TOWARDS THE PROFESSIONALISATION OF NEW ZEALAND MIDWIFERY 1840 - 1921

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ABSTRACT

This thesis examines the reasons behind the move to formalise New Zealand European midwifery care in 1904 and the impact this had on midwifery practice. 'The Midwives Act, 1904' concentrated on providing a training system for midwives, hence traditional midwives found their duties circumscribed by their lack of knowledge and training. While women were seen as the appropriate case managers for women during parturition, the Midwifery Act set in place regulations that required advanced knowledge and set standards of practice. The setting up of a nation-wide structure at St Helens Hospitals[1] for the training of midwives reinforced the role of the trained midwife, who in some instances was also a trained nurse, and began the move towards the hospitalisation of maternity patients which came to fruition around 1938.

The contention of this thesis is that the Midwifery Act contributed to the development of professional standards of midwifery practice leading to a more professionalised midwifery service in place of that which had, until 1904, been unstructured and informal. Through the inclusion of scientific developments into the syllabus of instruction the Midwifery Act gave formal direction to the training, examination and practices of midwives. Finally, it brought to the fore the trained midwife and single woman who replaced the traditional married midwife.

The developments and changes in midwifery that occurred following the 1904 Midwifery Act had their beginnings well in advance of the Act. Maternal and infant mortality and morbidity rates had become a concern in England during the 1860s. As early as 1867 maternity lying-in hospitals were beginning to develop protective mechanisms to prevent infection. In New Zealand an unstructured midwifery service comprised mainly of traditional midwives developed from 1840. Stringent use of antisepsis and advanced, professional, midwifery knowledge did not influence these midwives' practices until 1904 when the Midwives Act was implemented leading to the demise of the traditional midwife.

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[1] St Helens hospitals does not have an apostrophe.

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LIST OF ABBREVIATIONS

AJHR	Appendices to the Journal of the House of Representatives.
BCL	Bradford City Library, West Yorkshire, England.
BPS	British Practical Statutes.
CMB	Central Midwives Board.
JN-M	Journal of Nurse-Midwifery.
JNNZ	The Journal of the Nurses of New Zealand.
LOS	London Obstetrical Society.
MCNN	Midwives Chronicle and Nursing Notes.
NM	Nursing Mirror.
NZG	New Zealand Gazette.
NZL	New Zealand Listener.
NZPD	New Zealand Parliamentary Debates.
NZOYB	New Zealand Official Year Book.
NZS	New Zealand Statutes.
TBID	The Bertillon Index of Diseases.
SCNZ	Statistics for the Colonny of New Zealand.
SDNZ	Statistics for the Dominion of New Zealand.
WARC	Wellington Archives.
WDNZFU	Womens' Division of the New Zealand Farmers' Union.
WARC	National Archives of New Zealand. Wellington.
WTU	Alexander Turnbull Library.

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Introduction

This study examines the introduction of the 1904 New Zealand Midwives Act and the changes that occurred in midwifery as a result of the Act. The Act set in place a national structure for the training of midwives, the expected knowledge base for midwifery practice, and the development and organisation of a State midwifery service. The study reflects on why an Act was necessary and examines the movement away from an unstructured, unorganised service towards one which was ordered and regulated. The implementation of legislation, regulations and practices provided trained midwives with an approach to midwifery which reflected a new professionalism.

The focus and direction of this thesis has been maintained by two research questions:

1. Why did New Zealand midwifery formalise?

2. How did formalisation effect the practice of midwifery in New Zealand?

Midwifery practices in New Zealand between 1840 and 1921 experienced immense changes. Between 1840 and 1904 midwifery was almost exclusively the domain of traditional midwives in community settings.[1] This changed in 1904 when training programmes for midwives were established in newly created state maternity hospitals. Women who had previously sought midwifery training overseas began to seek this training in New Zealand. Developing a body of New Zealand trained midwives was however slow with direct entry midwives outnumbering those who first trained as nurses. However the numbers of

[1] J. Raisler, The International Confederation of Midwives: Past History, Present Activities and Future Challenges, *Journal of Nurse-Midwifery (JN-M)*, 39:5, September/October, 1994, pp. 326-328. In discussing the history of midwifery organisations internationally Raisler indicates that prior to the late 19th century midwives throughout the world 'were traditional practitioners who learned their craft through apprenticeship'.

traditional midwives remaining in practice outnumbered trained midwives until 1915 when the balance began to change.

During the debate on the 1904 Act and immediately after, the impression given by parliamentarians was that women were seen as the appropriate group to assist women in childbirth. However, doctors, who had held professional status since 1856 wanted to maintain their control over midwifery services which came into their range of contestable areas of concern. Midwifery training threatened the doctors' scope of activity, and while midwifery training moved ahead, it was not without conflict.

While the European childbearing population of New Zealand received midwifery services from neighbours or traditional midwives, by 1904 emphasis on knowledge about disease and childbirth traumas gave direction to both hospital and midwifery services, and the 1904 Midwives Act regulated for these features. The knowledge that infectious organisms could be contained through the use of antiseptics led to the introduction of Listerism into midwifery practice. The traditional midwife continued in practice well into the 1930s but in ever decreasing numbers, while the trained midwife numbers slowly increased.

This thesis examines the interpretation that professionalisation was a main feature for the introduction of midwifery training in 1904.[2] The traditional midwives were unwilling to receive a midwifery training. However, the trained midwife, who, in some instances had first trained as a nurse, became the greatest threat to the traditional midwife. The nurse-midwife was seen as having the required skill to extend her knowledge to areas of antisepsis and abnormalities associated with childbirth, combining her nursing knowledge with her midwifery knowledge.

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[2] S. Wallace, 'The Professionalisation of Nursing, 1900-1930', BA Thesis, University of Otago, 1987.

Three New Zealand midwifery accounts have focused on midwifery practice. Philippa Mein Smith's book *Maternity in Dispute: New Zealand 1925-1939*, and thesis, 'The State and Maternity in New Zealand 1925-1935',[3] examined the changing pattern of childbirth from home births and small, unlicensed one bed homes to the advent of an ideology that childbirth was best achieved in a public maternity hospital. Of relevance to this study is Smith's argument on the issue of maternal mortality which gave cause for concern in 1920. Central to the problem was the high incidence of puerperal sepsis which had consistently accounted for approximately one third of maternal deaths for the previous five years.

Gaynor Smith in her BA Honours Essay, ' 'Essentially a Woman's Question': A Study of Maternity Services in Palmerston North 1915-1945', examined the trend towards hospitalisation of midwifery services in one city of New Zealand during a period when medicalisation was seen to be becoming a normal event for childbirth.[4] The study sought to replicate Phillipa Mein Smith's study *Maternity in Dispute: New Zealand 1925-1939* on a regional basis. Gaynor Smith focused on European women, as finding sources on Maori women's experience was difficult. In particular Gaynor Smith identified the large number of Class B midwives who ran private maternity homes in Palmerston North.

Both Phillipa Mein Smith and Gaynor Smith identified the undercurrent of eugenic ideology which directed the reasoning of many politicians, medical doctors and leading academics of the time. Although eugenics eased to some degree the passing of the 1904 Midwives Bill this was tempered by humanitarian and philanthropic thinking.[5] I arrived at this conclusion after studying the debate

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[3] P. M. Smith, *Maternity in Dispute: New Zealand 1925-1939,* Wellington, V. R. Ward, Government Printer, 1986. P. M. Smith, 'The State and Maternity in New Zealand 1925-1935' MA Thesis, Canterbury, 1982.

[4] G. Smith, ' Essentially a Woman's Question': A Study of Maternity Services in Palmerston North 1915-1945', B A Honours Essay, Massey University, Palmerston North, 1987.

[5] Premier Richard Seddon, *New Zealand Parliamentary Debates (NZPD),* V 128, July 1, 1904, pp. 70/73. Mr. Witheford, Member for Auckland City, *NZPD,* 1904, p. 74. Mr. Rutherford, (Member for Hurunui) *NZPD,* 1904, p. 76. Mr. Taylor, (Member for Christchurch City) *NZPD,* 1904, p. 77.

on the midwives Bill alongside P. J. Fleming's MA thesis, 'Eugenics in New Zealand, 1900-1940'[6] and two articles by Eric Olssen, 'Breeding for the Empire',[7] and 'Truby King and the Plunket Society: An Analysis of a Prescriptive Ideology'.[8] Eugenic issues are not referred to in the body of this thesis.

Elaine Papps and Mark Olssen's book, *Doctoring Childbirth and Regulating Midwifery in New Zealand: A Foucauldian Perspective,* argues that midwives 'got pushed out of the birthing room in New Zealand' and place the cause of this upon the shoulders of doctors who wished to have control over women's birthing practices.[9] Papps and Olssen trace the legislative changes in midwifery from the 1904 Act to 1994. Their conclusion was that doctors resisted and contested midwives' place to act as the lead provider of maternity services in New Zealand. While this book takes a particular theoretical perspective and a wide scope, some elements have application to this thesis. I incorporate an investigation into the 1904 Midwives Act however a Foucauldian perspective is not used and this thesis is focused on a shorter time span.

Athena A. Hill in her thesis 'The History of Midwifery from 1840 to 1979, with Specific Reference to the Training and Education of the Student Midwife', examined the training and education of midwives in New Zealand from 1904 up to 1979.[10] Hill's thesis focused more on the later years of the period and included a detailed examination of the years 1973 to 1979. The training and education of

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6 P. J. Fleming, MA Thesis, Massey University, Palmerston North, 1981.

7 E. Olsen, 'Breeding for the Empire',*New Zealand Listener (NZL)*, 12 May, 1970, pp. 18-19.

8 E. Olsen, 'Truby King and the Plunket Society: An Analysis of a Prescriptive Ideology', *New Zealand Journal of History*, 1, April, 1981, pp. 3-23.

9 E. Papps, M. Olssen, *Doctoring Childbirth and Regulating Midwifery in New Zealand: a Foucauldian perspective,* Palmerston North, Dunmore Press, 1997.

10 A. A. Hill, 'The History of Midwifery from 1840 to 1979, With Specific Reference to the Training and Education of the Student Midwife', M A Thesis, University of Auckland, 1982.

midwives also features in my thesis but is confined to the years immediately following the 1904 Midwives Act.

The application of Listerism in midwifery practice was not unique to New Zealand. Rather it was reflective of an international trend which has been examined by Irwin Louden in *Deaths in Childbirth: An International Study of Maternal Care and Maternal Mortality, 1800-1950.*[11] In this study Louden identified puerperal sepsis as the major factor in maternal mortality and the scientific developments which assisted in reducing the incidence of this process. New Zealand was included in the study which identified the passing of legislation controlling the practice of midwives as a major factor in the reversal of death in childbirth. I also examined overseas legislation in relation to that developed in New Zealand but restricted my inquiry to the English Act of 1902 which was replicated in New Zealand. Ann Ward's two part article on 'The Passing of the Midwives' Act, 1902' has been helpful in identifying practice issues and key features in the history of English midwifery which preceded the passing of the English Midwives' Act and were also present in New Zealand midwifery practice.[12] Unlike Ward's study I have extended my investigation beyond the acceptance of the Act and examined the professional development of the midwife through training and education.

The professional status of nurses and midwives has been a topic of debate in recent years. Sandra Wallace has examined the professionalisation of nursing practice in New Zealand between 1900 and 1930.[13] Midwifery as a branch of nursing was included in this process and is linked to the establishment of legislation requiring training, education and registration. The criteria for professionalisation Wallace provided support midwifery's identity as a profession

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[11] I. Louden, *Deaths in Childbirth: An International Study of Maternal Care and Maternal Mortality, 1800-1950,* Oxford, Clarendon Press, 1992.

[12] A. R. Ward, 'The Passing of the Midwives' Act, 1902', *Midwives Chronicle and Nursing Notes (MCNN),* Part 1, June, 1981, pp. 190-194. Part 2, July, 1981, pp. 237-242.

[13] S. Wallace, B A Thesis, University of Otago, 1987.

from 1904 but not prior to this time (See Table 1). Rosalind Marshall in 'Birth of a Profession', gave a much stronger argument for the existence of professional midwives prior to 1904.[14] Marshall believed that women who were recognised in their community as midwives and who earned their living in the practise of midwifery were professional midwives (See Table 2). Belgrave supported this argument stating that within a developing medical economy a group of professionals existed prior to 1904[15] including midwives.[16] Belgrave refers to training, in some instances through apprenticeship, as an aspect of professional identity. His reasons for identifying midwives as a professional group is related to their inclusion 'in the health section in the professional classification of the census from 1874'.[17]

Thomas W. H. Brooking in teasing out the early developments in New Zealand dentistry provides four major stages in the development of a profession.[18] These stages are recognisable in the development of all professional groups including midwifery (See Table 3, p. 8). Brooking's description of the different stages has assisted in the development within this thesis of a progressive profile which, with other definitions, can be used to discern the professional status of an occupational group over time. This thesis however does not examine midwifery in all the stages defined. The third and fourth stages are not applicable to the period under study within this thesis. Chapter one brings together the work of

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[14] R. Marshall, Birth of a profession, *Nursing Mirror (NM)*, 157:22, November 30, 1983, pp. i-vi.

[15] M. Belgrave, 'Medicine and the Rise of the Health Professions in New Zealand, 1860-1939' p. 7-24. In L. Bryder, ed., *A Healthy Country: Essays on the Social History of Medicine in New Zealand,* Wellington, Bridget Williams Books, 1991.

[16] ibid. p. 11 and 20-24.

[17] ibid. p. 11.

[18] T. W. H. Brooking, *A History of Dentistry in New Zealand,* Dunedin, The New Zealand Dental Association Inc., 1980, p. 21.

Table 1: Defining characteristics of a profession identified by Wallace.

1. Systematic theory leading to a formal qualification
2. A distinct culture
3. A service orientation
4. Ethical codes
5. Autonomy

Source: S. Wallace, 'The Professionalisation of Nursing, 1900-1930', BA Thesis, University of Otago, 1987.

Table 2: Summary of pre-formal definition of Profession

1. The work involved is a persons occupation
2. Society recognises the person as someone offering a particular service, e.g. midwife
3. The person receives remuneration for services rendered

Source: R. Marshall, Birth of a profession, *Nursing Mirror,* 157:22, November 30, 1983, pp. i-vi.

Table 3: Stages in the development of a profession.

1. Sub professional - relates to the pre-formal definition of a profession
2. Semi-profession - relates to the dictionary definition of a profession and is marked by the separation of practitioners into two groups. 1. Sub-professional, 2. Demi-professional, seeking to distance self from sub-professional by education as opposed to apprenticeship. Embraces apprenticeship [practical skills] and moves beyond.
3. Fully-professional - excludes all uneducated practitioners from practice. Relates to the dictionary definition of profession.
4. Post-professional - Relates to the nursing/medical dictionary definition of profession.

Source: T. W. H. Brooking, *A History of Dentistry in New Zealand,* Dunedin, New Zealand Dental Association, 1980, p. 21.

Wallace[19] and Brooking through analysis of the concept of professionalisation and development of a profile for measuring the professional standing of occupational groups over time.

Application of the profile of a professional nurse is demonstrated in Christopher Maggs' book, *The Origins of General Nursing*.[20] Maggs included a chapter on the training and education of nurses and followed this with an examination of careers in nursing. I also investigate the training and education of pupil nurses in the first New Zealand midwifery schools, St Helens Hospitals. These early training programmes for midwives changed the career options for nurses and single women by opening up a new professional direction for those interested in women's health. An examination of the career paths of a small group of these early trained midwives is included in this thesis.

Statistical evidence of the need for change in the delivery of midwifery care was a principal element in the introduction of the Midwives Bill. Figures for both maternal and infant mortality were used to support the argument of the Bill.[21] These same issues continued to feature in arguments surrounding and related to midwifery care over the next two decades and beyond.[22] The inconsistencies in the keeping of statistics up until 1908 have been pointed out by Geoffrey W. Rice in his essay 'Public Health in Christchurch, 1875-1910: Mortality and Sanitation'.[23] Rice included a historiography on the relationship between sanitary reform and mortality statistics internationally before focusing on the impact of these issues in Christchurch. Sanitary reform does not feature in my thesis but

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19 S. Wallace, B A Thesis, University of Otago, 1987.

20 C. J. Maggs, *The Origins of General Nursing*, London, Croom Helm, 1983.

21 Premier Richard Seddon, *NZPD*, V 128, 1904, p. 70.

22 P. M. Smith, 1986. G. W. Rice, 'Public Health in Christchurch, 1875-1910: Mortality and Sanitation', in L. Bryder, ed., *A Healthy Country: Essays on the Social History of Medicine in New Zealand*, Wellington, Bridget Williams Books, 1991, pp. 85-108. F. S. Maclean, *Challenge for Health: A History of Public Health in New Zealand*, Wellington, R. E. Owen, Government Printer, 1964.

