been listened to check that the baby was alive, and in conjunction with palpation to establish the position of the baby.<sup>220</sup> By 1944 Kerr instructed the birth attendant that in the second stage of labour (the 'pushing' stage):

*The foetal heart should be auscultated every half an hour and at the same time the attendant may by means of abdominal palpation, or by rectal examination satisfy himself that the head is safely passing downward through the pelvic cavity.*<sup>221</sup>

Auscultation during the earlier stages of labour, apart from the initial examination on admission to hospital is not mentioned by Kerr.<sup>222</sup>

Jane: How often did you listen to the heartbeat during labour?

*Kathleen: I don't think it was any particular time, it wasn't every ten or twenty minutes or anything.*

---

<sup>220</sup> T. Davies et al., *The Queen Charlotte's Textbook of Obstetrics*, J & A Churchill, London, 1939, p. 93.

<sup>221</sup> M. Kerr et al., *Combined Textbook of Obstetrics*, 1944, p. 406.

<sup>222</sup> Interestingly, Kerr also admits that in second stage the squatting position 'favoured by primitive peoples' has much to recommend it and also suggests that apart from occasional rests the woman should be upright and moving around in the first stage of labour.

Green suggested that the foetal heart should be recorded at least half hourly when the woman was awake, occasionally during and straight after a contraction. He also recommended using a graph rather than a list of figures, to identify trends. In the section on observation of the patient's general physical and mental condition he suggested blood pressure, pulse and temperature should be recorded as the best objective measures four hourly, more often if necessary and went on to warn:

*Marked restlessness and anxiety usually indicate emotional distress, but not infrequently may herald some grave physical upset.*<sup>223</sup>

The inference is that as long as it is emotional distress it is acceptable.

Jane: Did you do rectal examinations?

Ruth: Yes.

Jane: And vaginal?

Ruth: Both.

Jane: So, why did you pick one rather than the other, was it to do with when the waters had broken?

Ruth: *I think the midwives had to learn both. Probably that was the story. I don't remember particularly that one was easier than the other, except that you had to scrub up for the vaginal examination. And if you were looking after a patient you had to do a rectal exam every half-hour or so, whereas you couldn't do a vaginal as often as that.*

Jane: No. So, you actually examined a woman quite frequently?

Ruth: Yes.

In second stage labour Green suggested that observations be made more often and the foetal heartbeat be measured every fifteen minutes. At this point he mentions the need for encouragement and help for the woman as being more important because of the increased physical stress. Although he mentions the woman lying on her side (left

---

<sup>223</sup> G.H. Green, *Introduction to Obstetrics*, p. 65.

lateral) for birth as the most common position for birth in New Zealand he recommends the dorsal position (on her back) as being easier for the attendant and suggests that lithotomy makes it easier for the woman's "expulsive efforts".<sup>224</sup>

Episiotomy was not usual – the focus was on trying to maintain an intact perineum but by 1958 Corkill was suggesting that an episiotomy was preferable to a laceration. There was a theory that the perineum was numbed by the pressure of the baby's head and therefore the woman would not feel being cut but it was normal practice to numb the area with local anaesthetic to be sure. When the baby's head was born the perineum was protected by 'guarding' with the attendant's hand and often the baby's chin was pushed upward to facilitate the birth – this was known as 'chinning' and in my experience it was an acutely uncomfortable proceeding. The baby was 'delivered' by the attendant in a much managed way, with little scope for the baby to be born simply by maternal effort.

The management of the delivery of the placenta was changing from physiological to a more managed procedure as doctors became more familiar with the use of pituitary extract as an ecbolic and began applying its use to 'third stage labour'. Corkill discusses the use of Pitocin in second stage to expedite the birth of the placenta and also the routine use of Ergometrine as a prophylactic to prevent haemorrhage following the birth. Emphasis is placed on watching for signs that the placenta has separated from the wall of the uterus. Green gives three methods of managing the third stage: 'Voluntary expulsion' by the patient, 'Expression' where the uterus is used as a piston to push the placenta out of the vagina, The 'Brandt-Andrews method', which is the method used for 'managed third stage' with some small variations today.

If a tear or episiotomy was present it was sutured with interrupted stitches using catgut or silk. Catgut had an advantage in that it did not require removal later. The uterus was watched carefully and checked by the nursing staff at least every fifteen minutes until the woman was rested, fully sponged, had a cup of tea and transferred to the postnatal

---

<sup>224</sup> G.H. Green, *Introduction to Obstetrics*, p. 67.

ward. She would also be encouraged to use a bedpan to urinate, would have a perineal toilet with a pad and cloth 'diaper' applied and a firm cotton abdominal binder applied.

Jane: Did you get a binder wrapped around your tummy?

*Noeline: Yes and my breasts. They were bound tight, tight as tight, this was before I breast-fed. This was to help bring my milk in, they told me.*

Jane: Oh, really? So they wrapped you up really tight to help your milk come in?

*Noeline: Yes and around my stomach this binder, oh, you felt like you were... something stiff, anyway.*

The woman had very little to do with her baby during that time. In St Helens Hospital the baby was usually left, wrapped up in the bassinette where the parents could see, while the parents had a drink and a biscuit. In Wellington Hospital the baby was whisked away quite quickly to the nursery so that the nurse could perform the sterile procedure of the baby's 'initial toilet', and the mother might not see the baby until the next day.

Jane: When you first had the baby, did you get a chance to see her?

*Noeline: No. We weren't allowed to handle out babies then. She was taken straight away. I remember thinking, I wonder if there's something wrong with her. But anyway, the Sister in Charge, she was very good; she brought Christine out to show her to me. To show me she was alright, and then I had the chance to count her toes and fingers.*

This section has examined the actual birth and explained the system in use at that time. The main impression one is left with is that of a totally managed medical process with the woman being required to conform to the needs of the hospital and being subject to the theories and preferences of the medical practitioners, with little consideration for her emotional needs. The women's stories show how the management of labour added

to their feelings of 'being alone' and their 'lack of autonomy'.

### **Postnatal and Infant Care**

This section will examine the postnatal care that the woman received, including the care following discharge home from hospital.

After her baby was born the woman would be wheeled, in her bed, to the postnatal ward, which could vary in type. In the new St Helens Hospital it was a single room, in Wellington Hospital, usually a four-bed cubicle. Alexandra Hospital was described by Noeline:

*Noeline: As far as I can remember it was quite nice...*

Jane: Where there a lot of beds in the room?