23 G. W. Rice, in L. Bryder, ed., 1991, pp. 85-108.

the issues Rice identified in relation to the official keeping of mortality statistics have relevance to the analysis and interpretation of my research findings.

The Open University, England, have published a study guide, *Caring for Health: History and Diversity,* edited by Charles Webster.[24] This book links together five themes including the contribution traditional care providers made to health and the changes professionalisation had, and was expected to have, on health services. The interconnection identified between these two variables are confirming of the findings of this thesis.

Archival sources on early childbirth practices (1840 to 1900) are limited. Records become more readily available following the 1904 midwifery legislation. The archival material used in this thesis comes from a variety of sources. The Alexander Turnbull library (WTU) holds personal files written by amateur and trained midwives. Frederick Truby King's Papers date from 1885 and include lecture notes on midwifery which reflect the teachings of Sir James Young Simpson, 1811 - 1871.[25] A contemporary book, *A Short Practice of Midwifery for Nurses,* Third Edition, Revised, dated 1908, written by Henry Jellett, who was Master of the Rotunda Hospital in Dublin 1910 to 1919, and was viewed as an authority on obstetrics, was a supporting text.[26] A medical text of Jellett's featured as a text for medical students in New Zealand prior to Jellett's arrival here in 1925. A contemporary nurses dictionary, *The Nurse's Dictionary of Medical Terms and Nursing Treatment,* by Honnor Morten was used to define some of the terms used in files and texts.[27] The Health Department files held at National Archives provided input for practice aspects of midwives work, and the

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[24] Charles Webster, editor, *Caring for Health: History and Diversity,* Open University Press, 1993.

[25] King, Frederick Truby (Sir) 1858-1938, *MS 1119-1121,* Lecture Notes on Midwifery and Gynaecology, 1885, WTU.

[26] H. Jellett, *A Short Practice of Midwifery for Nurses,* Third Edition, Revised, London, J. & A. Churchill, 1908.

[27] H. Morten, *The Nurse's Dictionary of Medical Terms and Nursing Treatment,* London, The Scientific Press Limited, 1900.

organisation of the St Helens Hospitals, the State maternity hospitals set in place from 1905 onwards.

Overseas archival sources were located in the Bradford City Library, (BCL), West Yorkshire, England. These documents supported the arguments in the secondary sources on English midwifery practice during the 1800s and early 1900s. They also demonstrated practices amongst untrained midwives parallel to those found in New Zealand following the 1904 Midwives Act. These documents assisted in the development of chapter two.

Other popular histories on midwifery have aided by identifying women who practised as midwives, and movements of these women throughout New Zealand. Accounts of midwives from the memories of members of the Women's Division of the New Zealand Farmers' Union, Joan Donley's *Save the Midwife,* and hospital histories served a purpose by indicating who were the midwives when other formal documentation does not.[28] However, like many celebratory histories, these accounts blur the narrative with subjective anecdotes and refrain from placing the history within the context of the social period.

While this thesis focuses on the New Zealand Midwifery Act of 1904 and the changes that occurred as a result of the Act, it begins with the wider issue of midwifery changes in England. It shows that New Zealand consciously followed standards set by England with minor alterations. Chapter two examines these changes and the Act which was implemented in 1902.

European midwifery practice in New Zealand had developed with the arrival of the immigrant population. In 1904 there was an uncoordinated, unsatisfactory service comprising mainly of traditional midwives. Chapter three examines this service.

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[28] J. Donley, *Save the Midwife,* Auckland, New Women's Press Ltd., 1986. Anon, *Brave Days: Pioneer Women of New Zealand,* Women's Division of the New Zealand Farmer's Union, (WDNZFU), Dunedin, A. H. & W. H. Reed, 1939. J. Rattray, *Great Days in New Zealand Nursing,* London, George G. Harrap & Co. Ltd., 1961.

Chapter four examines the introduction and acceptance of the New Zealand Midwives Bill as a directive for midwifery practice. One directive was the provision of state maternity hospitals known as St Helens Hospital, which were opened in the four main centres.[29] These served as both training schools for midwives and a safe, affordable, environment where the wives of working men could give birth.[30] Chapter five examines the programmes for pupil nurses.

A second directive of the Midwives Bill was the regulation of midwifery practice which included inspection of the untrained registered midwives and simple instructions which introduced them to Listerism. Suggestions that they attend the lectures that were given to pupil midwives in St. Helens Hospitals were rejected and other alternatives were provided. It was proposed by Grace Neill with support from Premier Richard Seddon to admit single women to the midwifery schools. This caused some discussion during the debate on the Midwives Bill with some parliamentarians wishing to exclude single women from training or proposing that they be prevented from marrying as a means of retaining them in practise. Chapter six examines the integration of untrained registered midwives into the new midwifery service. The career paths of fifty seven women who trained in the Wellington St Helens Hospital are also examined to identify the appropriateness of admitting single women to the training programmes. The average length of careers within the identified group was eight years. To examine each midwife's length of service for a minimum of eight years the investigation spanned the years 1907 to 1921. The last group of pupils to qualify as midwives did so in 1914. (See Appendix 2).

The Midwives Act of 1904 was designed to provide a safe, state midwifery service which would improve the quality of care and reduce maternal and infant mortality. This service was to serve as a training environment for pupil midwives who were to eventually replace traditional midwives. The Act constituted a

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[29] The Midwives Act 1904, [4 EDW II, No. 31] *New Zealand Statutes,* [NZS] 1904.

[30] Health III, B64 111, St Helens Hospitals - General, 1905-38, WARC.

change in professional direction for midwives separating nursing and midwifery through legislation and establishing a forum within which future professional development could take place.

Chapter One

Phases in the development of a profession: a concept analysis with application to the profession of midwifery.

Professionalism is a dynamic concept the defining of which changed considerably in the late 1800's and early 1900's.[1] This was a period when work groups moved from informal to formal organisation and expected knowledge and skills of a named group were formalised. The expected professional characteristics of a person practising a given occupation also changed and traditional practitioners found themselves challenged in their calling. In the mid 19th century many professional groups were traditional practitioners. By the early 20th century members of these groups had successfully lobbied for state legislation which set the formalities of their calling into statute and dictated the educational requirements for entry to practice. This excluded or confined the activities of the traditional practitioner. This chapter examines the defining characteristics of a profession over time and relates these to professions in general and to New Zealand midwifery.

The pre-formal definition of a profession included any person in a community who regularly provided a particular service for which they were paid either in money or in kind.[2] (See Table 2, p. 7. Introduction). The people in history who fit this description are frequently described as traditional practitioners. Their knowledge was acquired through practice, sometimes within an apprenticeship. Many professions acknowledge the presence of this type of practitioner within the history of their profession.[3] However not all professional histories refer to the traditional practitioner as a professional. An alternative description identifies

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1 S. Wallace, BA Thesis, University of Otago, Dunedin, 1987, p. 66. Wallace states that the term 'professional' is ambiguous and often misused.

2 R. Marshall, *NM,* 1983, pp. i-vii.

3 M. Belgrave, in L. Bryder, editor, 1991. p. 10.

these practitioners as sub-professionals.[4] Their professional activities were frequently linked with other specific activities.[5] In New Zealand society doctors were often gentleman farmers. Dentistry, usually teeth pulling, was performed by chemists who competed with doctors in this as well as in diagnosing and dispensing medicines.[6] This early dental activity was also performed by blacksmiths.[7]

When the pre-formal definition of a profession is applied to midwifery the early professional midwife becomes a person, usually a woman, recognised within their community as someone who provided care for women in childbirth and who received payment for this service.[8] This activity may or may not have been linked with general nursing duties. In this phase of midwifery history the midwife could be considered a traditional practitioner. Alternative names by which traditional midwives were known are 'handywoman'[9] and lay-midwife.[10] The term 'handywoman' often became confused with that of monthly nurse, a woman who supported the doctor during confinements and also attended to the laying out of the dead.[11] Sairey Gamp is the personification of a monthly nurse whose professional characteristics left much to be desired.[12] Australia began training

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4 T. W. H. Brooking, 1980.

5 M. Belgrave, in L. Bryder, 1991, p. 10.

6 ibid. p. 18.

7 T. W. H. Brooking, 1980.

8 R. Marshall, *NM,* 1983, pp. i-vii.

9 N. Leap, B. Hunter, *The Midwives Tale: An oral history from handywomen to professional midwife,* London, Scarlet Press, 1995. R. Perks, *Life as a Textile Worker and a Midwife (MBE),* BHRU Unrestricted, A0067, Bradford City Library, (BCL), 1984.

10 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, editor, *A Healthy Country: Essays in the Social History of Medicine in New Zealand,* Wellington, Bridget Williams Books Limited, 1991, pp. 165-180.

11 J. Towler, & J. Bramall, *Midwives in History and Society,* London, Croom Helm, 1986, p. 160-161. The Midwives Act 1904, [4 EDW VII, No. 31] 1904. The midwives trained under this Act were required to have a knowledge of the monthly nurse's duties.

12 C. Dickens, *Martin Chuzzlewit,* Wordsworth Editions Limited, 1995.

'ladies' monthly nurses' in 1861.[13] These women were usually widowed or married women with personal experience in childbirth. Lack of personal experience of childbirth was a common reason for excluding single women from the profession of midwifery within the pre-formal period.[14]

Further verification of the professional status of pre-formal midwives is found in the census returns.[15] As a public document defining the characteristics of a society this document separates occupational status into professional and non-professional groupings. As early as 1874 the census returns for New Zealand included midwives as a professional group. This alignment continues in the formal phase of professional development and beyond.

As professions formalised the definition of profession changed. The general definition identifies a profession as a calling to do a particular type of work for which the individuals have obtained special training in liberal arts or sciences.[16] Such professionals declared themselves to have a calling in a particular type of work and obtained the special training required to support the calling. (See Table 4).

The general definition is narrow in comparison to that given in nursing and medical dictionaries. These dictionaries embrace the general description but also identify wider requirements.[17] These include autonomous practice grounded in higher learning with a commitment to continue enlarging the body of knowledge of the profession. High standards of achievement and conduct are maintained

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[13] F. M. C. Forster. 'Mrs. Howlett and Dr. Jenkins: Listerism and Early Midwifery Practice in Australia', *The Medical Journal of Australia,* II:26, December 25, 1965, pp. 1047-1054.

[14] ibid. p. 1048.

[15] M. Belgrave, in L. Bryder, editor, 1991. p. 10.

[16] J. M. Hawkins, R. Allen, *The Oxford Encyclopedic English Dictionary,* Oxford, Clarendon Press, 1991, p. 1154.

[17] B. F. Miller, C. Brackman Keane, editors, *Encyclopedia and Dictionary of Medicine, Nursing and Allied Health,* Fourth Edition, Philadelphia, W. B. Saunders Company, 1987, p. 1014.

Table 4: Summary of dictionary definition of Profession.

1. A vocation or calling
2. Occupation requiring special training in liberal arts or sciences
3. The body of people in such a profession
4. A declaration or avowel

Source: P. Hanks, T. H. Long, L. Urdang, editors, *Collins Dictionary of the English Language,* London, Collins, 1979, p. 1167. J. M. Hawkins, R. Allen, editors, *The Oxford Encyclopedic English Dictionary,* Oxford, Clarendon Press, 1961, p. 1154.

Table 5: Summary of the Medical/Nursing dictionary definition of Profession.

1. A calling or vocation
2. Requires specialised knowledge, methods and skills grounded in scholarly, scientific and historical principles gained in an institution of higher learning
3. Continuously enlarges its body of knowledge
4. Functions autonomously
5. Maintains high standards of achievement and conduct through force of organisation or concerted opinion
6. Members of body committed to continuing study
7. Members of body committed to providing practical services vital to human and social welfare
8. Members of body place service above personal gain

Source: B. F. Miller, C. Brackman Keane, editors, *Encyclopdia and Dictionary of Medicine, Nursing and Allied Health,* Fourth Edition, Philadelphia, W. B. Saunders Company, 1983, p. 1014.

through the organisation and concerted opinion of the professional group. This is achieved through continued study following successful completion of basic studies. This professional group is committed to providing services which meet the vital needs of human and social welfare and which it places above personal gain. (See Table 5). The progressive development of professions embraces these two definitions. Three distinctive phases are identifiable.

A semi-professional phase in the profile of a profession followed the informal period.[18] In this phase of development two distinct groups within a profession existed side by side. Firstly the sub-professional group described above continued to practice within communities. Secondly a demi-professional group developed and distanced itself from the traditional practitioners.[19] This group sought to change the entrance of new practitioners into the occupation from that of an apprenticeship to one of education in schools of higher learning. Linked to this change was the introduction of registers of practitioners who had graduated from the schools.[20] Registers were linked with the passing of legislation controlling practice. Much of the early New Zealand legislation controlling groups of health practitioners was adoption of similar Acts passed in Britain.[21] The formalisation through statute excluded uneducated or traditional practitioners from practice and moved the occupation into a phase of full professionalism.[22]

The semi-professional phase of professional development separated out several occupational groups. Dentistry, pharmacy and medicine are examples of professions which developed their own body of knowledge and formalised into

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[18] T. W. H. Brooking, 1980, p. 21.

[19] ibid. p. 21.

[20] ibid. p. 33.

[21] F. S. Maclean, 1964, p. 11.

[22] T. W. H. Brooking, 1980, p. 21.

separate groups of health professionals.[23] Nursing and midwifery are inter-related professions which have been linked together as one profession through time.[24] Both professional groups however followed separate pathways following formalisation of knowledge to the extent that both had a separate Act governing preparation and registration of practitioners.[25] Massage was viewed as a skill which supported health professionals in their work yet it developed into the profession of physiotherapy.[26] Following completion of nursing courses New Zealand certificated nurses in the late 1800's were encouraged to take courses in massage.[27] Some nurses followed this advice including one Class B midwife, a Miss Margetts,[28] who with her sister ran a private maternity hospital in Auckland.[29]

Professions are not static in their practices and progression continues beyond full professionalism into a phase described as post-professionalism.[30] This phase embraces another major shift in educational expectations within preparation of individuals entering the profession. It is characterised by changes in the expected proficiency of graduates completing the preparatory courses. In the semi-professional phase of development certificates of proficiency were issued to successful candidates from occupational courses.[31] The fully-professional phase

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23 M. Belgrave, in L. Bryder, editor, pp. 16-20.

24 S. Wallace, BA Thesis, University of Otago, Dunedin, 1987, pp. 17-20. C. J. Maggs, 1983, pp. 82-84.

25 The Nurses Registration Act, 1901 [1 EDW, VII, No. 12] *NZS,* 1901. The Midwives Act, 1904 [4 EDW, II, No. 31] *NZS,* 1904.

26 M. Belgrave, in L. Bryder, editor, 1991. pp. 13-16.

27 S. Wallace, BA Thesis, University of Otago, Dunedin, 1987, pp. 17-20. C. J. Maggs, 1983, p. 55.

28 List of Registered Nurses, *NZG,* 1922, p. 369.

29 Report on Private Hospitals, *AJHR,* H22, 1907, p. 3.

30 T. W. H. Brooking, 1980, pp. 21-22.

31 M. Belgrave, in L. Bryder, editor, 1991. T. W. H. Brooking, 1980. S. Wallace, BA, University of Otago, Dunedin, 1987.

embraced the certificates of proficiency as acceptable for practice but sought to introduce degree status for all practitioners. The success of individual groups striving to achieve this level of professional standing has been variable.[32] Nursing in New Zealand made an early attempt to establish a degree course but this did not come to full fruition.[33]

The application of knowledge by members of a professional group is the fabric by which a profession is judged. Where practice is negligent, particularly when it affects the lives of others, then the profession is found wanting. It is in this situation that competent practitioners within the profession and other interested parties within society take action to change the status quo.[34] Seeking to distance themselves from the questionable practice and to stop such activities these people call for formal preparation of practitioners in educational settings. They also seek certification of competency through examination of knowledge as a pre-requisite to entering the profession. Such activity was demonstrated across the health related professions internationally during the late 1800s and early 1900s as part of formalisation.[35]

In English nursing and midwifery Florence Nightingale and Alice Gregory, although not instrumental in the fight to gain legislation to control midwifery practice, did recognise the need for preparation of midwives and provision of a safe place for childbirth to be conducted. Nightingale abandoned her own endeavours to establish a training school for midwives and turned to the study of maternal mortality, an activity which gave rise to her proscription for midwifery training schools.[36] Gregory, a competent midwife herself, established a training

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[32] ibid.