*Noeline: Yes, I think we had about six or eight beds in the room. Big wards, like a hospital, with beds down either side.*

In Bethany there were apparently single cubicles for the private patients:

Jane: What was Bethany like?

*Helen: Bethany, I think I was in a cubicle of my own there.*

Helen experienced Wellington Public Hospital:

*Helen: Yeah, in Wellington Hospital I was in bed most of the time. But you could get up and about....*

*...I had no stitches. I was really good with them all.*

Jane: Did you think much about the routines, or did you just accept them?

*No. I just accepted it, because you didn't know any different. It's just, this is it, you know.*



In the 1950s, and in some hospitals in the 1960s, women were expected to stay in bed, having bed-baths or getting up only to shower.

Jane: You were in bed then, for about eight days?

*Noeline: Yes, you weren't allowed out to the toilet or anything for eight days. It used to be horrible. I used to think, oh I stink. I was used to being able to have a shower or a bath or something.*

Jane: What about having to use the bed pans when you were in the room with a lot of other women?

*Noeline: Oh, they'd pull a curtain around you.*

They would be given bedpans and followed by perineal toilets every four hours for at least three days, seven days if there were perineal stitches. In Wellington there was a special method of bed-panning and perineal toileting these bedridden women. Two student nurses worked together. The first would put a group of four women on to bedpans. Then she would move to the next room, pulling curtains around the beds and giving the next four women bedpans. She would then return to the first group, remove the soiled pans and replace them with clean ones continuing until she had panned all of the women. The second nurse would have a large trolley set up with trays, one per woman, set with forceps, bowls and warm Dettol (Chloroxylonol).

She would go to the women waiting on the clean pans, swab them down with Dettol, give them clean pads and a cloth 'diaper' and take the pan and trays to the utility room for cleaning and washing her hands, until she had toileted all of the women. The women would also give the nurses a used perineal pad to be inspected daily to check for signs of infection.<sup>225</sup> As the nurse/midwife worked she would be checking the women's lochia, uterine involution, and perineal stitches and chatting to them about how they felt. It was quite an efficient method. It allowed very good observation of the women's physical condition but as the nurses were always in a hurry because of their large workload it certainly was not personalised care.

---

<sup>225</sup> This was common to many hospitals and was still happening in some places in the 1980s.

In my experience women, as Noeline expressed, accepted that this was the way it had to be. They certainly did not complain and usually showed gratitude for everything done for them. At the new St Helens (after 1965) women stayed in bed for forty-eight hours and, as in Wellington Hospital were washed in bed and used bedpans, but they were able to get up to the shower fairly quickly and use toilets as the new hospital had bidets. The postnatal stay in hospital for fourteen days was not always liked but the women in this study enjoyed the rest, particularly with subsequent pregnancies.

*Mabs: By the time the third came along, you were almost asking, can you have ten or twelve days...?*

Jane: So that you could have a rest?

*Mabs: Yes.*

Many babies were scarcely seen in the first few hours by their mothers. Even if the woman had been allowed out of bed the babies were kept in the 'twenty-four hour' nursery where patients were not allowed. A nurse wearing a sterile gown, mask and gloves, using sterile equipment, would wash the baby and dress it in sterile clothing with two thick cotton cord ties applied to the umbilicus, covered by a gauze dressing and bandaged in place using a crepe bandage around the midriff. Iodine would be applied to the umbilical stump. The cord ties were checked as the cord shrank over the next twenty-four hours, and extra ties were applied if the earlier ones had loosened. If the baby had been delivered by forceps often the mother could not handle it for days because those babies were 'rested' for at least twenty-four hours and were even bottle-fed in their bassinets in an effort to reduce the complications, such as cerebral haemorrhage which sometimes followed difficult instrumental births.

Babies were brought out to the mothers to feed at set times, usually four-hourly. In the first twenty-four hours they might only be brought out to the mother twice, so the mothers and the babies could rest, the babies being fed formula, water or sugar-water by the nurses in the nursery.

*Noeline: We didn't have our babies with us, they were in the nursery and you'd hear all these babies crying and think, oh my goodness is that my baby crying? I mean the babies were brought to you and you'd be waiting and waiting. Thinking, well I've had my baby but I can't have it.*

Jane: Do you remember how they were bought out to you?

*Noeline: They were put in a trolley, with babies here and babies there.*

These large painted metal trolleys were used in most of the hospitals to deliver the babies simultaneously to their mothers at the set four hourly feeding times. Some were double-decker with two rows of babies, swaddled, lying in their own cubby holes.<sup>226</sup> The curtains were pulled around the beds and the babies handed out like parcels to their mothers. They wore 'alphabet bead' necklaces around their necks with their names spelt out by the beads for identification.

Jane: Did you start breast-feeding straight away?

*Noeline: I think it was two days afterwards.*

Jane: So you didn't breast-feed for the first two days?

*Noeline: No.*

Jane: Did they give the babies bottles?

*Noeline: They must have done because when they cried, they used to say, "Oh we gave baby a feed at such and such a time."*

Jane: Did you breast-feed?

*Noeline: Yes. But at first it was very frightening because I didn't know what to expect.*

Jane: So, did they help you put the baby on the breast?

*Noeline: Yes.*

Because the babies were not fed frequently by their mothers as they would be in nature, the mothers tended to get very full, engorged breasts. Women expected to have

---

<sup>226</sup>The tall trolleys tended to lurch as they went around corners and were banned by the Health Department in the mid 1970s.

these red, swollen, engorged breasts for several days ‘when their milk came in’ and it was considered a normal part of the establishment of lactation. The women were swathed in breast binders, cocooned in hot oil packs for the breast feeders and cold methylated spirit packs for the women whose breasts were bound firmly to suppress lactation. These packs would need reheating or renewing for replacement after each feed. The ‘support’ or ‘suppression’ binders were put on the women’s breasts using at least eight large safety-pins. They were long, shaped pieces of strong white cotton fabric which were folded and tucked so that they fitted each woman like a waistcoat to give maximum support and hold the ‘oil packs’ in place. Once they were fitted to the individual woman they could be taken on and off like a jacket, usually needing replacement after about twenty-four hours.<sup>227</sup> While nobody wanted to be ‘bound up like a mummy’ they did give real relief to the women who needed them. This was augmented by the use of analgesics such as aspirin and sleeping pills such as soneryl, a butobarbitone.