[33] S. Wallace, BA Thesis, University of Otago, Dunedin, 1987, pp. 17-20. C. J. Maggs, 1983, pp. 57-60.

[34] J. O. C. Neill, *The Story of as Noble Woman,* Christchurch, N. M. Peryer Limited, 1961.

[35] M. Belgrave, in L. Bryder, editor, 1991. S. Wallace, BA Thesis, University of Otago, Dunedin, 1987. C. J. Maggs, 1983.

[36] F. Nightingale, *Introductory Notes on Lying In Institutions,* London, Longmans, Green, and Co., 1871.

school for midwives.[37] The fight to gain legislation to control practice was left to another group of women. Over a period of several years these trained and certificated midwives strove to achieve legislation and improve the professional standing of their profession.[38] In New Zealand nursing and midwifery Elizabeth Grace Neill and her allies worked unstintingly to establish legislation which would remove incompetent nurses and midwives from practice and replace them with well prepared practitioners.[39]

The process of formalisation usually, but not always, included statuary legislation which established the boundaries of knowledge and ethical practice of the profession.[40] If a profession is viewed internationally then this phase can be distinctly observed, if examined from a national perspective then it can appear to merge with the next stage. New Zealand midwifery is a good example of this blending of the two stages. Having adapted the English Midwives Act of 1902 to suit colonial requirements, the architects of the New Zealand Midwives Act, 1904, set in place legislative changes which changed the profession of midwifery in New Zealand. England took much longer to blend these two stages and in fact made the process of developing the profession in New Zealand much easier for Neill and her colleagues.[41]

Clear stages in the progressive development of all professional groups have been identified within the literature dealing with issues of professionalism. A set of characteristics which assist in establishing the professional standing of occupations also emerges in relation to the nursing profession (See Table 1, p.

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[37] E. Morland, *Alice and the Stork: the life of Alice Gregory 1867-1944,* London, Hodder and Stroughton Ltd., 1951.

[38] A. R. Ward, *MCNN,* 1981, p. 238.

[39] J. O. C. Neill, 1961.

[40] T. W. H. Brooking, 1980. p. 21 & p. 33.

[41] A. R. Ward, *MCNN,* 1981, p. 238.

7).[42] The application of these characteristics do not support the notion of professionalism in the pre-formal phase described but are relevant to the other phases. They do assist in forming theory on characteristics of professionalism in the pre-formal phase of nursing and midwifery.

The systematic development of knowledge is formally embraced within and beyond the semi-professional phase of professionalism. Legislation related to all professions dictates the training period within which theory and practice relating to the profession are to be attained. Histories of professional groups identify this development of knowledge.[43] Establishing the development of a traditional practitioner's knowledge base is relevant to the understanding of a professional within the pre-formal phase of professionalism. This knowledge would have to be linked to the knowledge claimed by the semi-professionals who rose from the ranks of the traditional practitioner.[44]

The popular and folk history of traditional midwives internationally suggests a sequential approach to development of knowledge which is partially subscribed to by the circumstances of the practitioner.[45] Personal experience of childbirth was a socially required knowledge which traditionally precluded the single female from practice.[46] It was expected that married, sometimes widowed, females would practice midwifery. Geographical location placed some women into situations where neighbour helped neighbour in health related matters.[47] In this type of situation women applied their personal experience of childbirth to the experience of another women in similar circumstances. Such learning related to

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[42] S. Wallace, BA Thesis, University of Otago, Dunedin, 1987, p. 66.

[43] M. Belgrave, in L. Bryder, editor, 1991. T. W. H. Brooking, 1980. S. Wallace, BA Thesis, University of Otago, Dunedin, 1987.

[44] T. W. H. Brooking, 1980.

[45] Anon, *WDNZFU,* 1993.

[46] *NZPD,* 1904, pp. 70-71. B. Salmon, 1991, p. 305-307.

[47] Anon, *WDNZFU*, 1993, p. 36.

childbirth has been described by a politician in derogatory terms as something the midwife 'picked up'.[48] Despite the irregularity of this method of acquiring knowledge if assisting neighbours in childbirth became a regular practice for some women then a body of knowledge would develop. The quality and application of that learning would be individual and may well replicate the ministrations of the mythical Sairey Gamp. There was however just as much chance that a woman could become an exemplary practitioner as did women like Granny Harrold[49] and Granny Cripps.[50] Doctors frequently sought married women to assist them in their midwifery practice.[51] When this happened the doctor assisted in the development of the woman's knowledge of midwifery.

A distinct culture arising from the application of Nightingale's legacy to nursing has been described.[52] A wider view of culture would align nursing and midwifery with other health related professions. In the described view of culture the qualities Nightingale bequeathed to nursing are relevant. However during the transition from sub-professional to semi-professional nursing and midwifery[53] both embraced knowledge and skills which emerged from the realms of medicine.[54] Incorporation of medical knowledge into the skills used in nursing challenges the received view of culture. Listerism is a prime example of a scientifically based practice which emerged from the scholarship of a medical

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48 Premier Richard Seddon, *NZPD,* 1904, p. 70.

49 M. Barlow, 'Agnes Harrold', in W. H. Oliver, (ed), *A People's History: Illustrated Biographies from The Dictionary of New Zealand Biography, Volume One, 1796-1869,* Wellington, Bridget Williams Books Limited/Department of Internal Affairs, 1992, pp. 101-102.

50 F. A. B. Bett, *Micro MS Papers 1836-1957,* Reel 2, Series 1, Folders 5 - 27, 29, WTU,

51 F. M. Forster, 'Mrs. Howlett and Dr. Jenkins: Listerism and Early Midwifery Practice in Australia', *The Medical Journal of Australia,* II:26, December 25, 1965, pp. 1047-1054.

52 J. A. Rodgers, 'Nursing Education in New Zealand, 1883 to 1930: The Persistence of the Nightingale Ethos', M A Thesis, Massey University, Palmerston North, 1985.

53 S. Wallace, BA Thesis, University of Otago, Dunedin, 1987. Within this thesis nursing and midwifery are considered as one and the same profession.

54 I. Louden, 1992.

man.[55] Application of the principles of Listerism changed the culture of a wide range of health related professions including that of nursing and midwifery. In the sub-professional phase the culture of midwifery practice embraced the characteristics Sairey Gamp and her contemporaries displayed.[56] This culture brought fear and anxiety into the experience of childbirth.[57]

Sacrifice of self in the care of others has been linked with the legacy Nightingale bequeathed to nursing through the dedication and devotion to duty she preached.[58] This interpretation of service is linked with the semi-professional phase of nursing and midwifery. Records indicate that traditional practitioners of these professions were in many instances as dedicated in their service to others.[59] In the colonial situation which prevailed in New Zealand circumstances brought forth qualities in people which were equally self sacrificing.[60] Within midwifery care this sacrifice in some instances deprived the family of a wife and mother,[61] in other situations the call to serve others was passed from one generation to the next as a service was provided.[62]

Codes of ethics were linked with censure of unsafe practices and practitioners. Also other actions classified as indictable offences would be dealt with under the

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55 I. Louden, Chapter 4, 1992. J. O. C. Neill, 1961, p. 89.

56 C. Dickens, *Martin Chuzzlewit,*, Wordsworth Editions Limited, 1995. J. O. C. Neill, 1961.

57 *NZPD,* 1904, pp. 70-91.

58 S. Wallace, BA Thesis, University of Otago, Dunedin, 1987, p. 70. J. A. Rodgers, M A Thesis, Massey University, Palmerston North, 1985.

59 M. Barlow, 'Agnes Harrold', in W. H. Oliver, (ed), 1992, pp. 101-102. F. A. B. Bett, *Micro MS Papers 1836-1957,* WTU. Anon, WDNZFU, 1939.

60 J. Donley, 1986, pp. 27-28. Anon, *WDNZFU*, 1939.

61 J. A. Salmond, 'Salmond, Sarah 1864-1956', in *The Dictionary of New Zealand Biography, Volume Two, 1870-1900,* Wellington, Bridget Williams Books/Department of Internal Affairs, 1993, p. 213.

62 K. Duder, 'Hicks, Adelaide 1845-1930, in *The Dictionary of New Zealand Biography, Volume Two, 1870-1900,* Wellington, Bridget Williams Books/Department of Internal Affairs, 1993, p. 213.

code of ethics.[63] A code of ethics within the sub-professional phase of nursing or midwifery is identifiable within anecdotal accounts which identify the concern some traditional midwives had in relation to their practice. This mainly surrounded the safe delivery of a healthy baby and survival of the mother.[64] Formalisation of a professional service began the establishment of parameters of safe and acceptable care. Such standards were embedded in the legislation governing professional practice and did not take effect until 1902 for New Zealand nursing and 1904 for midwifery.[65] These Acts called for a register of practitioners which included many traditional practitioners working at the time the Acts were passed.[66] These same Acts provided for the supervision of all practitioners and the removal from the register of those deemed to be unsafe or of unacceptable character.[67] In this way some traditional midwifery practitioners, later identified as Class B midwives, were removed from the register.[68]

Payment for services has been identified as a factor in determining professional status.[69] This is a controversial characteristic of a profession and is closely linked to autonomy within practice, an identified characteristic of semi-professional practitioners.[70] Central to the issue of payment for services is the idea that the person practising the profession charges a fee for services rendered as opposed

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63 S. Wallace, BA Thesis, University of Otago, Dunedin, 1987, p. 70.

64 Sarah Higgins, *MS Papers 1146,* WTU. M. Cooper, 'The Midwives Case 1920 to 1930, in N. Chick, J. Rodgers, editors, *Looking Back, Moving Forward: Essays in the History of New Zealand Nursing and Midwifery,* Palmerston North, Department of Nursing and Midwifery, Massey University, 1997, p. 37. J. Donley, 1986, p. 28.

65 The Nurses Registration Act, 1901 [1 EDW, VII, No. 12] *NZS,* 1901. The Midwives Act, 1904 [4 EDW, II, No. 31] *NZS,* 1904.

66 The Midwives Act, 1904 [4 EDW, II, No. 31] *NZS,* 1904. Regulations under the Midwives Act, 1904, NZS, 39, April 27, pp. 1022-1023.

67 The Midwives Act, 1904 [4 EDW, II, No. 31] *NZS,* 1904. Regulations under the Midwives Act, 1904, NZS, 39, April 27, pp. 1022-1023.

68 Health I, 21/29, Removal of registered midwives from the register, WARC.

69 M. Belgrave, p. 8, in L. Bryder, editor, 1991.

70 S. Wallace, BA Thesis, University of Otago, Dunedin, 1987, p. 66.

to drawing a salary from an employer. If the person charges a fee for their services then the services would have been provided independently by the practitioner, that is as a part of private practice. Many midwives were practising independently and collecting a fee, albeit in kind, prior to the passing of legislation to govern practice. With legislation a choice came into force. Midwives could choose to work in state run hospitals and draw regular monetary reimbursement for their services. The state run hospitals provided a subsidised care within the St Helens Hospitals with clients of moderate means expected to pay a nominal amount for the care they received.[71] This arrangement ensured that all women received professional care of a high standard from professional practitioners. These activities were no less professional than the service provided by other midwives who autonomously ran maternity homes and received reimbursement directly from clients who chose private care.[72] The independence and autonomy of midwives who were employed by the state to work throughout the country in isolation from other professional practitioners was demonstrated in the publication of accounts of their experiences.[73]

Professionalism is dated from pre-formal practice within all health related professions. The dynamic nature of professionalism is integrated with change which advances the profession but excludes or curtails the practice of some members of the group. Viewed longitudinally this change can be demonstrated to occur within a continuum with peaks of activity constituting major change, frequently linked with legislation. These peaks translate into phases within the concept of professionalism. Four phases have been identified. (See Table 3, p. 8, Introduction). To find answers to the research questions the sub-professional and early semi-professional phases within New Zealand midwifery have been examined within the next five chapters.

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[71] J. O. C. Neill 1961, 50.

[72] *AJHR,* H22, 1907, p. 3.

[73] N. Kelly, 'My First Case of Twins', *The Journal of the Nurses of New Zealand, [JNNZ].* V:IV, October, 1912, p. 118. F. McDonald, 'Backblocks Nursing - My First Experience', *JNNZ,* VII:III, July, 1914, pp. 123-124.

Chapter Two

The English Midwives Act

Maternal and infant mortality and a decline in the birth rate were primary concerns which directed the development of midwifery practice in England and gave rise to the British Midwives Act of 1902. Florence Nightingale did an in depth study of maternal mortality which led to a prescriptive model for a midwifery training school. Scientific knowledge developed prior to the 1902 Act was adopted in the training and education of midwives directed by this Act. This included the stringent use of antiseptics. These events were the blueprint from which New Zealand midwifery developed after 1904 when a Midwives Act was implemented. These early Midwifery Acts represent one of the first formal moves in the standardisation and progressive development of the midwifery profession. Although midwifery training was available in England prior to the 1902 Act a large proportion of the practitioners were untrained and ignorant of the new scientific findings which were revolutionising health care.[1] This chapter examines the new order of maternity practices in England post 1860.

While in recent years historians have questioned the influence Florence Nightingale had on nursing, her influence on the training and education of midwives cannot be questioned. In 1861 Nightingale arranged with Kings College Hospital to open a maternity ward which, within a period of 5 years, was closed following alarming numbers of maternal deaths.[2] Over the next five

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1 A. R. Ward, *MCNN*, 1981, pp. 190-194 & 237-242.

2 F. Nightingale, 1871, p. 3.

years Nightingale studied maternal mortality statistics supplied by various individuals within England and overseas.[3] She corresponded with various individuals on the topic, including, according to one biographer, Sir James Young Simpson in Edinburgh.[4] This investigation led to the publication of a book, *Notes on Lying-in Institutions,* in which Nightingale detailed her investigation and the conclusions to which she came.[5] Although this book was less than informative on the care of women in childbirth it did state the importance of keeping the maternity wards apart from general wards, preferably in separate buildings. More important, Nightingale concluded that the home was at that time the safest place for women to give birth.[6]

Nightingale's interest in midwifery was to provide a training school for women who intended to practise independently as midwives.[7] These midwives would be educated women and would be known as 'lady midwives'. Although this venture foundered the knowledge gained from the inquiry which followed found expression in recommendations for the establishment and running of midwifery schools.[8]

Nightingale's venture into the education of midwives was part of the challenge to traditional midwifery being waged during the nineteenth century. Traditional midwives had no formal education as practitioners having learnt the art and craft

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3 C. Woodham-Smith, *Florence Nightingale 1820-1910,* London, Constable and Company Ltd., 1950, p. 474. Nightingale took three years to develop her conclusions. The work was conducted alongside other issues Nightingale was involved in and the book on lying-in institutions was collated by her friend Dr. Sutherland.

4 ibid. p. 474.

5 F. Nightingale, 1871.

6 ibid. pp. 3.

7 F. B. Smith, *Florence Nightingale, Reputation and Power,* London, Croom Helm, 1982, p. 160.

8 F. Nightingale, 1871, pp. 69-70.

of their profession[9] through apprenticeship with established midwives in their community.[10] A strong move was underway from various groups to educate midwives.[11] Several lying-in hospitals offered training and education in midwifery.[12] Recognition of women's midwifery knowledge was made by the London Obstetrical Society (LOS) in 1872 when they offered certificates to women who were able to successfully pass a midwifery examination.[13] Establishing a socially recognised body of knowledge for midwives through education, training, and examination, was a step in the process of redefining the professional status of midwifery.[14] This move from traditional to educated midwife assisted in making midwifery a respected profession for women. Certificates awarded to successful examinees set them apart from the uneducated women personified by Sairey Gamp.[15] Traditional midwives were predominantly married women, the new practitioners were often young, single women from respected families.[16]

A move to implement legislative changes controlling midwives' practices had been made by the LOS in 1870.[17] The Bill they brought before parliament sought to exclude from practice midwives without any formal training. An inquiry they had conducted showed that very few midwives had any formal preparation and many were both ignorant and incompetent. This Bill was not successful but was

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[9] R. Marshall, NM, 1983, pp. i-vii. In her article Marshall states 'professional' to be applicable to any person who regularly participates in an occupation for which they are paid and by which society recognizes them.

[10] J. Raisler, JN-M, 1994, pp. 326-328.

[11] A. R. Ward, *MCNN*, 1981, pp. 190-194. & pp. 237-242. F. B. Smith, 1982, p. 162. J. Towler, J. Bramall, 1986

[12] J. Towler, J. Bramall, 1986, p. 159.

[13] A. R. Ward, *MCNN*, 1981, pp. 237.

[14] S. Wallace, B A (Hons) Thesis, University of Otago, 1987, p. 66.

[15] A. R. Ward, *MCNN*, 1981, p. 192. C. Dickens, Wordsworth Editions Limited, 1995.

[16] E. Morland, 1951. A. R. Ward, *MCNN*, 1981, pp. 192.

[17] J. Towler, J. Bramall, 1986, p. 160-161. A. R. Ward, *MCNN*, 1981, pp. 237.

the first of a number of similar Bills introduced over the next thirty years with the aim of regulating midwifery practice. [18]

In 1881 educated, certificated midwives, began to form a society, the Trained Midwives' Registration Society, later known as the Midwives' Institute.[19] This group worked to improve the public image of midwives through publication of a register of educated, certificated, midwives. A sister organisation was formed five years later with the aim of gaining compulsory registration of all midwives through parliamentary statute. Early Bills were defeated through lack of support and opposition from the General Medical Council.

In 1892 a government committee report revealed that many traditional midwives lacked proper training. Further there was a distinct lack of the use of antiseptics within their practice[20] and a high incidence of maternal deaths from post natal septicaemia as a result.[21] Other leading causes of maternal and infant mortality included miscarriages, ante natal toxaemia, and problems in labour.[22] These deaths were linked with the poor care given by uneducated midwives. Nevertheless it was not until 1902 that The English Midwives Act was passed. This Act was intended to prepare midwives to recognise the identified problems and minimise or prevent the effect they had on women's health in childbirth.

The Act was 'to secure the better training of Midwives and to regulate their practice' and was to take full effect on the first day of April, 1910.[23] Such a delay gave midwives in practice the opportunity to become aquainted with the

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[18] A. R. Ward, *MCNN*, 1981, p. 238.

[19] ibid. p. 237.

[20] ibid. p. 238.

[21] R. Perks, Life as a Textile Worker and a Midwife (M.B.E.), *BHRU Unrestricted, A0067*, Bradford City Library [BCL]. 1984.

[22] ibid.

[23] The Midwives Act, 1902 [2 EDW VII, CAP 17] *BPS 1902.*

Act and to provide the necessary documents required to demonstrate they were entitled to appear on the roll of midwives which was published each year. Midwives notified their local council or borough council at the beginning of each year of their intent to practice. These bodies were responsible for supplying a list of midwives practising in their area to the Central Midwives Board. The roll of midwives was compiled from these lists. The local bodies were to make the roll available for the public to inspect.

Supervision of midwives was also carried out by these local bodies. Rules were established for the guidance of supervision.[24] These included investigation of charges of malpractice, suspension from practice of midwives likely to spread infection, reporting of midwives convicted of offences and on the death of practising midwives in the area. Provision was made for midwives to appeal any suspension or disciplinary action taken.

Supervision of midwives at the local level proved difficult where midwives lived in outlying districts and were out at a case or other business associated with a birth. A report presented by an inspector in the City of Bradford, Yorkshire demonstrates some of the frustration felt in the face of these difficulties.[25] This report deals with issues which have been associated with setting the standards for the character and behaviour of untrained midwives. The report related to the inspection of 93 midwives comprising both certified and uncertified but practising midwives. Out of this group only 4 were fully trained and 6 described as satisfactory. Many of the midwives were described as being 'of the clean and old fashioned type, but very ignorant.'[26]

Ignorance was identified as the inability to write and a lack of knowledge of disinfectants. Identified practices related to the storage of equipment and the

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[24] ibid, Clauses 6 and 8.

[25] Report of 30.12.1905, *Report of the Work of Female Sanitary Inspectors 1902-11,* Wm. Byles & Sons Limited, Printers, Piccadilly/Tapp & Toothill Ltd., Printers, Charles Street, Bradford.

[26] ibid.

keep and cleanliness of the midwife's home. Several midwives were stated to keep their scissors in tangled and untidy drawers. The report indicated that most of the cases of puerperal fever occurring during the period covered by the report were related to the carelessness of the midwives and it suggested the need for a lady to be appointed full time to administer the Midwives Act of 1902.[27] Later reports indicate that this suggestion was acted upon.[28] Despite this appointment the high number of untrained midwives in practice, and their lack of knowledge, made the inspectors' work difficult. This was compounded by a poor level of literacy and record keeping.

Carelessness in practice included a lack of handwashing and cleansing and sterilisation of instruments, particularly syringes which were used for both enemata and vaginal and uterine douching. Inspection of this instrument in some cases demonstrated contamination with both blood and faeces.[29] When puerperal fever occurred this went undetected as the signs were not observed and acted upon. Changing these practices called for a strategy which encouraged the midwives to want to change. With the backing of the Mayoress of Bradford a series of lectures followed by a tea and prize giving for those who attended was arranged.[30] The reduction in the death rate from puerperal septic diseases could be attributed in part to this type of instruction since the number of trained midwives in practice did not increase. The death rate which in 1893 had been

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[27] ibid.

[28] ibid. Reports between 1902 and 30. 9. 1904 were signed by C. F. Stephens who bore the title of Associate R. Sanitary Inspector. Reports from 30. 12. 1904 were signed by Eva H. Jones. Her title was Associate R. Sanitary Inspector until 31.3.1908 when she became Chief Woman Inspector. The report of 30.12.1906 indicated Jones had completed a course of study which led to the Diplomée Nat. Health Soc.

[29] ibid. Report of 30. 9. 1906. King, Frederick Truby (Sir) 1858-1938, *MS 1120*, Lectures on Midwifery and Gynecology, 1885, WTU. These lectures identify unwashed hands and dirty instruments as a direct cause of puerperal sepsis. The use of handwashing and vaginal and uterine douching were considered prophylactic measures in the prevention of puerperal sepsis.

[30] *Report of the Work of Female Sanitary Inspectors 1902-11*, Wm. Byles & Sons Limited, Printers, Piccadilly./ Tapp & Toothill Ltd., Printers, Charles Street, Bradford.

202 per million living females was reduced in 1907 to 81 per million females living.[31]

The incorporation of antiseptics into midwifery practice and the enforcement of strict hand washing and sterilisation of instruments used in the provision of midwifery care was only possible due to the work of medical men in different locations who were investigating puerperal sepsis. They formed a chain of scientific findings which led to the changes in midwifery practice with the aim of eliminating puerperal sepsis.[32] Ignaz Philipp Semmelweiss (1818-1865) is the person popularly associated with puerperal fever. Alexander Gordon (1752-99) and Oliver Wendell Holmes (1809-94) were also looking for the cause of the condition. Gordon's carefully documented observations indicated that the incidence of puerperal fever was confined to the practice of a small group of midwives. Gordon accurately predicted that patients attended by these midwives would develop puerperal fever.[33]

Gordon also identified the spread of the fever in his own practice. He practised bleeding and purging and believed early intervention in this manner to be imperative to the recovery of his patients.[34] Holmes's work on puerperal fever resulted in a paper on the topic which was based on research of written accounts of the disease rather than his own clinical experiences.[35]

Semmelweiss is credited with making links between the practices which took place in the Vienna Maternity Hospital and puerperal sepsis. Having attended the post-mortem of a colleague who died of septicaemia he was 'impressed by the

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[31] ibid.

[32] I. Loudon, 1992, Chapter 4. pp. 49-84.

[33] ibid.

[34] ibid. pp. 59.

[35] ibid. pp. 49-84.

similarity of certain pathological lesions to those seen routinely in women dying from puerperal fever'.[36] Semmelweiss recorded his reflections from this experience including the idea that 'cadaverous particles' could adhere to the knife used in the post-mortem.[37] When used for other purposes these cadaverous particles could transfer to the surfaces of the person or article, causing infection to spread. Developing from this experience was the idea that the 'cadaverous particle' should be washed from the hands before attending a labouring or lying-in woman. Similarly the link between the attendants' clothes and the spread of the infection was identified.[38]

Between 1865 and 1879 the isolation of bacteria causing puerperal fever occurred. Several individuals contributed to the evidence that a causative organism was responsible for the condition. Louis Pasteur (1822-1895) made the final discovery that the vaginal discharge of all women sick with the disease would grow bacteria.[39] Joseph Lister (1827-1912) is credited with a method of preventing surgical sepsis. Lister applied carbolic acid dressings to the wounds of his patients as a barrier to bacteria. Soon after he used a carbolic spray to prepare the theatre where he performed his surgery. These measures were the forerunners of the aseptic technique which was adopted. The process became known as Listerism.[40]

Simpson first identified the similarities between surgical sepsis and puerperal sepsis.[41] He believed that following childbirth the lining of the woman's uterus needed to heal, particularly the placental area. The cervix, vagina and perineum

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[36] ibid. pp. 49-84.

[37] ibid.

[38] ibid. pp. 65-66.

[39] ibid. pp. 78.

[40] J. M. Hawkins; S. Le Roux; Editors, *The Oxford Reference Dictionary*, London, Guild Publishing, 1987, p. 483. H. Morten, *The Nurse's Dictionary of Medical Terms and Nursing Treatment,* London, The Scientific Press Limited, 1900, p. 82.

[41] King, MS 1120, 1885, WTU, 695-709. I. Loudon, 1992, pp. 203-204.

could also have been injured during the birth. Simpson considered these wounds as reciprocal to the wounds of a surgical patient and believed them to be a point of entry for bacteria in the post partum woman.[42] Healing of these areas took place over the next few weeks, particularly within the first two weeks. Treatment, he said, began with prophylaxis and included washing hands and instruments in antiseptic solution, and wearing clean clothes when attending women in childbirth.[43] The application of Listerism to childbirth was an appropriate step towards controlling puerperal sepsis.[44]

The moves to develop the professional status of midwifery in England had implications for midwifery in New Zealand. The English Midwives Act of 1902 was a model for the New Zealand Midwives Act of 1904.[45] Incorporated into the New Zealand Act was the Nightingale model of a midwifery training school.[46] The certificates awarded by the LOS and the Central Midwives Board (CMB) were two of the several recognised in New Zealand. The holders of these certificates were registered in New Zealand as Class A midwives. (Years later the CMB were to state that granting of such certificates was not a guarantee of creditable practice).[47] The midwifery curriculum incorporated Listerism into the practice of midwifery with pupil nurses required to demonstrate their ability to apply the use of antiseptics in their practice.

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[42] I. Loudon, 1992, Chapter 4, 49-84.

[43] King, MS 1120, 1885, WTU, 695-709.

[44] H. Morten, 1900, p. 82.

[45] The Midwives Act, 1902 [2 EDW VII, CAP 17] *Bristish Practical Statutes 1902*, [BPS] Premier Richard Seddon - *New Zealand Parliamentary Debates,* [NZPD], 28th June - 28th July, 1904, 128.

[46] The Midwives Act, 1904 [4 EDW. II, No. 31] *NZS,* 1904. F. Nightingale, 1871. Midwifery Training, *JNNZ,* VII:III, October, 1914, p. 174.

[47] Health I, 79/5, Marlborough Hospital Board - Maternity Hospital Blenheim, WARC, Memo dated 17.10.1916 identifies a Class A midwife with CMB certificate who did not practice at the standard expected of a well qualified midwife. C. J. Maggs, 1983, p. 145.

The New Zealand Midwives Act of 1904 legally changed the practice of midwifery by incorporating Nightingale's midwifery training scheme into a State system of lying in hospitals. The training programme improved the experience of childbirth for women throughout the colony. Untrained women who were in practice at the time the Act was passed were enabled to continue in practice if they met the requirements as stated in the Act. The untrained women who registered and practised in New Zealand post 1904 provided as much of a challenge to the New Zealand midwife inspectors as did their counterparts in England. The following chapters examine these changes and challenges in the history of New Zealand European midwifery.

Chapter Three

New Zealand European Midwifery Practice Pre 1904

European colonisation of New Zealand began in 1840. Sixty years later the settlers had established a Hospital and Charitable Aid system which embraced a series of hospitals in main areas of settlement. The hospitals administered charitable aid to the needy, the elderly and sick were cared for, and in some hospitals provision was made for lying-in cases.[1] The hospitals in the main centres independently established a training programme for nurses and awarded a certificate to all successful students.[2] Many of the immigrants were young females of childbearing age yet no state provision was made for either the preparation of midwives or the care of women in childbirth.[3] By 1904 an unstructured midwifery service had developed. Women received care from the most appropriate person in their area. This could be a medical man, a midwife, traditional or trained, or the woman next door. These various practitioners played a part in the delivery of midwifery care in pre 1904 New Zealand society.[4]

The nineteenth century was a time of professional transition in New Zealand nursing and midwifery. In traditional practice the art and science of nursing and midwifery was demonstrated through the application of homeopathic, aromatic, and herbal remedies and in the use of clean running water, fresh air, and

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1 *AJHR*, H-23, 1882, pp. 1-7.

2 D. Macdonald Wilson, *A Hundred Years of Healing, Wellington Hospital 1847-1947,* Wellington, A. H. & A. W. Reed, 1948. p. 78. P. C. Fenwick, *The Christchurch Hospital: Historical and Descriptive Sketch,* Christchurch, Andrews, Baty & Co. Ltd., 1926, p. 20.

3 C. Macdonald, *A Woman of Good Character: Single Women as Immigrant Settlers in Nineteenth Century New Zealand,* Wellington, Bridget Williams Books, Historical Branch, 1990.

4 A. R. Ward, *MCNN,* 1981, p. 191. Ward states that the term midwife was used freely to refer to any person who was available and attended a delivery.

sunshine.[5] Rest and nutritional beverages were also used.[6] The person who traditionally practised nursing or midwifery and was recognized in their community was a professional within the context of that society's understanding of professional.[7]

A changing paradigm in the understanding of the spread and containment of infectious conditions challenged the management of surgical and midwifery cases. By 1885 the use of antiseptics to cleanse both the skin of patient and practitioner and to sterilise instruments was incorporated into an expanding body of theoretical knowledge. When applied to the clinical situation this reduced the incidence of mortality and morbidity.[8] Translation of this new scientific knowledge into practice was demonstrated through the art of nursing and midwifery. Training and education was needed to understand and apply the new knowledge. Certification was the formal verification of that knowledge. These elements were embraced within a new definition of a professional person, as nursing and midwifery moved towards the preparation of women for their role of nurse or midwife.[9]

The hospitals established in New Zealand from 1846 onwards provided very simple care for those in the population who did not have a home and family to care for them.[10] The development of anaesthesia enabled simple surgery, particularly amputation of limbs, a procedure that could be carried out in a

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5 M. Hughes, *Women Healers in Medieval Life and Literature,* New York, King's Crown Press, 1943, p. 110. R. W. Johnson, *Friendly Caution to the heads of families and others,* Philadelphia, 1804, p. 56., E. B. Hanbury, *The Good Nurse: Hints on the management of the sick and lying in chamber and the nursery,* London, And. W. Phillips, 1825, Chapter XX.

6 B. Harper, *Petticoat Pioneers, South Island Women of the Colonial Era,* Book Three, Wellington, A. H. & A. W. Reed Ltd., 1980. H. Morten, 1900, p. 114.

7 R. Marshall, *NM,* 1983, pp. i-vii.

8 King, *MS 1120,* 1885, WTU. I. Louden, 1992.

9 S. Wallace, BA Thesis, University of Otago, Dunedin, 1987, p. 66.

10 R. E. Wright-St Clair, *Caring for People: Wanganui Hospital Board 1885-1985,* Wanganui, Wanganui Newspapers Ltd., 1987, p. 9.

person's home. The introduction of antiseptics into practice made procedures safer by reducing the incidence of infection. These two innovations increased the possibilities for surgery and created an increased need for hospital care. The need to upgrade hospital conditions was perceived by society. Expansion and upgrading of existing buildings occurred.[11] Despite these changes provision was not made for lying-in care. The majority of beds provided care for general patients with most being allocated to male patients.[12]

Two hospitals are identified in the 'Hospital Returns For 1881' as providing for General and Lying-in patients. These are Dunedin and Dunstan hospitals, both situated in the province of Otago.[13] A special report on hospitals in 1883 describes the accommodation set aside for the care of lying-in women.[14] In Dunedin Hospital the lying-in department was accommodated in a wooden annexe on the north side of the main hospital.[15] The midwifery service was provided independently from the rest of the hospital the building having been divided into two wards, a small kitchen and a private room for the midwife.[16] These arrangements were superior to those in Dunstan Hospital where the female ward is described as being in a wing of the main building.[17] Staffing did not include a midwife but instead a husband and wife acted as house stewards. Despite the poor quality of the building a high level of cleanliness and order was indicated in the inspectors report showing that the stewards understood the importance of good hygiene. The arrangements in the Dunedin Hospital replicated the recommendations Nightingale and Simpson believed should be

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[11] D. Macdonald Wilson, 1948. p. 25.