Jane: What happened when you did start breast-feeding, did they bring the baby out to you from the nursery?

*Noeline: Yes.*

Jane: ...Did they give you sleeping pills to help you sleep at night?

*Noeline: The first two or three nights they did. Then after that they didn't. I didn't really need them because I think I was on a high or something....*

Jane: So, on the third day you started to breast-feed, and by then your breasts were okay?

*Noeline: Yes, they took the binder off, and because I was big anyway, oh they were so heavy, but I used to get very bad cracked nipples.*

*They used to bring this horrible goo in to put on and I would think, oh you give me that to put on, what about my baby? Because he was still suckling. The nurses would always bring you a cloth so you could sponge yourself before you fed them anyway.*

---

<sup>227</sup> With babies feeding on request it is now fairly rare to see a woman with severely engorged breasts.

Jane: When you were first breast-feeding, did your breasts get really full and sore?

Noeline: Yes.

Jane: Did they put anything on them?

Noeline: Sometimes they used to get really hard and they used to put a hot... something on them. A hot pack.

Mabs felt that she received little help with breastfeeding:

*Mabs: We were left very much to our own devices, and at the same time we had the babies bought in and they were left... We didn't have feeding help. That's one thing.*

Jane: So, the babies were just given to you and you were left to get on with it?

*Mabs: And I remember, because baby had the first suckle, and being such a fair skinned, I was really quite unprepared for breast feeding, and my nipples split, I can remember that. And gentian violet and all this stuff going over it. Well, anyway we had this particular Sister, who used to delight somehow, in leaving us all in tears in the night. Everyone would be crying because of this wretched woman. She never helped you.... All these women around trying to feed these babies, with not a great success rate because it was said to us that, if we couldn't manage, they went on to the bottle. So, I did try,*

The breastfeeding mothers were expected to feed their babies every four hours for one to two minutes on each breast on the first day, three minutes for the second day, increasing by a minute each day. Five minutes on each breast was considered adequate. During the first three days the mother topped up the baby with “formula”<sup>228</sup> as we were taught that her lactation was not “in” and the baby needed to be fed. If the baby woke

---

<sup>228</sup> Pasteurised cows milk was boiled for a set time to break down the protein into smaller particles. Sugar – usually ‘Karilac’ – a simple sugar produced by the Karitane factory, was added with extra water to make the ‘formula’ more like breast milk. The ‘formula’ was changed to make a more concentrated mixture for older babies who were also given ‘Farex’ (a type of gruel for babies).

and cried between feeds it was either left to cry, a dummy was given, or Karilac and water or a bottle of formula. Babies were 'test weighed' on the fourth and seventh day. This meant baby was weighed before and after the feed, wearing the same clothes and wraps. The difference in weight was the amount of breast milk baby had taken in. This could be nerve-wracking for the mother, not a help for lactation, and it was easy for the nurse to make mistakes. Weighing the bare baby every few days to check the weight gain and observing baby's output was also done to ensure that baby was thriving.

In the new St Helens some changes were made as the babies were brought to their mothers in their own perspex bassinets on metal trolleys with cupboards for their equipment. The babies were taken out at night for the first few days but remained rooming-in with mothers from the third day during the day and night. The mothers were encouraged to care for them with support from the staff. It seems as though Kenepuru in the late 1960s also encouraged rooming in as Ivanka stated that her son was 'in the room'.

In Wellington Hospital there were sometimes 'boarder babies' in the nurseries. These were usually babies who were waiting to be adopted. Sometimes they were several months old. They were fed by the student nurses and often used to demonstrate baby bathing to groups of mothers. The mothers all had to be shown how to change and bath a baby before going home but except in the new St Helens the women usually did not change their own babies at all. The babies stayed in the nursery except for feeding times. This meant that often mothers had little confidence dealing with their baby on discharge. Mothers who came from large families were often more confident:

*Noeline: I came from a very large family. I was helping to bring up brothers and sisters....*

When the mother and baby were discharged home there was a little ceremony at the hospital entrance as the nurse cut the 'alphabet beads'<sup>229</sup> from the baby's neck and

---

<sup>229</sup>Miss Hamilton, Matron of St Helens Hospital in the 1950s and early 1960s told me, years later, that she had introduced the idea of the baby necklaces from America to New Zealand.

checked the baby's name and date of birth on the necklace with the mother. Once the mother was sitting in the back seat of the car or taxi the student nurse handed the shawl wrapped baby to her.<sup>230</sup> Planning for discharge was not always done with care or consultation with the woman. Ivanka and Helen both benefited from their Karitane Hospital sojourns but experienced being discharged home in different ways.

Jane: When you took baby home, did you have a book from Plunket that told you how to do it?

*Ivanka: Right. One of those little blue Plunket books? Yes.*

Jane: It had stuff about waking your baby up at a certain time. You dress him at a certain time and bath him etc.

*Ivanka: The four-hourly thing.*

Jane: Yes, did you have that?

*Ivanka: Yes. Yes, I think so, cod liver oil in the milk and all that. I appreciate the time that they allowed me to do that. Y'know, learn to boil the bottles, make the milk, and everything else, y'know changing and all that. It probably would have come naturally, but it was good to have that wonderful time in Karitane.*

Jane: Was there any support when you got home? Did you get Plunket or anything like that?

*Ivanka: I can't remember, after I got home. I really can't remember. ...It wasn't an issue at all. It's not something I ever thought I couldn't do.... Well, I just accepted my situation, and just carried on.*

Helen and her husband Ari had no family in New Zealand that could help Helen as a new mother.

*Helen: Yeah. I lay in bed. He was out there crying, y'know. The young ones, y'know, they don't know how they've got it these days, y'know, with all the support they've got.*

---

<sup>230</sup> Baby car seats were introduced later.

Jane: So, the main thing you found difficult about your maternity experiences was the lack of support once you got home.

Even though a Plunket Nurse came, she only came for a short while.

*Helen: Yes. The Plunket Nurse... it was good to have her. Really, I don't know what I would have done without her. Because, she more or less, gave me that bit of confidence. I know that I needed it. When I got home with Eric I would have liked what my daughter-in-law had the first day she was starting with a baby – she had a midwife that came in and all, and was doing that, and she was so relaxed and all.*

*Where I was lucky that the next day my girlfriends called in and one of them had twins, she was used to premature, small babies, so she took him and bathed him, and I stood there watching her.*

*After that it was alright. I just needed that, someone to be with me, I was so nervous.*

Jane: So, you went to Karitane with Eric but you still were really nervous about bathing him when you got home.