[12] *AJHR*, H-23, 1882, pp. 2-7.

[13] ibid. pp. 1-7.

[14] *AJHR*, H-3A, 1883, pp. 1-28.

[15] ibid. pp. 7-8.

[16] ibid. p. 7.

[17] ibid. p. 8.

implemented for all midwifery cases.[18] Their understanding was that this would reduce the incidence of maternal mortality caused through the spread of puerperal sepsis.

One way of preventing the spread of puerperal sepsis was to isolate women who developed the infection. Women nursed in their own home could be isolated during the course of their infection. This could not be achieved as easily in hospital unless provision was made for an isolation ward. Neither Dunedin nor Dunstan Hospitals appear to have had this provision. Dunedin Hospital had three lying-in beds accommodated in two wards. Dunstan Hospital had four beds in the 'female sleeping-ward'. The number of lying-in beds is not stated which could mean that both lying-in women and females receiving general hospital care were nursed together. One hospital which did provide for isolation of lying-in women was Wellington Hospital. This did not happen until 1890 when a puerperal fever ward with four beds was added to the existing isolation hospital.[19] The frequency with which this was used is uncertain. The possibility is that the use was infrequent.[20] In the event that the woman did not recover from the fever she became part of the statistical returns for the colony. Until 1908 puerperal fever is listed under the category labelled 'Septic Order of Zymotic Diseases'[21] which makes it difficult to provide a finite figure of deaths due to puerperal fever.[22] There was no requirement to provide the authorities with information on each case of puerperal fever that occurred.

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[18] F. Nightingale, 1871, p. 33. C. Woodham-Smith, 1950, p. 474.

[19] D. Macdonald Wilson, 1948. P. 27-28.

[20] ibid. p. 28.

[21] W. T. McLeod, Managing Editor, *Collins Dictionary and Thesaurus in One Volume,* England, HarperCollins Publishers, 1994, p. 1173. Zymotic refers to diseases caused by infection.

[22] *Statistics for the Colony of New Zealand,* (SCNZ), 1904, Wellington, Government Printer, p. 41. *NZOYB,* 1920, p. 43.

Death in maternity was no stranger to the immigrants. Letters and journals indicate the uncertainty of childbirth. The safe arrival of many of the early pioneer children was placed in the hands of people like Granny Cripps, a traditional midwife practising in the Wairarapa.[23] Granny Cripps, like many other women, rendered assistance in an area where the nearest doctor was many miles away or if the local doctor was unavailable.[24] Women placed their lives and that of their unborn baby equally in the hands of whoever was available, and in God, the Lord who sustained them in all things.[25] Mary Cuddie who acted as a midwife in Dunedin is believed to have based her practice on personal experience linked with respect for the natural process of labour and birth and a faith in God.[26] This faith did not prevent tragedy from happening. Babies were stillborn[27] or died soon after birth,[28] women died in or soon after childbirth.[29]

These deaths were blamed on the ignorance of the traditional midwives who attended the births.[30] Lacking in knowledge related to the management of safe labour and birth they contributed to the uncertainty associated with childbirth for

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[23] Francis A. B. Bett, , *Micro MS Papers 1836-1957,* Reel 2, Series 1, Folders 5 - 27, 29, WTU, The account of Granny Cripps life was written for presentation on a 'Womens' Hour' program with information provided by her Grandson who was known to Dr. Bett.

[24] F. Porter, C. Macdonald, *"My Hand Will Write What My Heart Dictates: The unsettled lives of women in nineteenth-century New Zealand, to sister, family and friends,"* Auckland, Auckland University Press/Bridget Williams Books, 1996, pp. 341-342.

[25] F. Porter and C. Macdonald, 1996, p. 346. Letter from Mary Preece to Charlotte Brown, Tauranga, 1842.

[26] Dr. F. O. Bennett, 'Mary Cuddie', in G. J. Griffiths, (ed.), *The Advanced Guard Series II,* Dunedin, Otago Daily Times, 1974, p. 168. Dr. Bennett states that Mary Cuddie's obstetrical knowledge 'was probably based on personal experience ... respect for a natural process and on faith in the Lord.'

[27] F. Porter and C. Macdonald, 1996, p. 346, Letter from Mary Preece to Charlotte Brown, Tauranga, 1842. 348, Letter from Mary Marshall to her Grandfather, 1850.

[28] ibid. p. 356. Letter from Helen Hursthouse to her sister, Lely Richmond, 1861.

[29] ibid. p. 351-2, Letter from Douglas (Susan) McLean to her husband, New Plymouth, 1852.

[30] Premier Richard Seddon, member for Westland, *NZPD, 1*904, 28th June-28th July, 1904, p. 70-71.

both mother and baby.[31] Lack of knowledge of the control of infection through the use of antiseptics was a major part of this uninformed practice. Although some traditional midwives had this knowledge[32] many others did not.[33] Furthermore they were unable to understand and apply the concept of sterilisation or aseptic technique within their practice or to detect the presence of fever in their patients through the use of a clinical thermometer.[34]

From the time New Zealand has kept statistics childbearing age has been placed between the years 15 to 45.[35] (See Table 6). This interpretation is based on the age parameters of married women in the colony[36] and does not acknowledge that girls under 15 years could have babies nor that women over 45 years continued to expand their families. It does indicate a strong moral code relating to marriage and legitimacy and supports the notion that the majority of women gave birth between the ages of 15 and 45. Death could happen at any point within this continuum and at any stage in pregnancy. This is indicated in the official records of statistics, a record which also identifies cause of death.

Abortion or miscarriage, puerperal convulsions and placenta previa all contributed to maternal mortality.[37] The category however which claimed the

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[31] J. O. C. Neill, 1961, p. 89. M. Tennant, 'Mrs Grace Neill in the Department of Asylums, Hospitals and Charitable Institutions', *The New Zealand Journal of History,* 12:2, October 1978, pp. 3-16.

[32] C. I. Baldwin, 'Jacobson, Inger Katherine 1867 to 1939', in *The Dictionary of New Zealand Biography, Volume Three, 1901-1920,* Auckland University Press/Department of International Affairs, 1996, p. 246-247.

[33] Health I, 21/29, Removal of registered midwives from the register, WARC, Memo dated 16.8.24.

[34] ibid.

[35] Registrar General's Report, *Statistics of New Zealand 1886,* Wellington, Government Printer, 19th October, 1887, p. xiv.

[36] ibid p. xiv.

[37] *Statistical Tables in Anticipation of the Annual Volume of Statistics of New Zealand, 1887,* Wellington, Government Printer, 1887.

largest number of mothers was labelled 'other accidents of childbirth'.[38] (See Table 7). The death of a woman from puerperal convulsions left a new born baby without a mother to nurture it. When bleeding occurred from placenta previa during labour heroic attempts to effect a vaginal delivery sometimes saved the life of mother and/or child.[39] The statistics give no indication of the time of death making it difficult to link placenta previa with the loss of both mother and foetus, lack of the word puerperal attached to the term indicates the deaths occurred in the ante natal period.

Table 6: Maternal mortality in relation to age.

Year → Age ↓	1873	1879	1900
15 and ↓ 20	0	4	0
20 and ↓ 25	6	8	2
25 and ↓ 30	9	13	0
30 and ↓ 35	13	10	2
35 and ↓ 40	11	13	0
40 and ↓ 45	3	7	1
45 and ↓ 50	1	1	1

Source: Statistics for the Colony of New Zealand, 1873, Wellington, Government Printer. Statistic for the Colony of New Zealand, 1879, Wellington, Government Printer. Statistic for the Colony of New Zealand, 1900, Wellington. Government Printer.

During the first year of life children were at their most vulnerable, particularly in the first month. The number of such deaths gradually increased by one fifth

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[38] *SCNZ*, 1886,

[39] *ABBR 60902/1*, Home Delivery Casebook 1907-1913. WARC. Cases 422, 423 - Ante Partum Haemorrhage occurred in this case with the infant stillborn. Bleeding is not specifically linked to placenta previa. 363 - This woman bled due to placenta previa. The doctor 'plugged and performed podalic version and delivered the baby as a breech.' Despite sustaining a fractured clavical during the delivery the baby thrived and was entirely breast fed.

Table 7: Maternal Mortality 1894-1903.

Year → Cause of Death ↓	1894	1895	1896	1897	1898	1899	1900	1901	1902	1903
Abortion/Miscarriage	15	6	13	14	17	20	8	10	16	25
Puerperal Mania	1	3	0	0	2	1	1	1	0	0
Puerperal Metritis	1	0	0	0	0	1	0	1	0	1
Puerperal Albuminuria Eclampsia	7	14	14	10	13	9	8	6	11	8
Placenta Previa [flooding]	13	18	20	11	10	4	14	12	18	11
Phlegmesia Dolens	1	2	0	3	4	0	2	1	0	1
Other accidents of childbirth	35	26	30	26	26	36	18	39	40	54
Puerperal Septicaemia, Puerperal fever, Pyaemia, Septicaemia *	38	32	10	18	19	15	24	20	25	28
Total Maternal Deaths	73+38 = 111	69+32 = 101	77+10 = 87	64+18 = 82	72+19 = 91	71+15 = 86	51+24 = 75	80+20 = 90	85+25 = 110	100+28=128
% Of Total Births	0.59%	0.54%	0.46%	0.43%	0.48%	0.45%	0.38%	0.43%	0.53%	0.58%
Total Births	18528	18546	18,612	18,737	18,955	18,835	19,546	20,491	20,655	21,829

Source: Statistics of the Colony of New Zealand for the years 1894 - 1903, Wellington, Government Printer. Key: * - These conditions appear in the section labelled Septic Order of Zymotic Diseases.

between 1899 and 1903 with prematurity at a consistent high level.[40] The statistics relating to these deaths caused concern to Richard Seddon and were used by him in 1904 when he wrote his Memorandum on Child Life Preservation in New Zealand.[41] This work preceded the introduction of the Midwives Bill into parliament and formed the catalyst for his introduction of the Bill.[42] Seddon stated that the loss of infant life would have appeared much higher if stillbirths and maternal deaths in pregnancy and maternal/foetal deaths in labour had been taken into consideration.[43] Stillbirth occurred after the twenty-eighth week of pregnancy the foetus not having 'made a complete breath'.[44] Registration of stillbirths was not required until 1913.[45]

The lack of provision for maternity care forced communities and individuals to make their own arrangements. From 1840 to 1904 the provision of midwifery care varied from one community to another. Celebratory anecdotes indicate that immigrants who arrived in the early days of colonisation had to make arrangements for themselves. Accommodation was primitive, often a partially finished building constructed by the settlers themselves.[46] Immigrant ships travelling to New Zealand often had a ship's surgeon or a midwife who intended settling in New Zealand upon arrival here. These individuals provided midwifery care in the area they settled in.[47]

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[40] *NZOYB, 1905,* Wellington, p. 252.

[41] Seddon, *MS 1619*, WTU, Richard Seddon's Memorandum on Child Life Preservation in New Zealand, May 7, 1904.

[42] Premier Richard Seddon, *NZPD*, 1904.

[43] ibid. Seddon's comments illustrate one of the inconsistencies found in the official statistical data and which challenges the historical interpretation of maternal and infant mortality issues.

[44] H. Morten, 1900, p. 128.

[45] F. S. Maclean, 1964, p. 184.

[46] Anon, *WDNZFU*, 1939, p. 85.

[47] J. S. Gundry, *Dr. Gundry's Diary, Part II: Commencing Practice in Christchurch June-October 1851,* Christchurch, The Naggs Head Press, 1982. Anon, *WDNZFU,* 1939, p. 85.

One such woman was Granny Harrold, (1830/31?-1903) of Stewart Island. This lady was recognised in her community for her skill as both a nurse and a midwife. She used 'squaw tea', a brew of raspberry leaves and tansy, which she gave to women in labour and to young girls with period pains.[48] Within her practice Granny Harrold was demonstrating the art and craft of the old order of professional midwives.[49] She also used other ideas within her practice which a hundred years later are applied under the umbrella of active birthing.[50] This included keeping the woman up and mobile during the process of first stage labour and kneeling on the floor for the delivery of the baby. Recognising the need to keep the baby warm after birth she wrapped it in clean linen and a garment she had worn during the birth and which was warmed by her own body. Her final care of the mother was to give a cleansing sponge and nourishment in the form of a bowl of gruel.

The care Granny Harrold provided was not unique. Another woman who lived and worked in Ashhurst also used herbs.[51] This woman referred to *Culpepper's Complete Herbal*[52] for the remedies she used in her midwifery practice. Herbal cures were also part of the care Florence Bennett (1882-1962) used in her care

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[48] M. Barlow, 'Agnes Harrold', in W. H. Oliver, (ed.), *A Peoples History: Illustrated Biographies from The Dictionary of New Zealand Biography, Volume One, 1796-1869,* Wellington, Bridget Williams Books Limited/Department of Internal Affairs, 1992, pp. 101-102. The exact year of Agnes's birth is uncertain. It was either 1830 or 1831.

[49] R. Marshall, *NM,* 1983, pp. i-vi.

[50] M. Barlow, 1992, pp. 101-102. J. Balaskas, *New Active Birth : A Concise Guide to Natural Childbirth,* London, Thorsons, 1991.

[51] J. A. Rodgers, M. A. Thesis, Massey University, Palmerston North, 1985, p. 4.

[52] N. Culpepper, *Culpepper's Complete Herbal,* Hertfordshire, Wordsworth Editions Ltd., 1995. This edition is a modern publication of the original book by Culpepper which gives the reader an indication of the type of remedies used by this woman and others who used Culpepper's herbal medicines.

of the people in the Te Arakura district, care which included midwifery practice.[53]

Herbal remedies were not the only form of relief available to women. The use of anaesthesia in childbirth, although not common, had been the subject of experimentation in Edinburgh.[54] Chloroform was introduced by Simpson to assist in cases of contracted pelvis.[55] This experimentation was part of the changing paradigm which slowly encroached upon traditional practices. A new immigrant to New Zealand, Elizabeth Cauldwell, is reported to have used chloroform when giving birth to her fifth child in November 1850. Newly arrived from Edinburgh she had brought a supply with her for use during the birth of the baby.[56] Although chloroform became fashionable with women who could afford it[57] there is no indication it was widely used in childbirth in New Zealand until after 1904 by which date records are available to substantiate both the use and abuse of the anaesthetic agent.[58]

Not only were untrained women practising professionally as midwives, in some areas they organized themselves into groups each taking responsibility for a part of their community. This was the case in the North East Valley of Dunedin

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[53] E. Carthew, B. Williams, 'Florence Bennett', in C. Macdonald, M. Penfold, B. Williams, *The Book of New Zealand Women: Ko Kui Ma Te Kaupapa,* Wellington, Bridget Williams Books, pp. 81-83.

[54] A. E. L. Bennett, *MS 1346-211,* WTU. J. O. C. Neill, 1961. In a letter dated 1909 from Grace Neill to Agnes Bennett, Neill tells Agnes Bennett that she was 'one of Sir J. Y. Simpson's first experiments in maternal chloroforming.' Neill was born on 26 May 1846 to James Archibald Campbell and Maria Grace Cameron.

[55] M. Poovey, *Uneven Developments: The Ideological Work of Gender in Mid-Victorian England,* London, Virago Press Limited, 1989, p. 24-50.

[56] E. Washbourne, *Courage and Camp Ovens: Five Generations at Golden Bay,* Wellington, A. H. & A. W. Reed, 1970, p. 65.

[57] F. Porter, C. Macdonald, with T. Macdonald, 1996, p. 339.

[58] *ABBR 60902/1,* Home Delivery Casebook 1907-1913. WARC. Health 1, Midwives Registration - Hester McLean, WARC. Memo from Miss Bagley to the District Health Officer for Auckland dated 26 August 1916 which deals with reports of untrained midwives, some registered but untrained, administering chloroform to labouring women.

where Mary Cuddie (1821-1889) was the midwife on one side of Saddle Hill and Mrs. Allan worked on the other side.[59] This form of organization extended to recognition of seniority amongst the midwives themselves. Alice Helena Thomas (1859-1917) is identified as a chief midwife and medical adviser.[60] Whilst the organization within midwifery practice ensured a service to the communities this service required the midwives to be available for long periods of time. This commitment to others took a toll on family life as the midwives could be so busy that they had no time to look after their own families. Sarah Salmond (1864-1956), the daughter of a midwife practising in Queenstown, was taken out of school at the age of eleven to look after the family when her mother was working.[61]

The continuation of such organized midwifery care was ensured in many communities through the socialization of generations of daughters into the practice their mother had begun. Adelaide Hicks (1845-1930) who established a practice in Mosgiel was helped in this work by several of her daughters.[62] This practice continued into the twentieth century and is demonstrated in the early gazetted lists of midwives printed after 1904. Mrs. Clerkin and her daughter practised together in Hokitika,[63] as did Mrs. Boyce and her daughter in Wellington, and Mrs. Whiting and her daughter in Hawera[64].

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[59] F. O. Bennett, 1974, p. 168.

[60] J. Wordsworth, *Women of the North,* Auckland, William Collins Publishers Ltd, 1981.

[61] J. A. Salmond, 'Salmond, Sarah 1864-1956', in *The Dictionary of New Zealand Biography, Volume Two, 1870-1900,* Wellington, Bridget Williams Books/Department of Internal Affairs, 1993, pp. 439-440.

[62] K. Duder, 'Hicks, Adelaide 1845-1930, in *The Dictionary of New Zealand Biography, Volume Two, 1870-1900,* Wellington, Bridget Williams Books/Department of Internal Affairs, 1993, p. 213.

[63] List of Registered Midwives, List A, *The New Zealand Gazette, (NZG),* April 13, 1905, p. 937.

[64] Names of Midwives Register Under "The Midwives Registration Act, 1904", Class B, *NZG,* April 26, 1906, pp. 1126-1130.

Not all the women who practised midwifery in New Zealand at the end of the nineteenth century were untrained. Some who had graduated from New Zealand General Hospital programmes practised midwifery.[65] There was no midwifery content in these programmes and a general nurse came out with no knowledge of how to care for women in childbirth.[66] These women did however have an understanding of antiseptics and their application in a nursing situation. They also had a knowledge of general hospital duties which was useful in a midwifery situation. These programmes formed the initial progression from traditional to certificated nurse practitioner and marked the change in defining professional as it related to the practice of midwifery.

With no midwifery training in New Zealand some general trained nurses chose to seek midwifery training outside New Zealand. Alice Holford took this step in 1902 and was one of 18 New Zealand women who travelled to Australia or Tasmania for this training. Holford registered as a midwife in New Zealand in 1905.[67] Twenty four other New Zealand women sought midwifery certificates in England and other parts of the world at the same time.[68] This trend continued until New Zealand made provision to train midwives in 1904 when a change began to take place. By 1909 increasing numbers of women were gaining midwifery qualifications in New Zealand training schools as an alternative to

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[65] *NZG*, April 13, 1905, p. 937.

[66] Premier Richard Seddon, *NZPD*, 1904, p. 71.

[67] B. Salmon, 'Alice Holford', in C. Macdonald, M. Penfold and B. Williams, *The Book of New Zealand Women: Ke Kui Ma Te Kaupapa*, Wellington, Bridget Williams Books Limited 1991, p. 305-307. Register of Midwives under 'The Midwives Act, 1904', *NZG*, April 25, 1907, pp. 1343-1345.

[68] Names of Midwives Register of Midwives under "The Midwives Act, 1904", Class A, *NZG*, 1907, pp. 1343-1345.

training in Australia, Tasmania,[69] Scotland and Ireland. Although the number of New Zealand women seeking midwifery training in England dropped in 1907 and 1909 it did not alter greatly during the period 1905 to 1912. In 1907 only nine New Zealand women gained midwifery certificates in England whilst in 1909 the figure was a low as five. These figures were replicated by a similarly low number training in other overseas countries. In 1907 there was an increase of 100% in New Zealand trained midwives as compared with the numbers for 1906, the first complete year for New Zealand midwifery training schools. A similar increase in New Zealand trained midwives was demonstrated in 1910. (See Table 8).

Table 8: Country of training of New Zealand registered midwives 1905-1913.

	1905	1906	1907	1908	1909	1910	1911	1912	1913
New Zealand St. Helens Hospitals	0	10	22	13	18	41	53	44	[-]
New Zealand Other Training Schools	0	0	6	3	4	9	7	11	[5]
Australia and Tasmania	18	18	7	13	2	5	1	2	[1]
England	14	11	9	13	5	11	10	13	[9]
Scotland and Ireland	8	5	2	0	0	4	2	4	[3]
Rest of the world	2	1	0	1	0	0	1	2	[0]

Source: Midwives registered under 'The Midwives' Act, 1904', *NZG*, 1905-1913.

Holford stepped outside of the societal norm both professionally and personally when she undertook her midwifery training. As a single woman she was engaging in work which was considered improper.[70] Also the profession of midwifery was not considered favourably in nursing circles.[71] Holford however believed that

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[69] Midwives Act, 1901, [I Edward, VII, No. 24] *Tasmanian Statutes*, 1901. Health I, Midwives Registration - Hester McLean, WARC, Copy of page 27 from The Tasmanian Government Gazette, Tuesday, January 3, 1911, with a portion of the 'List of Midwives under the 1901 Midwifery Act' attached to an internal memo for attention of H. Mclean. Tasmania was the first country in the world to pass an Act controlling the practice of midwives.

[70] *NZPD*, 1904, pp. 70-91. B. Salmon, 1991, p. 305-307.

[71] B. Salmon, 1991, p. 305.

motherhood was the highest ideal for women and that midwifery was closely aligned to this ideal.[72] These beliefs made her a suitable ally to Mrs. Elizabeth Grace Neill during the campaign to obtain legislation controlling the preparation and practice of midwives.[73] Acting on her beliefs about motherhood she engaged in political activities to improve conditions for women and children in the city of Dunedin.[74]

Pregnancy outside of marriage was as unacceptable within society as were the single midwives.[75] For some single women who became pregnant marriage removed the stigma and resulted in a 'premature' birth. Abortion, although not legal, was a preferred option for others. Those who remained single and pregnant were in a difficult position with no man to provide support. Philanthropic bodies, many under the auspices of the churches, were the only acknowledged groups to provide aid.[76] The care came with expectations which reflected the attitudes of the wider society. The women were considered to have 'fallen' and were to be rehabilitated during the time they were in the refuges or homes.[77] The reports written by the Registrar General which expanded on the statistical returns reinforced this attitude by separating illegitimate births from legitimate and

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[72] P. Sargison, 'Holford, Alice Hannah, 1867-1966', in C. Orange, (ed.), *The Dictionary of New Zealand Biography: Volume Three 1901-1920,* Auckland University Press/Department of Internal Affairs, 1996, p. 226.

[73] B. Salmon, 1991, p. 305.

[74] P. Sargison, 1996, p. 226.

[75] Registrar General's Report, *Statistics of New Zealand 1886,* Wellington, Government Printer, 19th October, 1887, pp. xiii-xv.

[76] F. Porter, C. Macdonald, with T. Macdonald, 1996, p.342.

[77] *Health III*, B64, St Helens Hospitals General, WARC, Letter to a Mr. Herries from Mr. George MacMurray, St. Mary's Vicarage, dated August 2, 1912, chairman of the Committee of Management for St. Mary's Homes, Otahuhu, a Maternity Hospital, Training Home and Nursery, for single, pregnant women and their infants. F. Porter, C. Macdonald, 1996, pp. 342-343. M. Tennant, *Paupers and Providers: Charitable Aid in New Zealand,* Wellington, Allen & Unwin/Historical Branch, 1989

reporting on the increasing trend towards illegitimacy.[78] Those single women who sought help in the refuges and homes received care during the birth of their baby and afterwards although this was not necessarily from a qualified midwife.[79]

The care afforded to the single women in childbirth was part of the catalyst from which the state run St Helens Hospitals were developed to provide midwifery care for the wives of working class men. A complaint from a woman whom Neill met during her work for the New Zealand government fuelled the idea.[80] This woman accused the traditional midwives of ignorance and uncleanliness in their practice. These characteristics were also implicated in official papers dealing with maternal and infant mortality.[81] They were not to be revealed officially until after legislation controlling practice supported investigation and removal from practice of midwives unable to meet the new professional standards.

Ignorance of the new knowledge in the control of infection through the use of antiseptics was a major issue.[82] This knowledge was to be provided in the new midwifery programmes which were established post 1904 and from which the new professional midwives graduated.[83] The midwifery schools which ran the programme were administered by the hospital and charitable aid system which in 1895 was administered by Dr Duncan MacGregor, Inspector of the Hospitals and Charitable Aid. MacGregor had requested the secondment of Neill to work

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[78] Registrar General's Report, *Statistics of New Zealand 1886,* Wellington, Government Printer, 19th October, 1887, pp. xiii-xv. This report indicates that illegitimacy rate have increased by 50% during the previous ten years. The 1877 rate was 2.08 to every 100 births. In 1886 the rate was 3.12 per 100 births.

[79] Premier Richard Seddon, *NZPD*, 1904, Vol. 128, p. 72.

[80] *Health III*, B64, St. Helens Hospitals - General, WARC, Letter from Grace Neill to the *Evening Post* dated 10 May 1912.

[81] Seddon, *MS 1619,* WTU, Richard Seddon's Memorandum on Child Life Preservation in New Zealand, May 7, 1904.

[82] *Health I*, 21/29, Removal of registered midwives from the register, WARC.

[83] Regulations under "The Midwives Act, 1904", *NZG,* 39, April 27, pp. 1022-1023.

as his assistant handling women's issues which arose within the department.[84] Neill was a widow with one child and had trained both as a nurse and a midwife in England. She came to New Zealand via Australia where she had worked as a journalist and an administrator.[85] In 1893 Neill had been appointed as the first female factory inspector in New Zealand.[86] She reformed nursing practice in 1902 by lobbying for the introduction of an Act to control nursing practice.[87] In 1904 Neill campaigned for similar legislation to control the practice of midwives and the introduction of training schools to prepare the practitioners. Chapter four examines the progress of this Bill through the parliamentary system.

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[84] M. Tennant, 1989, p. 43.

[85] W. B. Sutch, *Women with a Cause,* Wellington, New Zealand University Press, 1973. p. 95.

[86] J. O. C. Neill, 1961. p. 20. W. B. Sutch, 1973. p. 95.

[87] J. O. C. Neill, 1961, p. 35-37.

Chapter Four

New Zealand European Midwifery Practice: Introducing the 1904 Midwives' Bill to Parliament

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The first Liberal Government had been in office two years when Grace Neill was appointed as Assistant Inspector of the hospital and charitable aid system.[1] With no other significant parties to oppose the move the House of Representatives had installed the Liberal Party as New Zealand's first centralised government with Premier John Ballance as Prime Minister. Richard John Seddon, a man viewed to have tremendous political persuasion, replaced Ballance in 1893.[2] Believing that the pace of reform should be acceptable to the people, legislative changes were made subject to the people's requests. This enabled powerful liaisons between civil servants and reform minded politicians who collaborated to instigate change which carried forward into statute. As a civil servant, Neill, with strong support from Holford, a nurse and midwife,[3] and Hon. George Fowlds, member of parliament for Grey Lynn[4], generated the interest of Seddon to introduce legislation controlling midwives' practices.[5] Seddon accepted the challenge of introducing the Midwives' Bill before parliament.

The move to regulate midwifery practice coincided with a world-wide decline in fertility and rising infant mortality.[6] Maternal mortality was also a cause for

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1 D. Hamer, 'Centralization and Nationalism (1891-1912)' in Keith Sinclair, editor, *The Oxford Illustrated History of New Zealand,* Auckland, Oxford University Press, 1990, p. 125.

2 ibid. p. 126.

3 C. Macdonald, M. Penfold with B. Williams, 1991, p. 305.

4 Statistics Department, *Statistics for the Colony of New Zealand, 1904.-Blue Book*, Wellington, Government Printer, 1904, p. 14.

5 J. O. C. Neill, 1961. p. 52. Two years earlier Neill had successfully negotiated for the passage of a Bill which provided for the training and registration of nurses.

6 *NZOYB,* 1920, p. 22. D. Hamer, 1990, p.144.

concern.[7] Seddon had been investigating these issues in New Zealand and published a Memorandum on Child Life Preservation in May 1904.[8] This was a good strategy which prepared parliamentarians for the introduction of the Midwives' Bill in July of the same year. Seddon's information came from a report prepared by an Australian Royal Commission into the falling birth rate in New South Wales. The report provided statistics of the infant mortality figures in New South Wales.[9] Seddon's Memorandum acknowledged this report and identified the existence of a similar situation in New Zealand.

The decline in births experienced in New Zealand was demonstrated in 1920 in a graph showing birth, death and marriage rates in relationship to each other and to the rate of natural increase between the years 1855 and 1919.[10] The fall of the birth rate and natural increase began in 1878, reaching its lowest level in 1899 at which time the rate levelled off with fluctuations within 7% of the lowest level. The fall in marriage and death rates began two years earlier in 1876 and was less dramatic. From 1895 there was a steady rise in marriage rates with a constant death rate fluctuating between 1 to 2%. Official interpretation of the decline in the birth rate indicated that the country was experiencing a period of economic depression.[11] This was a reflection of a world wide trend which peaked in 1879.[12] A second decline in all of the identified areas occurred in 1917 when the first world war influenced births and deaths internationally.[13]

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7 Seddon, *MS 1619*, WTU. P. M. Smith, 1986, p. 145.

8 Seddon, *MS 1619*, WTU.

9 *NZOYB*, Wellington, Government Printer, 1905, p. 253.

10 *NZOYB*, Wellington, Government Printer, 1920, p. 22.

11 ibid. p. 22.

12 R. Dalziel, Railways and Relief Centres (1870-1890) in K. Sinclair, (ed.), *The Oxford Illustrated History of New Zealand,*, Auckland, Oxford University Press, 1990, p. 110.

13 *NZOYB*, 1920, p. 22.

Seddon's interpretations of these occurrences was made with statistics from 1893 to 1903. In addition to the declining birth rate Seddon was also aware that a large proportion of the children born in the colony did not survive beyond the first year of life. The average per five years between 1893 and 1903 was 82 infants in every 1,000 born.[14] This is demonstrated in figure 1, page 56. Seddon indicated ten measures that would reduce the infant mortality rate. The first of these was the passing of the Midwives' Bill and the establishment of qualified midwives in each centre to attend the wives of the poor.[15]

Many of the Acts passed by New Zealand at this time were adaptations of Imperial Acts.[16] New Zealand's first Midwives' Bill was no exception being a colonial adaptation of 'the Imperial Act passed in the year 1902.'[17] The main architect was Neill, an English trained nurse and midwife with an interest in nursing reform as expressed in her address to the International Congress of Nurses in 1899. Neill was also an Honorary Member of the Matrons' Council of Great Britain and a member of a Provisional Council which drafted a Constitution and By-laws for an International Council of Nurses.[18] Neill's inside knowledge of moves internationally to professionalise nursing and midwifery fitted her for the role she played in upgrading the professional standard of nursing and midwifery in New Zealand.

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[14] *NZOYB,* 1904, p. 276.

[15] Seddon, *MS 1619,* WTU.

[16] F. S. Maclean, 1964, p. 11 - Contagious Diseases Act 1869, 419 - Public Health Act 1872.

[17] Premier Richard Seddon, *NZPD*, 1904.

[18] J. O. C. Neill, 1961. p. 38.