*Helen: Yes, I think it was because... you see... when you're in Karitane you've got all the nurses around, and, I think I did bath him myself but you've got all the nurses in there, with the special bath and the toilet and all the special things. So you feel quite good, but it's a different story when you're left on your own. Nobody, just you in the house with the baby.*

Helen also found being discharged at Christmas from St Helens with her last baby traumatic:

*Actually, they put me out, and that was a real performance. They put me out on Christmas Eve, and I had to go home. Ari was on the late shift. He wasn't there. I had to go home to three other kids, get the stuff and trying to breastfeed David. I mean, you know, really... I don't think that was so well organised. Nobody thought... I'd never had any after support, which I would have needed.*



Jane: Because you had no family here?

*Helen: No, no family here. Nobody ever asked, do you need support?*

*Yeah, and my milk went away. ...David was screaming his head off. I was trying to get my milk to come. Just a wee bit of support, was all. In the hospital was alright. It was just getting home, you know.*

The Plunket Nurse service was valued by The women interviewed:

*Noeline: Yes, I had the same Plunket Nurse for all five of my babies.*

Jane: So, you really got to know her.

*Noeline: Yes, but I can't even remember her name. It was in Johnsonville. She was lovely and she never turned you away. If you needed help, she was there. No trouble.*

Not everyone found that the Plunket regime worked well for them: 'The Plunket book' was given to each mother with the record of the baby's weight and comments written in by the Plunket Nurse. There was also a book of mothercraft which laid down in strict detail exactly how a baby should be managed. The regime suggested did not allow for any individual needs and responses by either the mother or the baby. It included a strict four hourly feeding regime controlled by the 'four hourly feeding clock' illustrated in Figure 6. The expectations of the baby laid down in these books were so high that if the baby did not conform there was likely to be immediate loss of confidence by the mother in her ability to care for her child.

*Helen: Oh yes, I had a Plunket book.... It never really worked out, y'know. But I tried to keep them to a routine, but I would get them to have a sleep in the morning, that was more for your own benefit, y'know. So you could get on with your work. I kept them to a good a routine as I could.*



The process over the two decades was becoming increasingly technical and intrusive. Women's psycho-social and emotional needs were only just beginning to be recognised by the end of the 1960s with increased participation by fathers and the introduction of rooming-in. While treatment of women was often kindly some maternity staff displayed little understanding or empathy toward the women. There was little or no opportunity to gather information upon which to make choices and little, if any, opportunity to refuse treatment or to choose care other than that laid down by medical protocols. The next chapter discusses some of the issues which emerged in the women's interviews in more depth.

## *Chapter 6*

### **DISCUSSION**

In this chapter the study is summarised and issues which emerged are identified and discussed. This study set out to describe maternity in Wellington in the 1950s and 1960s. Historical inquiry techniques using oral testimony were used to provide the main primary sources. To enable the oral testimony to be placed into context the history of twentieth century maternity in New Zealand was traced, highlighting factors which contributed to the physical and cultural environment in which the women participants experienced childbirth.

The more significant changes in the maternity services from the early twentieth century were traced, highlighting the registration and regulation of midwives, the move from home birth to hospital birth and the medicalisation and nursification of midwifery. Earlier chapters have explained how the private, home-based midwifery system of the 1900s, evolved into a medical, publicly funded hospital based maternity system. Factors have been identified which were instrumental in changing maternity from a lay, unregulated midwifery service to a professional, nursified service which by 1970 was medically controlled within the hospital system.

The professionalisation and nursification of the midwifery service began with the passing of the Midwives Act 1904 and the formation of the St Helens Hospitals and Training Schools for Midwives. The Act placed midwives under medical control and by introducing a new type of midwife, the 'nurse-midwife', began the process of the nursification of midwifery. Despite homebirth and midwifery being supported by the Health Department, technological progress, especially the developments in asepsis and anaesthesia, aided the medical profession in making hospital and medically controlled birth attractive to women.

The restrictive practices introduced with Paget's 'H-Mt.20' had a highly significant influence on the manner in which maternity services developed and on the women's experience of birth. The Obstetrical and Gynaecological Society was formed to resist control from the Health Department, and once formed became a strong lobby group, achieving its aims which were the setting up of a Chair of Obstetrics at Otago University and the reformation of the maternity service. The Social Security Act 1938 granted free medical, midwifery and hospital care to women thus accelerating the hospitalisation of birth and establishing doctors as the gatekeepers to the maternity service. Midwives became skilled in their specialised areas of hospital nursing, but lost the knowledge and confidence to care for birthing women outside the hospital system.

The examination of role of women in society during the 1950s and 1960s explained that marriage and family life were idealised as proper fulfilment for women but that women were often deprived of the ability to make choices, particularly in regard to fertility and childbirth, because of the lack of information available to them. Married women were expected to be full-time mothers and home-makers and only a small percentage of women worked outside the home, thus creating a situation where the maternity service was provided mainly by a hierarchy of single women who staffed the hospitals.

From 1950 to 1970 with the advent of reliable contraception and some changes in attitude, there was a slow increase in the numbers of married women joining the workforce but not until the end of the period of the study were there any significant changes to the composition of the hospital workforce. It could be conjectured that the role of women in society and their dependence on men as providers could have contributed somewhat to women's readiness to accept the opinions of the (usually male) doctors as experts even in childbirth, traditionally a women's area of expertise.

At the start of the twentieth century homebirth was still available but became increasingly rare as an option because of the growing medicalisation of birth and the establishment of doctors as 'gatekeepers' to the maternity service. As the small private hospitals closed because of political and financial pressures they were replaced by state

provided maternity beds. These were usually in facilities administered by the Wellington Hospital Board in response to the government's requirement that Hospital Boards provide sufficient beds for maternity in their areas. This was occurring at a time when there was increasing demand for hospital childbirth, due to the Obstetrical and Gynaecological Society's successful selling of hospital birth as safer and less painful, combined with an upsurge in the birth-rate. The Hospital Board's situation was also exacerbated because of the postwar shortage of nursing and midwifery staff.

The two most important maternity hospitals in Wellington during the study period were the Wellington Public Hospital, a teaching hospital for medical and nursing students, and St Helens Hospital which was a teaching hospital for student midwives and maternity nurses. St Helens was under the auspices of the Health Department until the Wellington Hospital Board took over in 1966. The two charitable institutions, Bethany and Alexandra (also a maternity nurse teaching hospital), were still available until the end of the study period. Karitane Hospital was an important complementary facility and 'backup' to the maternity hospitals, providing care for small, weak babies or mothers who needed help caring for their babies, particularly prior to the development of neonatal units in the early 1970s.

Not only the 'bricks and mortar' of some of the maternity facilities were important to the maternity experience of women, but also the working conditions for staff, with particular emphasis on nursing and midwifery students and midwives. Using the testimonies of the two interviewed midwives, my own memories, and other primary and secondary sources the hospital culture which framed the environment in which the women laboured and birthed was explored. Long hours, heavy workloads and a culture of control and discipline in the workforce were identified as possible contributing factors to the reported lack of empathy among some nurses and midwives toward the consumers. There was also considered to be some potential for lack of empathy and understanding because the workforce was composed almost exclusively of unmarried women. This was a monumental change from the centuries of midwifery care by women with experience of birth.

The women interviewed displayed pragmatic attitudes toward pregnancy and childbirth. It was the expected outcome of marriage. They expected to have children and work in the home. Society fostered the idea that marriage and the consequent bearing and nurturing of children was the most desirable and fulfilling role a woman could attain. The acceptance of this role is shown by the comments of the women. However, although most tolerated their childbearing experience with the attitude that the doctors and nursing/midwifery staff were the experts, discontent with the system was demonstrated in the wider maternity area with the formation of the Parent's Centre movement. Parent's Centre achieved some improvement, introducing antenatal classes and encouraging natural birth, but the system had become so entrenched that change was slow in coming. Rooming-in, for instance, although first mooted in the early 1950s did not arrive in Wellington until the new Kenepuru and St Helens Hospitals were opened in the mid to late 1960s.

The acceptance of the health professional as 'the expert' had become part of New Zealand's culture in line with the wider acceptance of technology as the modern miracle. The adoption of Truby King's teachings also reinforced the idea of the expert health professional. Women's belief in their own instinctual knowledge was downgraded and minimized. Expertise in childbirth had been lost to mothers and midwives with the promotion of medical knowledge and technology. This not only supplanted women's ways but treated women in a manner that was detrimental to their emotional and cultural well-being. The women were isolated from their support systems and required to adapt to alien institutions and routines at a time when they were at their most vulnerable, adapting to their new roles as women.

The childbearing process over the two decades was becoming increasingly technical and intrusive and women's psycho-social and emotional needs were only just beginning to be recognised by the end of the 1960s with increased participation by fathers and the introduction of rooming in. While treatment of women was often kindly some maternity staff displayed little understanding or empathy toward the women. There was little or no opportunity to gather information upon which to make choices and little, if any, opportunity to refuse treatment or to choose care other than that laid

down by medical protocols based on the prescriptive practices which had been introduced by Paget in H-Mt.20 in 1923.

### **Lack of Autonomy**

A major issue which emerged from the study was the lack of autonomy for the women who were obliged to become 'patients' and conform to the requirements of the institutional environment and the maternity hospital staff. This included instruction from health professionals on all aspects of maternity including the physical act of birthing, breastfeeding and care of the infant. The women generally accepted the routines and the regimentation because they believed in the expertise of the health professionals and that acceptance would make themselves and their babies safer. This was partly in response to the excellent propaganda campaign which had been mounted by the doctors in the 1920s and 1930s and had kept up a degree of momentum throughout.

Women's role in society at that time may have also helped them to be more open to accepting direction as the majority of authority figures in society, in politics, law and education were male because women's place as home-maker meant that few women had the potential to 'rise in the ranks'. Although they did generally accept direction from the health practitioners they did not always feel happy about it, and as mentioned earlier, this was demonstrated nationally with the formation of Parents Centre to promote natural birth and to disseminate information to women through antenatal classes.

A lack of autonomy could also be felt by midwives. Their role was directed by doctors and nurses leading to their special status as 'midwives' being hidden. This was an era in which the increased birthrate and the shortage of midwives and nurses were putting severe pressure on the hospitals and their workforce. Within that workforce midwives were quite 'invisible' to the women participants. Noeline speaks of the 'head nurse' and the matron and only speaks of midwives when she discusses 'Sister Ritchie' who had a Nursing Home, and the elderly lady 'Mrs. Sullivan' who cared for her mother during her births at home and was 'probably a midwife'. Ivanka mentions a midwife



once and otherwise talks of nurses. Mabs who is descended from a midwife and more aware of midwifery was definite that the word midwife was not used in the hospital.

This lack of recognition of the hospital staff as midwives reflects the invisibility of midwives and is indicative of the nursification of midwifery and possibly reflective, at least in Wellington Hospital, of the use of nursing students to deliver much of the direct care.

### **Being alone**

Another major issue to emerge from this study was that of 'being alone'. The maternity system and the culture of the study period isolated women from their families, their support systems and their babies. The change from the 1900 system of a woman birthing at home usually with family and other women supporting her had changed to one where the woman was removed from society and placed in an institution, alone. Her husband was sent home and it was not until later in the study period that he was able to stay for part of the labour. Visiting hours were controlled quite strictly and children were usually not allowed to visit or were allowed only at certain times. Even at home after the birth and the postnatal period women were often expected to sit alone in their rooms to breastfeed as the prudish culture of the day meant that many women felt uncomfortable breastfeeding in company, particularly in front of men, even within the family circle.

The other sense of 'being alone' the women experienced was that of being isolated from their babies. Sharing a bed and cuddling baby were also forbidden by the strictures of the day which dictated that this was 'spoiling' the baby. Before rooming-in became accepted practice, babies were taken to the nursery and mothers could only view them through the window. Some did not see their baby for days. Separation from babies was even more acute for women who became ill and were transferred to Wellington Public Hospital, as babies were not admitted to the hospital with their mothers. In Helen's case her baby was transferred to the Karitane Hospital. Even when rooming-in began to be adopted, it was not uncommon for babies to be held in the nursery for the first few days with limited visits to their mothers for feeding.