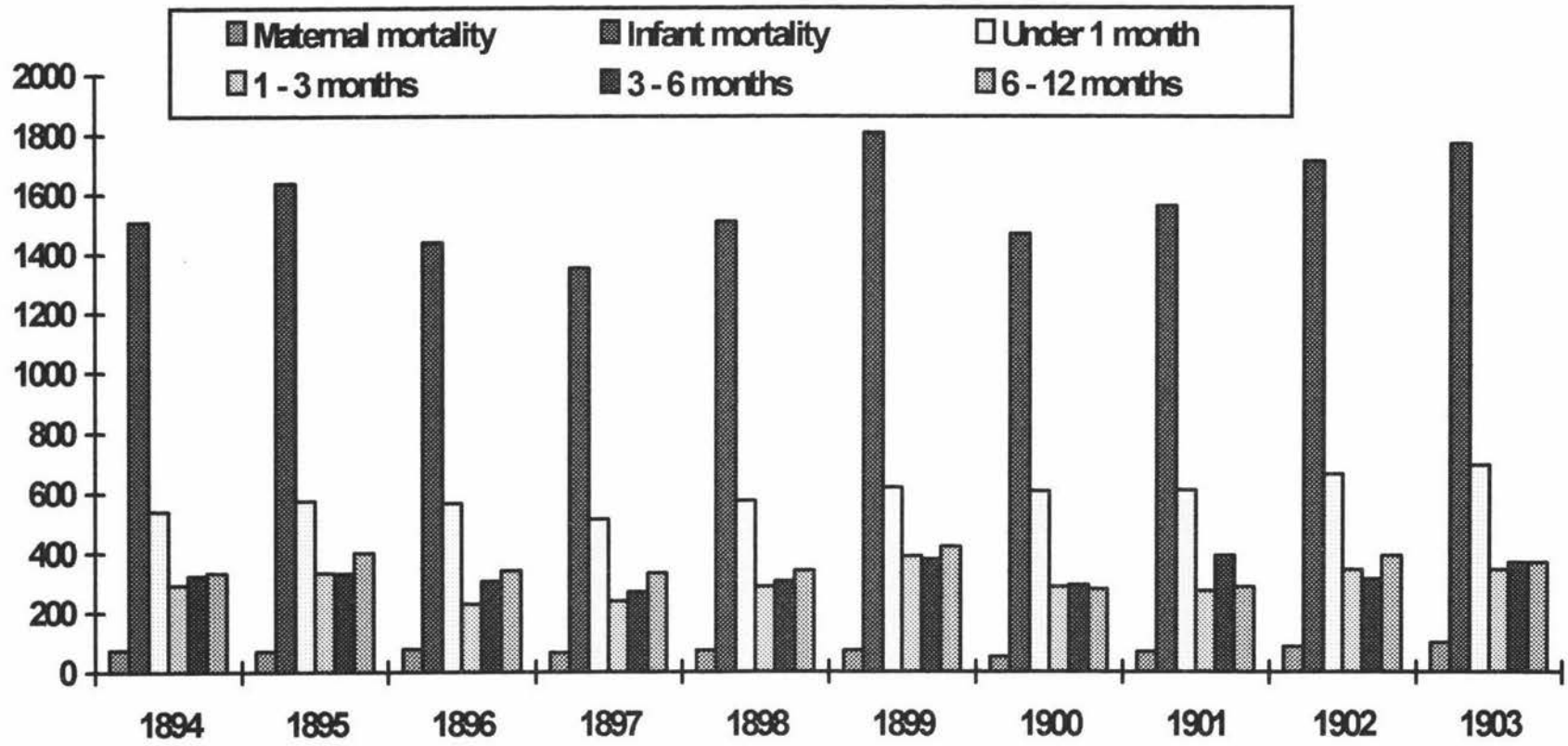

Figure 1: Maternal and infant mortality figures 1894 - 1903.

Source: *NZOYB*, 1904, p. 277.

The new legislation needed to foreclose on poor practices[19] and provide for the development of a training programme for pupil midwives.[20] New maternity facilities which served a dual purpose were needed. These would become both a training school for midwives and a place where married women with limited finances could have their babies in safety. [21] Recognition that these issues would take time to implement also called for an interim measure to keep the existing services legal. Traditional midwives who formed the bulk of the care were needed until sufficient certificated, registered midwives were available to provide a service.[22] As the traditional midwives' practices were a cause for concern and part of the catalyst for change a mechanism for removing them from practice if necessary was needed.[23] Administration costs, likely to be considerable in the first instance, needed to be acknowledged within the Bill.[24] All of these factors were accounted for in the initial draft which went before parliament.

Seddon's introduction of the Midwives' Bill supported his work on Infant Life Preservation.[25] The death of the mother during childbirth affected the way her infant and any other children were nurtured with subsequent potential compromise of their ability to be effective members of the human race. Similarly the death of the infant in preventable circumstances was rapidly reducing the numbers of potential adult colonists. The causes of infant mortality relevant to the practice of midwifery included inadequate care of the new-born by ignorant or careless midwives and lack of hospital accommodation for the poorer classes of parturient women. Prematurity related to congenital abnormalities, infections

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[19] *Health III*, B64, St. Helens Hospitals - General, NA, Letter from Grace Neill to the Evening Post dated May 1912.

[20] P. A. Sargison, 1996, p. 225. C. & C. Manion, *Doctor Agnes Bennett,* London, Michael Joseph, 1960, p. 48.

[21] J. O. C. Neill, 1961. p. 89.

[22] The Midwives Act 1904 [4 EDW, II, No. 31] *NZS 1904,* Clause 4.

[23] ibid, Clause 12.

[24] ibid. Clause 20.

[25] Seddon, *MS 1619*, WTU.

acquired during the pregnancy and injuries or disease acquired during the birth were also identified.[26]

In his opening address Seddon indicated that the Bill, a departure from previous Bills, would preserve life by ensuring the efficiency of those who attended at deliveries in the future.[27] To illustrate the gravity of the situation Seddon claimed

> Sir, The deaths at maternity are alarming, and I say, without hesitation, that if these proposals are given effect to the number of deaths will be decreased. During the ten years from 1894 to 1903 inclusive, the total number of children of five years of age and under that died in the colony was 20,487, of which number no fewer than 15,767 died before reaching the age of one year. The number of actual deaths at maternity - that is, the deaths of the mothers - I am awaiting information about; but, if I recollect aright, it was something between seven and eight hundred, and you may double that number and then you will be within the mark, because the death is given in the maternity returns as the mother only.[28]

Seddon followed these statistics with a caricature of the average midwife then in practice. They were frequently elderly and had gained their midwifery knowledge from assisting other women in childbirth rather that through formal instruction.[29] The description did not support an image of competence or professionalism on the part of the midwife. The impact this person had on society might well have been expressed in the remarks made by other politicians. They identified feelings of fear and anxiety that childbirth evoked in the general population and the sense

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[26] *NZOYB*, 1905, p. 253.

[27] Premier Richard Seddon, *NZPD*, 1904, p. 70. The Midwives Act, 1904 [4 EDW, II, No. 31] *NZS*, 1904, Clause 1. Is the title of the Act which states that there will be provision 'for the Better Training of Midwives,' and that their practice will be regulated.

[28] ibid. pp. 70-90. Table No. 5. A note at the foot of this table reads 'The Numbers of Unregistered Births and Deaths cannot be ascertained. Births and Deaths of the Aboriginal Natives are not included in the above Numbers.

[29] Premier Richard Seddon, *NZPD*, 1904, p. 70.

of danger that accompanied pregnancy.[30] Sentiments which were reflected privately in letters exchanged by women and their female friends and relatives and recorded in their diaries.[31] The need for change and a commitment to the effective preparation of midwives was clear throughout the debate.

In the final stages of the debate Seddon presented the figures for maternal deaths for the previous ten years.[32] As he had indicated earlier in the debate 732 women were known to have died in childbirth within this period. Of this figure 73 had died during 1894. With minor fluctuations, excepting during 1900, this figure had risen steadily and had reached 100 deaths in 1903. During 1900 the figure was as low as 51. (See Table 9, p. 61). Seddon indicated a belief that a law such as that being debated would have reduced these statistics and increased the confidence people had in midwifery care.

In presenting the figures Seddon gave no indication of how the deaths related to the number of births in the colony. He did state that the figures were far from accurate since they related to the deaths of the mothers only.[33] In this statement Seddon was talking about deaths from accidents at childbirth, a situation which could include deaths of actual and potential life. The deaths of the mother were a reality. Death of the foetus was a loss of potential life, a life which robbed the colony of a future citizen, an important issue in the development of the British Empire.

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[30] Mr. Hall, Member for Waipawa, *NZPD*, 1904. p. 81. Mr. Witty, Member for Riccarton, *NZPD*, 1904. p. 80.

[31] F. Porter and C. Macdonald, 1996, pp. 337-380. J. Campbell, *qMS CAM/1-9-52/85773*, WTU.

[32] Premier Richard Seddon, *NZPD*, 1904, p. 90.

[33] ibid, p. 90.

The figures used by Seddon were slightly different to those issued in the official statistics.[34] In 1901 the recorded maternal deaths were ten higher being 80 and in 1903 the figure was 110 as opposed to 100. When examined against the total number of births the maternal death rate was smaller than the increase in births that occurred each year with the exception of 1899 when there were 120 births less than in 1898. In relation to the total births occurring each year the maternal mortality rate increased from 0.37% in 1895 to 0.50% in 1903. The average maternal mortality rate per total births for this period was 0.38%. (See table 10).

The term 'accident at childbirth' included all factors contributing to death other than abortion and miscarriage, puerperal convulsions, placenta previa (flooding), puerperal mania and metritis, and phlegmesia dolens.[35] (see table 7, p. 44). Maternal deaths related to septic conditions were not included in these figures but were listed under septic conditions.[36] Despite being listed separately these deaths were included within the total figures for maternal deaths in the yearly reports from the Registrar.[37] However, this official recognition did not extend to the figures used by Seddon during the debate on the Midwives' Bill.[38] (See Tables 7, 9 & 10). For this reason the category 'Other Accidents of Childbirth' stood out as the main contributing cause of maternal mortality (see Table 7). This indeed was the case, but the puerperal septic conditions were equally as alarming and were increasing. In the ten years 1894 to 1903 'Other Accidents of Childbirth' comprised an average of one third of recorded maternal deaths, puerperal septic conditions averaged approximately a quarter. Both of these categories would be addressed if the Midwives' Bill was passed.

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[34] Premier Richard Seddon, *NZPD,* 1904, p. 90. *SCNZ,* 1901. *SCNZ,* 1903.

[35] *SCNZ,* 1894-1903.

[36] ibid.

[37] Report of the Registrar General, S*CNZ, 1886,* Wellington, Government Printer, 1887, p. xxiv. Report of the Registrar, *SCNZ, 1888,* Wellington, Government Printer, 1889, p. xlii.

[38] Premier Richard Seddon, *NZPD,* 1904, p. 90.

Table 9: Deaths of mothers from accidents at childbirth 1894-1903.

Year	Number of Recorded Maternal Deaths
1894	73
1895	69
1896	77
1897	64
1898	72
1899	71
1900	51
1901	70
1902	85
1903	100
Total	732

Source:Premier Richard Seddon, *NZPD,* 1904, p. 90.

Table 10: Relationship between deaths of mothers from accidents at childbirth 1894-1903, total births and rate of increase or decrease in births compared to previous year.

YEAR	NUMBER OF RECORDED MATERNAL DEATHS	% OF TOTAL BIRTHS	TOTAL BIRTHS	INCREASE OR DECREASE ON PREVIOUS YEAR
1893	-	-	18,187	-
1894	73	0.39%	18,528	↑341
1895	69	0.37%	18,546	↑18
1896	77	0.41%	18,612	↑66
1897	64	0.34%	18,737	↑125
1898	72	0.37%	18,955	↑218
1899	71	0.37%	18,835	↓120
1900	51	0.26%	19,546	↑711
1901	80	0.39%	20,491	↑945
1902	85	0.41%	20,655	↑164
1903	110	0.50%	21,829	↑1174

Source: *Statistics for the Colony of New Zealand 1893-1903,* Wellington, Government Printer.

The Midwives' Bill was read a second time in November 1904.[39] Government experts advised on the wording and minor changes were made to the original proposal. It was noted that there was no provision for the development of regulations to guide the control of midwives and prevent malpractice, particularly in the use of drugs and instruments. This power was created and the motion was agreed to.[40] The Bill was to become law from 31st January 1907. This waiting period would allow midwives time to become registered. It also gave time for the new state midwifery hospitals, St Helens Hospitals, to become established.

It was envisaged that several state hospitals would provide the environment for the new midwifery schools. To continue the theme of rendering childbirth safer for women these hospitals needed to be independent of other hospital buildings.[41] This arrangement would support the historical findings on safe maternity.[42] The midwifery schools were to provide instruction through lectures and practical teaching on an in and out patient basis, and also through clinical experience in the country districts.[43] This was amended to read 'a period of midwifery experience'[44] to allay the fear that pupils would be practicing their skills on women who lived in the country. The benefit of the scheme to country districts would be in the placement of qualified midwives in these areas who would be able to work effectively and independently of other health professionals.[45] The arrangement was a reflection of the ideas Nightingale had proposed more than

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[39] *NZPD*, 1904, p. 904.

[40] ibid.

[41] F. Nightingale, 1871, p. 69.

[42] F. Nightingale, 1871, p. 69. I. Loudon, 1992.

[43] *NZPD*, 1904. P.72. Clause 6.

[44] The Midwives Act, 1904 [4 EDW, II, No. 31] *NZS 1904,* Clause 6b.

[45] *NZPD*, 1904. P.71-72.

fifty years earlier when she first ventured into the training of midwives in England.[46]

The Bill did not detail the finer points of the teaching that was to take place. This was to be expressed in the regulations which were to be developed later.[47] These regulations would reflect the safety of women in childbirth in the course prescription which identified who was to do the teaching and what was to be taught.[48] The programme followed the instructions handed down by Nightingale in 1871.[49] This and the planned geographical location of the proposed hospitals purposely excluded medical students from contact with a large group of women in childbirth.[50] Nightingale's understanding of the dangers medical students brought into lying-in facilities was very real in her time when no means of understanding for containing the spread of disease was known.[51] As architect of the New Zealand Midwives' Bill Neill had an understanding of Listerism and the benefits of using antiseptics in midwifery practice. Despite this knowledge she set in motion a statute which perpetuated Nightingale's conclusions and began a protracted feud between doctors and midwives.[52]

The proposed training programmes did not discriminate against any woman, married or single, enrolling as a pupil.[53] Seddon believed that all young women

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[46] F. Nightingale, 1871, Preface.

[47] *NZPD*, 1904. P.73. Clause 19.

[48] Regulations under the Midwives Act, 1904, *NZG*, 39, April 27, 1905, pp. 1022-1023.

[49] F. Nightingale, 1871, p. 69.

[50] ibid. p. 70.

[51] C. Woodham-Smith, 1950, p. 474.

[52] Mr. Bollard, member for Eden, *NZPD*, 1904. *Health III*, B64, St Helens Hospitals - General, NA. Letter dated 10 May 1912 from G. Neill to the Editor, Evening Post re Medical Association's attitudes to the St Helens Hospitals. M. Belgrave, in L. Bryder, editor, 1991, pp. 23-24. D. Gordon, *Backblocks Baby-Doctor*, London, Faber & Faber Limited, mcmlvii, pp. 63-64.

[53] The Midwives Act, 1904 [4 EDW, II, No. 31] *NZS*, 1904, Clause 4. Regulations under the Midwives Act, 1904, *NZG*, 39, April 27, 1905, pp. 1022-1023.

should have a knowledge of reproduction and childbirth.[54] Their lack of knowledge was identified as false modesty and ignorance. Parliamentarians were reminded that trained nurses, many of them single women, on completion of their training remained largely in ignorance of the type of knowledge that would be required by a midwife. Seddon indicated his belief that all women should have a knowledge of reproduction and childbirth as

> ignorance on the part of women has caused many a death and sorrow and anguish and trouble in a family. We are only doing our duty if we realise this and do something by this Bill to do away with this ignorance.[55]

This position was not reflected by other politicians or the wider society.[56] Concern was expressed by parliamentarians that upon marriage these single women would be lost to the profession. Mr Lewis, the member for Oroua, stated that this could be prevented by stopping the young women from getting married.[57] Seddon responded by indicating that nurses made excellent wives being able to use their nursing knowledge in caring for their family.[58]

The majority of traditional midwives were married women. Without them the existing services would collapse. This was particularly an issue in country areas which frequently had no midwifery practitioner.[59] Provision had been made within the Bill for these women to register as bona fide midwives if they were able to demonstrate that they had been in practice for three years and were of

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[54] Premier Richard Seddon, *NZPD*, 1904.

[55] ibid, p. 71.

[56] C. Macdonald, M. Penfold, B. Williams, 1991, p. 305-307. *Health 1,* Midwives Registration - Hester Maclean, NA. Letter from Ettie Rout to Dr. Valintine dated 1914. This concept persisted and in 1914 Ettie Rout, a forerunner of the first wave of feminists was stating her belief that virgins should not 'train and practice as maternity nurses'. Rout also believed that young women would leave the profession to marry and would be a loss to the state.

[57] Mr. Lewis, Member for Oroua, *NZPD*, 1904, p. 71.

[58] Premier Richard Seddon, *NZPD*, 1904, p. 71.

[59] Mr. Hall, Member for Waipawa, *NZPD*, 1904. p. 81. Mr. Witty, Member for Riccarton, *NZPD*, 1904. p. 80.

good character.[60] This established a criteria to guide the registrars when women came forward for registration. It also gave a very crude form of reciprocity to women who had qualified as midwives overseas. Women with a LOS certificate were admitted without question as were those with certificates from recognised midwifery training schools.[61] The registrars who were to administer this Clause in the Bill were to be given considerable power in determining the future midwifery services for the country over the next few years. It was their discretion which would accept bona fide midwives onto the register and decide which unidentified overseas midwifery training schools were reciprocal to the programmes being established in the colony.[62] The danger of this practice was that incompetent practitioners might be admitted to the register which was to be established. To deal with this possibility a clause giving authorities the right to remove such midwives from practice was included.[63]

Following acceptance of the Bill a blueprint for the preparation of midwives was set into the statutes. It was believed that the incompetent, untrained midwives would quickly disappear from practice.[64] This did not happen but practice was effectively changed through inspection and instruction of these midwives. Newly trained midwives filtered into the body of midwives servicing New Zealand and took with them the ideals that Neill, Holford and Seddon envisaged. The reformation of midwifery had begun.