The sense of aloneness while hospitalised was exacerbated because of shift work and task oriented nursing practices. The people who were caring for the woman changed constantly because the midwives and nurses worked in shifts. In hospitals where task nursing was practised there would be no particular nurse or midwife assigned, which increased short-term contact with a large number of staff. Even if, over time, a woman began to recognise and become familiar and at ease with individuals, there was no guarantee that they would be available at the birth of her baby or at any crisis point. Many women felt alone.

The birth of the baby was another time when many women experienced feelings of aloneness with no family support allowed, and the sense of alienation made more intense by the masks and gowns which hid the attendant's facial expressions. The position of the woman and the sterile drapes put her in the situation of 'being delivered' which in many ways divorced her from full involvement in the birth of her baby often with a resulting sense of disempowerment.

### **Uncaring attitudes**

The women indicated that the lack of autonomy and feelings of aloneness were mitigated somewhat because the staff treated them well. They described care and kindness from nursing and midwifery staff. However, although there were many instances of kindness from staff, this was not always the case. Mabs recounted how a 'Sister' "left all the women in tears". Ivanka also felt a lack of empathy from the staff caring for her and was subjected to a severe 'telling off'. Stevenson's account of the authoritarian control and discipline of nurses<sup>231</sup> and Kathleen's account of the unkindness of some of the midwives in the old St Helens to the students, would seem to demonstrate that the authoritarian control and discipline that nurses and midwives were subject to was passed on by some staff.

It is interesting to consider the idea that the unmarried workforce may have been less empathetic to the women because they had never experienced marriage and

---

<sup>231</sup> A. Stevenson, *Realities and Rhetoric*, p. 102.

childbearing themselves. This, of course, is a generalization, and there are many excellent midwives who have never had children. However, when I asked Ruth Belton whether she thought that having a large number of single women in the workforce made a difference she replied:

*Yes, I think it did. I think once we had more married Sisters too, at St Helen's, I felt that it was ever so much easier for the patients, as the registered nursing staff, the married women seemed to understand the patients much better. Actually, getting married when I did in the 1970's, I thought I would have been a much better midwife, of much more help to people, had I had known more about what it was like to be married, beforehand.*

It may have been the combination of the authoritarian discipline, the busyness and the large number of single women that created a culture where some nurses and midwives were able to ignore the feelings and wishes of other women, staff or 'patients'. Certainly the busyness and unavailability of staff was mentioned by several of the women and Kathleen has revealed the amount of work that needed to be done by the midwives. Workforce issues concerning unpaid overtime were discussed by Stevenson.<sup>232</sup>

## **Conclusion**

The findings of this thesis suggest that the childbearing women of the 1950s and 1960s passed through a medicalised and interventionist ordeal in order to give birth in what they understood to be a less painful and safer manner. They coped with it because they believed in the health professionals' expertise and good intentions and they believed that the process was necessary for their own and their babies' well-being. Because other women were managing and everyone went through the same process they realized that they could also cope.

---

<sup>232</sup> A. Stevenson, 'Realities and rhetoric', p. 101.

Noeline: *I thought, Oh heck. It was a bit frightening but however, I soon got over all that, and realised that there were other women in the same position.*

Women were role models for each other. The process could be seen as a rite of initiation into motherhood. Body exposure and invasive procedures and pain although, of course, disliked by most women do not appear to have been the factors that engendered lack of faith in the system or caused the most stress.

While I had envisaged the loss of modesty and the indignities visited upon childbearing women during their preparation for birth, from such procedures as shaves and enemas, as epitomising the saying 'leaving your dignity at the door', comments were made by women that these procedures were endured and thought of as a necessary evil but nevertheless were not of great concern to them.

Helen: *I just thought it was part and parcel of the thing. I just did everything I was told to do. To get it over with, you know.*

The issues which were elicited from this study as being difficult for women to cope with were those of **'lack of autonomy'**, as they were forced into a situation where they lost control over decision making for themselves and for their babies, **'being alone'**, which included separation from social support systems such as family, separation from their babies and alienation because of certain hospital practices such as task nursing and the wearing of gowns and masks in the birthing room, and **'uncaring attitudes'** particularly when the women's physical and emotional needs were not met or ignored and minimised by busy or unsympathetic attendants. These issues were engendered by the hospital culture which had developed from a hierarchal regimented nursing workforce, the busyness caused by the high birth rate and the nursing shortage, the task oriented nature of practice and the stringent medical requirements based on 'H-Mt.20' which were time-consuming for staff as well as depersonalizing for the women.

At the beginning of this journey I set out to describe the 1950s and 1960s maternity

‘scene’ in Wellington. I explored the history to discover what had produced the ‘scene’. That was important and created a framework for the structure of this study. I needed to study women’s role in society in the 1950s and 1960s to understand why women, including the hospital staff, behaved as they did. The women’s stories and the midwives’ accounts posed more questions than they answered necessitating more exploration into the physical and cultural aspects of the maternity system in Wellington. The women’s stories told some of the story but I needed to expand this by including a description of the management of the birth process to complete the picture. This chapter has attempted to bring all of the components together.

I did not set out to prove any particular theories although having experienced the maternity system of the 1960s I suspected that the regimentation and rigidity of the system might come to the fore, but did not know in what form. The participants were recruited as a convenience sample but the commonalities in their stories were inescapable and evolved quite spontaneously. Through the loss of autonomy, loss of social support systems, enforced isolation, and sometimes not being treated with respect, each of the women ‘left their dignity at the door’.

Maternity in Wellington in the 1950s and 1960s was a state-provided hospitalised system, with a very busy workforce composed of mainly single nurses and midwives who had been socialised into medicalised midwifery and had lost the knowledge of women-centred midwifery and the confidence and ability to work outside the hospital. Homebirth was non-existent, hospitals were becoming fewer, larger, increasingly medicalised, interventionist and regimented. Women suffered the loss of autonomy, feelings of aloneness and the uncaring attitudes of some health professionals because they had been socialised into the belief, promulgated by the doctors, that they were safer in hospital. The mitigating factors that arose from the participant’s stories were the enjoyment of a hospital ‘rest’ for some women who had several children and the kindness and caring attitudes of many of the nurses and midwives.

This thesis incorporates the stories of four women and two midwives in relation to maternity in Wellington, 1950 – 1970. It also contains contextual information from

documentary primary and secondary sources as well as from my own experiences as a student nurse and consumer of maternity services in Wellington at this time, and from my later experience as a midwife. This description of Wellington's maternity service between 1950 and 1970 will, I hope, contribute to our knowledge of midwifery history as well as of maternity in New Zealand.

## **APPENDICES**

Appendix 1.	Information Sheets
Appendix 2.	Consent forms used in this study.
Appendix 3.	Letter from Ethics Committee

VICTORIA UNIVERSITY OF WELLINGTON  
*Te Whare Wananga o te Upoko o te Ika a Maui*



**Information Sheet**

**Project Title:** Maternity in Wellington, 1950 to 1970

**Researcher:** Jane Stojanovic

I am a registered Midwife studying for the Master of Arts (Applied) in Midwifery degree at Victoria University of Wellington. As part of my degree programme I am writing a thesis from an historical perspective about women's and midwives' experience in the maternity environment of Wellington between 1950 and 1970.

The aim of this research is to examine and explain the maternity environment in the Wellington area in the years from 1950 – 1970 from the perspective of women who gave birth in those years and midwives who attended them.

To gather the information required I am aiming to interview between two to four women who gave birth in the Wellington district in the years between 1950 and 1970.

Themes identified from those will be used as topics for further interviews with between two to four midwives who worked in the Wellington area between 1950 and 1970. The women and the midwives will not be known to each other. The emphasis will be on their general experience of maternity.

If you are interested in being part of this project I would interview you at a time and place agreeable to you. The interview may last about 1 to 2 hours. I would audio-tape the interview. The audio-tape would be kept securely stored during the project. My supervisor, Dr. Pamela Wood and I would listen to the tape. No other person will have access to it unless you give your consent.

At the end of the project I would give the audio-tape to you or wipe it electronically.



As part of the thesis I will be writing analyses of the tapes and the other information gathered. The thesis will include quotations from the tapes which you will be able to see prior to the completion of the thesis. You can choose whether you wish the quotations to be identified using your own name or a pseudonym. If you do not want your name used no other identifying information will be associated with your tape, or in any written information. If you want a quotation withheld from the thesis your wishes will be respected. Your participation in this interview is entirely voluntary. You may withdraw at any time. If you decide to participate, I will ask you to sign a written consent form. You can stop the interview at any time, or withdraw from the project at any time. When the thesis is complete, I will give you a copy if you wish.

Please read this information sheet carefully. I will contact you again in a weeks time to discuss any further questions and to find out if you are interested in participating.

This project has been approved by the Human Ethics Committee of Victoria University of Wellington.

If you wish to discuss this project at any time you may write to or telephone:  
Thank you for your time and interest.

***Jane Stojanovic***

36 Bell St.

Otaki

Phone: 06 3648890

***Dr. Pamela Wood***

Graduate School of Nursing and Midwifery,

Victoria University of Wellington,

P.O.Box 600, Wellington, New Zealand,

Phone: 04 463 6650

VICTORIA UNIVERSITY OF WELLINGTON  
*Te Whare Wananga o te Upoko o te Ika a Maui*



**Consent Form**

**Project Title: Maternity in Wellington, 1950 to 1970**

**Researcher: Jane Stojanovic, RGON, RM, Adv. Dip. Nsg.**

**Declaration:**

I have been given an explanation of this oral history project.

I have had the opportunity to ask questions and have had them answered to my satisfaction.

I understand that I may withdraw any information I have provided until the data is analysed, without needing to give reasons.

I understand that this research has been approved by the Human Ethics Committee of Victoria University of Wellington.

**I agree to have my real name used for material I provide which is used in the written report of this research:**

Signed\_\_\_\_\_

**I do not agree to have my real name used for material I provide which is used in the written report of this research: I wish to use a pseudonym:**

Signed\_\_\_\_\_

**I wish to have the interview audio-tape electronically wiped at the completion of the project.**

Signed\_\_\_\_\_

**I wish to have the copy of the taped interview given to me at completion of the project.**

Signed\_\_\_\_\_

**I wish to receive a copy of the final report:**

Signed\_\_\_\_\_

Signature of Participant:.....date:.....

## **REFERENCES**

### **Primary Sources**

#### **Oral History Interviews**

Belton, Ruth, September, 2002.

Brosnahan, Kathleen, October, 2002.

Le Page, Mabs, August, 2002.

Marta, Ivanka, August, 2002.

Ruston, Noeline, August, 2002.

Van Kampen, Helen, August, 2002

#### **Personal Records**

Jackson, Joyce Florence, Oral History Tape, Stojanovic family archive, 2000.

Mikoz, Mrs. A., Personal Communication, April, 2000.

#### **Official records**

Annual Report of Director of Health, *AJHR*, Vol.1, H-31, 1945, p.7.

Special Committee on Maternal Mortality in N.Z, *AJHR* Vol. 1, H-31B, 1921, p. 4.

#### **Newspapers and Journals**

The Evening Post 1945 – 50.

The Dominion 1945 – 50.

## Books

Begg, N., *The Child and his Family*, Whitcoulls Ltd, Christchurch, 1975.

Bowerbank, F., *Doctor's Story*, Wingfield Press, Wellington. 1958.

Corkill, T.F., *Lectures on Midwifery and Infant Care: A New Zealand Course*, Coulls Somerville Wilkie Ltd., London, 1932.

Corkill, T.F., *Lectures on Midwifery and Infant Care: A New Zealand Course*. (5<sup>th</sup> ed.) Whitcombe and Tombs Ltd., Wellington, 1960.

Davies, Trevor et al., *The Queen Charlottes Textbook of Obstetrics*, J & A Churchill Ltd., London, 1939.

Davies, S., *Bread and Roses*, Australia and New Zealand Book Co. Pty. Ltd., Auckland, 1984.

The N.Z. Obstetrical and Gynaecological Society, *The Expectant Mother*, Whitcombe and Tombs Ltd. Wellington, 1953.

Gordon, D., *Backblocks Baby Doctor*, Faber and Faber Ltd. London, 1955.

Gordon, D., *Doctor Down Under*, Faber and Faber Ltd, London, 1957.

Green, G.H., *Introduction to Obstetrics*, N. M. Peryer Ltd, Christchurch, 1962.

Kerr, Munro et al., *Combined Textbook of Obstetrics and Gynaecology*, E & S Livingstone, Edinburgh, 1944.

Liley H. M. I. and Day B., *Modern Motherhood*, Heinemann, London, 1968.

Lummis, T., *Listening to History*, Century Hutchinson New Zealand Ltd, Auckland, New Zealand, 1987.

Maclean H., *Nursing in New Zealand, History and Reminiscences*, Tolan Printing Company, Wellington, 1932.

Peel, J. *Materia Medica for Nurses*, N. M. Peryer, Wellington, 1959, p. 24.

Truby King, F., *Feeding and Care of Baby*, Whitcombes and Tombs Ltd. Wellington, 1940.

## Secondary Sources

### Books

- Barber L.H. & R.J. Towers, *Wellington Hospital 1847 – 1976*, Wellington Hospital Board, Wellington, 1976.
- Campbell, H., *Mary Lambie, A Biography*, The New Zealand Nursing Education and Research Foundation, Wellington, 1976.
- Donley, J., *Save the Midwife*, New Women's Press Ltd. Auckland, 1986.
- Dow, D. A., *Safeguarding the Public Health, A History of the Department of Health*, Victoria University Press, Wellington, 1995.
- Campbell H., *Mary Lambie, A Biography*, The New Zealand Nursing Education and Research Foundation, Wellington, 1976.
- Hutching, M., *Talking History: A Short Guide to Oral History*, Bridget Williams Books and Historical Branch Department of Internal Affairs, Wellington, 1993.
- Irvine Smith, F., *The Streets of My City*, A.H. & A.W. Reed, Wellington, 1949.
- Katz Rothman, B., *Recreating motherhood: Ideology and technology in a patriarchal society*, W. W. Norton & Company, New York, 1989.
- Kedgley, S., *Mums the Word, The Untold Story of Motherhood in New Zealand*, Random House New Zealand Ltd. Auckland, 1996.
- Manson, C. & C., *Doctor Agnes Bennett*, Michael Joseph Ltd, London, 1960.
- McDonald, A.L. and Tulloch C., *Wellington Hospital: Educating Nurses for more than a Century, 1883 – 1991*, Wellington Hospital Nurses Reunion Committee, Wellington, 1991.
- Mein Smith, P., *Maternity in Dispute: New Zealand, 1920-39*, Historical Publication Branch, Department of Internal Affairs, Wellington, 1986.
- Neill, J.O.C., *Grace Neill, The Story of a Noble Woman*, N.M. Peryer, Christchurch, New Zealand, 1961.
- New Zealand College of Midwives, *Handbook for Midwifery Practice*, Christchurch, NZCOM. 1993.
- Odent, M., *Primal Health*, Century, London, 1986.

Papps E. and Olssen M., *Doctoring Childbirth and Regulating Midwifery in New Zealand*, The Dunmore Press Ltd, Palmerston North, 1997.

Rattray, J., *Great Days in New Zealand Nursing*, A.H. & A. W. Reed, Wellington, 1961.

Sinclair, K., ed., *The Oxford Illustrated New Zealand History*. Oxford University Press, Auckland, p. 120.

Sinclair, K., ed., *The Pelican History of New Zealand*, Penguin Books, Auckland, 1980.

Thompson, P., *The Voice of the Past, Oral History*, (3<sup>rd</sup> ed.), Oxford University Press, 2000.

Wassner, A., *Labour of Love, Childbirth at Dunedin Hospital 1862 – 1972*. Wycliffe Press Ltd., Dunedin, 1999.

### **Articles and Chapters**

Cooper, M., 'The Midwives Case 1920 – 1930', in Chick and Rodgers. eds., *Looking Back, Moving Forward: Essays in the History of New Zealand Nursing and Midwifery*. Department of Nursing and Midwifery, Massey University, Palmerston North, 1997

Church, O., Using Historical Sources, In Woods, N. F. and Cantanzaro, M. *Nursing Research: Theory and Practice*. C.V.Mosby, St Louise, 1988.

Cramer, S., The Nature of History: Meditation on Clio's Craft, *Nursing Research*, Vol. 41, No.1, Jan/Feb., 1992.

De Vore, C., Midwives as business women, in Norma Chick and Jan Rogers eds., *Looking Back, Moving Forward: Essays in the History of New Zealand Nursing and Midwifery*, Department of Nursing and Midwifery, Massey University, Palmerston North, 1997.

Helmstadter, C., Deconstructing and Reconstructing History, *Journal of Professional Nursing*, Vol. 14, No. 3, May-June, 1998.

Hunter, B., Oral history and research, part 1: uses and implications, *British Journal of Midwifery*, July 1999, Vol. 7, No. 7.

Lusk, B., Historical Methodology for Nursing Research, *Image: Journal of Nursing Scholarship*, Vol.29, No. 4, Fourth Quarter, 1997.

Orchard, S., 'More 'women of good character': Nurses who came to New Zealand as immigrant settlers during the period 1860 to 1883', in N. Chick and J. Rogers eds., *Looking Back, Moving Forward: Essays in the History of New Zealand Nursing and Midwifery*, Department of Nursing and Midwifery, Massey University, Palmerston North. 1997.

Parkes, C. M., 'The impact of the medicalisation of New Zealand's maternity services on women's experience of childbirth', 1904 -1937, in L. Bryder, ed., *A Healthy Country: Essays on the Social history of Medicine in New Zealand*, Bridget Williams Books, Wellington, 1991.

Russell, R.L., Historiography: a methodology for nurse researchers, *Australian Journal of Advanced Nursing*, Vol 16, No. 1, Sept-Nov., 1998, p. 141.

Schnorrenberg, B., Is Childbirth any place for a woman? The decline of midwifery in eighteenth century England, in P.K. Wilson, ed., *Childbirth Changing Ideas and Practices in Britain and America to the Present*, Vol. 1, Garland Publishing, Inc. London, 1996.

Summers, A., Sairey Gamp: generating fact from fiction. *Nursing Inquiry*, No. 4, 1997.

Tennant, M., 'Mrs. Grace Neill in the Department of Asylums, Hospitals and Charitable Institutions', *The New Zealand Journal of History*, Vol.12, No.2, October, 1978.

## **Theses**

Cooper, M., 'Towards the professionalisation of New Zealand midwifery 1840-1921', M Phil thesis, Massey University, Palmerston North, 1998.

Stevenson, A., 'Realities and rhetoric: general hospital nursing in New Zealand 1945 to 1960', MA thesis, Victoria University of Wellington, Wellington, 1997.