A register of midwives was established following the acceptance of the Midwives' Bill. This listed two classes of practitioner. From the second publication of the midwives register the 'Class A' list contained the names of those women who had trained either in New Zealand or a recognised overseas

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60 Premier Richard Seddon, *NZPD*, 1904. p. 72.

61 The Midwives Act 1904 [4 EDW, II, No. 31] *NZS*, 1904.

62 ibid.

63 ibid. Clause 12.

64 *AJHR*, H-1, 1906, p. 3.

training school.[65] A large number of single women were entered on to this part of the register.[66] The 'Class B' list contained the names of women who, although untrained as midwives, had been in practice for at least three years and were of good character.[67] The majority of these midwives were married women. Thus both single and married women were accepted as midwives. Both groups were enabled to meet the required practice standards. Those women who wished to undertake midwifery training entered St Helens Hospital training schools and were prepared for examination and registration.[68] Their programme is examined in chapter five. The midwives who were already in practice were best enabled to meet the required standards through the linking of inspection and instruction.[69] The effectiveness of this and the appropriateness of accepting single women for training is examined in chapter six.

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[65] List of Registered Midwives, *NZG,* 1905, p. 937. The first published register of midwives was divided into two lists, 'List A' and 'List B'. Bona fide midwives were entered on 'List A' and trained midwives on 'List B'.

[66] M. Belgrave, 1991, p. 23.

[67] The Midwives Act 1904 [4 EDW, II, No. 31] *NZS,* 1904, Clause 4. a. The Midwives Act 1902 [2 EDW VII, CAP 17] *British Statutes 1902* [BS] Clause 2. The identified clauses in both Acts relate to the registration of untrained women working as midwives at the time the respective Acts were accepted into statute.

[68] The Midwives Act 1904 [4 EDW, II, No. 31] *NZS 1904,* Clause 5.

[69] The Midwives Act 1904 [4 EDW, II, No. 31] *NZS 1904,* Clause 11. The Midwives Act 1902 [2 EDW VII, CAP 17.] *BS 1902,* Clause 8. The identified clauses in both Acts relate to the supervision of midwive's practices.

Chapter Five

Training and Education of Pupil Midwives 1904 - 1915.

Florence Nightingale did not acquire an in depth knowledge of midwifery nursing yet she left a permanent mark on the development of midwifery training in New Zealand. Her legacy was handed down in the model for midwifery training schools she articulated in her book, *Notes on Lying-in Institutions.*[1] This model was incorporated into the New Zealand Midwives Act, 1904.[2] An editorial note in *Journal of the Nurses of New Zealand* stated that the prescribed system of training within Nightingale's model was superior to that later adopted in England.[3] The programme integrated both a medical and a nursing focus into the training of midwives in New Zealand. Traditional methods of care were replaced by a medical focus on the process of childbirth. This change was validated in the light of scientific advances and the benefits of incorporating Listerism into midwifery practice.[4] This brought clean hands, clean rooms, clean instruments, in short 'everything in surgical and maternity work' into the practice of midwifery.[5] Pupil nurses were taught this new knowledge and the associated skills by medical practitioners and the hospital matrons.[6] Seddon described The Midwives Act, 1904 as a drastic measure which was necessary as a means of reducing maternal and infant mortality.[7]

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1 F. Nightingale, 1871, pp. 69-70.

2 The Midwives Act, 1904 [4 EDW. II, No. 31] *NZG*, 1904, Clause 6. Regulations under the Midwives Act, 1904. *NZG*, 39, April 27, 1905, p. 1023, Regulations 5, 6, 9, 10. 'Midwifery Training', *JNNZ*, October, 1914, p. 174.

3 *JNNZ*, October, 1914, p. 174.

4 H. Morten, 1900, p. 82. Listerism is defined as 'antiseptic surgery'.

5 J. O. C. Neill, 1961, p. 89. Quote from a pamphlet said to have been written by Premier Richard Seddon in July 1904.

6 *NZG*, 39, April 27, 1905, pp. 1023, Regulations 5, 6, 9, 10.

7 J. O. C. Neill, 1961, p. 89.

New State maternity hospitals provided the venue for the training programmes. They were named St Helens Hospitals after Premier Richard Seddon's birthplace, a strategy Grace Neill used to help gain Seddon's support for the Act.[8] The first St Helens Hospitals were private houses either rented or bought.[9] Using private houses as hospitals was standard practice during this period and very few private hospitals were purpose built.[10] In 1907 it was noted that patients' and nurses' accommodation in the Dunedin St Helens Hospital were overcrowded and more accommodation was needed. An isolation room for infectious cases was also required.[11] Additions and alterations were made in 1908-1909 including plumbing and installation of sink units and basins to support the practice of aseptic technique in the labour ward.[12] The same report indicated that the Wellington St Helens Hospital was unsuitable and created difficulties in applying modern midwifery care including aseptic technique. Accommodation for patients was limited. Despite this being an issue in all four of the early St Helens Hospitals women were still choosing to have their babies there, in some instances returning for the birth of their second child.[13] Neither did the overcrowding prevent isolation procedures being instituted in Christchurch when two cases of puerperal sepsis occurred in 1909.[14] Auckland also had patients isolated with septicaemia, one who also had tubercular disease died but the others recovered. This crisis was managed by attending booked patients in their own home or arranging for their care in private hospitals whilst the St Helens Hospital was closed for disinfection.[15]

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[8] ibid. p. 52.

[9] *AJHR*, H.-22, 1909. p. 11.

[10] *AJHR*, H22, 1907, pp. 3-4. Report on Private Hospitals. This report identifies Miss Sutherland's house in Dunedin, the Chalet, as purpose built. Miss Palmer of Wellington provided care for medical and surgical cases in a house built for the purpose.

[11] ibid. pp. 3-4. Report on St Helens Hospitals.

[12] *AJHR*, H.-22, 1909, p. 11.

[13] ibid, p. 5.

[14] ibid, p. 12.

[15] *Health I*, 13395, Infectious Diseases, Disinfection Methods, WARC. *AJHR*, H-22, 1909.

Lack of sufficient accommodation imposed a limit on the number of students each hospital could admit for training. This was set at 20 pupils per training school at any one time. Ten of these could be direct entry pupils, ten nurses registered under the Nurses Registration Act, 1901.[16] The intake of qualified nurses for midwifery training brought general nursing principles into midwifery practice. For direct entry pupils matron was detailed to teach general hospital duties. These pupils were trained over a period of twelve months. Qualified nurses trained over a six month period.[17] For those who chose or were detailed to work in country districts general nursing duties were expected as part of the responsibilities they undertook.[18]

The cost of training was set at £10. for a six month programme offered to registered nurses, £20 for untrained women undertaking a twelve month programme. These fees were considerably less than the £200 Alice Holford had borrowed to travel to Sydney for her midwifery training a few years earlier.[19] They were subsidised by the state who had estimated the cost of training fifty nurses a year to be £5,000.

Women between the ages of 23 - 40 years were eligible to enter the programme.[20] Prospective candidates needed to demonstrate they had received a basic education which embraced the 'ordinary subjects'.[21] The regulation identifying educational requirements is worded in such a way as to suggest that the pupil nurses' educational background was not assessed prior to the time of examination for entry onto the list of registered midwives. It was common in English hospitals to admit student nurses in general programmes for a trial period

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[16] *NZG,* 1905, pp. 1022-23. Regulation 8.

[17] ibid. Regulations 6,13c.

[18] J. O. C. Neill, 1961, p. 89.

[19] B. Salmon, 1991, pp. 305 - 07.

[20] *Health III*, B64, St Helens Hospitals - General, WARC.

[21] *NZG,* 1905, pp. 1022-23. Regulation 2.

and to dismiss those who were found unsuitable.[22] This process appears to have been perpetuated within the early midwifery training programmes in New Zealand. To be rejected for examination due to lack of general education and after the prescribed period of training was both harsh and a financial loss to the pupil nurse and the state who had subsidised entry to the programme.

In the first four years the St Helens Hospitals were open no one training school had a full intake of pupils. Neither did they record sufficient deliveries to support this number. In 1907-8 Wellington did not record sufficient cases to support the number of pupils stated to have completed training and registered. 185 cases were recorded with 13 pupils trained. The total number of cases required for this number of pupils would have been 260 as each pupil was required to have conducted twenty cases during labour and provided postnatal care for twenty lying-in women.[23] A possible explanation for the discrepancy could be that a portion of the pupils could have started training in the previous year when 111 cases were recorded and no pupils trained.[24] (See Table 11). Stillbirths were not required to be registered until 1913 and were not included in the number of births recorded to have occurred in any one institution.[25] The 1909 report on "The Midwives Act, 1908", a refinement of the 1904 Act, indicated that the training schools were now taking more pupils and in the coming year more trained midwives should have qualified in the Dominion.[26]

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[22] C. J. Maggs, 1983, p. 102.

[23] *NZG,* 1905, pp. 1022-23. Regulation 11.

[24] *AJHR*, H-22, 1906, pp. 2-3, *AJHR*, H-22, 1907, pp. 5-6. *AJHR*, H-22, 1908, pp. 9-11. *AJHR*, H-22, 1909, pp. 11-12.

[25] F. S. Maclean, 1964, p. 184.

[26] *AJHR*, H-22, 1909, p. 10.

Table 11: Number of midwives trained or in training in New Zealand St Helens Hospitals between 1905 and 1909 in comparison to midwifery cases attended.

St Helens Hospital	Year	Inside Cases Delivered	Outside Cases Delivered	Midwives Trained and in Training
Wellington	1905-6	111	-	-
Auckland Opened June	1905-6	-	-	-
Christchurch To be opened October.	1905-6	-	-	-
Dunedin	1905-6	69	-	-
Wellington	1906-7	120	52	6 trained
Auckland	1906-7	102	29	1 trained 2 almost completed training
Christchurch To open April	1906-7	-	4	-
Dunedin	1906-7	184	29	4 trained
Wellington	1907-8	135	50	13 trained 6 pupils in training
Auckland	1907-8	180	51	6 trained 7 pupils in training
Christchurch	1907-8	148	36	8 pupils in training
Dunedin	1907-8	204	23	11 trained 8 pupils in training
Wellington	1908-9	166	69	6 trained 9 pupils in training
Auckland	1908-9	217	145	8 trained 8 pupils in training
Christchurch	1908-9	218	93	9 trained ? 2 in training
Dunedin	1908-9	205	12	9 trained 8 pupils in training

Source: *AJHR*, H-22, 1906, pp. 2-3, *AJHR*, H-22, 1907, pp. 5-6. *AJHR*, H-22, 1908, pp. 9-11. *AJHR*, H-22, 1909, pp. 11-12.

Examination of records of outside cases Wellington pupil nurses attended between 1907 and 1913 provides a unique insight into the care of women in childbirth and the clinical experiences of pupil nurses during the early development of the new midwifery services.[27] The printing of a formal case book for recording attendance and care provides details of the nursing input outside cases received during confinement and the post natal period. (See Tables 17-26, Appendix 1). Brief notes on observations during the birth and puerperium were required with times of visits made during the 10 days of post natal care. These case records show the application of the new approach to midwifery care embraced within the Midwives Act, 1904. The later records show changes which incorporate demonstration of performance of abdominal palpation. (See Tables 22, 23 & 26). This assessment provides information on the position of the foetus in-utero. Deviations from the norm can lead to prolonged and obstructed labour requiring interventions during the birth process. Intervention of this nature was a leading cause of puerperal sepsis for the mother and birth injuries for the baby. In total some five hundred normal and abnormal deliveries are recorded in the records. (See Figures 2 and 3).

Preparation of pupil midwives included a wide range of knowledge embracing normal and abnormal aspects of pregnancy, labour and birth, and post natal care of mother and baby.[28] The preparation and use of antiseptics was also required knowledge.[29] Assessment skills were important in diagnosing abnormal situations needing medical intervention throughout the experience of childbirth. Correct assessment in practice led to the safety of the mother and baby. A developing expertise is identifiable within the case records which were written by the

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[27] *ABBR*, 6902/1, Home Delivery Casebook - 1907- 1913, WARC.

[28] *NZG*, 1905, pp. 1022-23. Regulation 1(a) - 1(l). *NZG*, 1914, pp. 2534-35. Regulation 1(a) - 1(l).

[29] ibid.

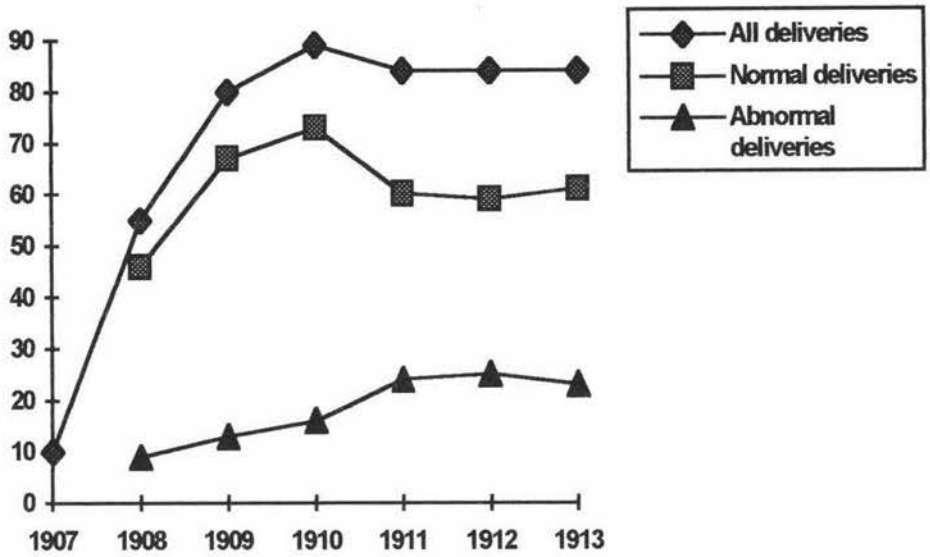

Figure 2: Graphical representation of normal and abnormal deliveries attended as outside cases by Wellington St Helens Hospital pupil nurses between 1907 and 1913.

Source: *ABBR*, Home Delivery Casebook, 1907-1913, WARC.

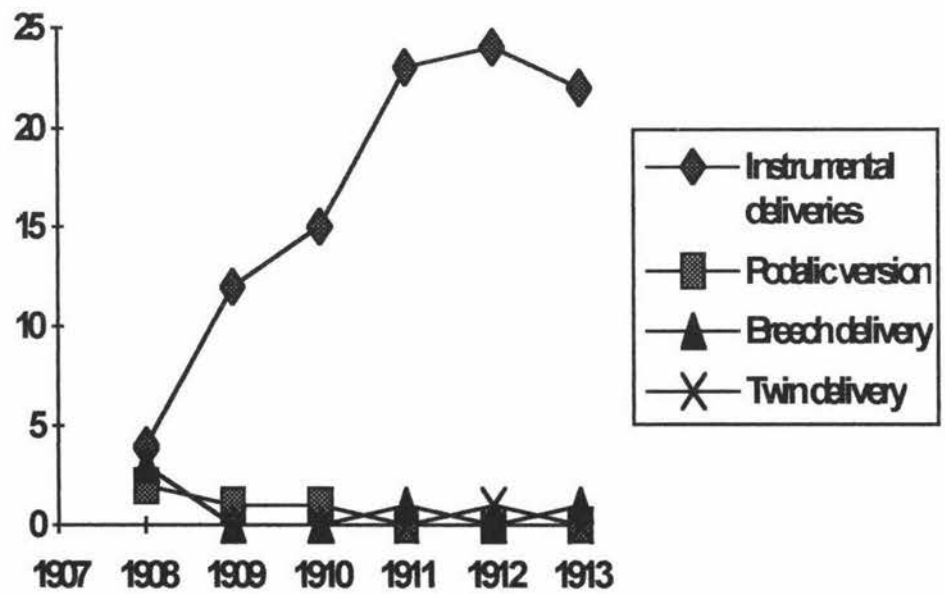

Figure 3: Graphic representation of abnormal deliveries attended by Wellington St Helens Hospital pupil nurses between 1907 and 1913.

Source: *ABBR*, Home Delivery Casebook, 1907-1913, WARC.

students attending each case.[30] This was probably due to improved teaching of the students as the records name a new group of pupils every six months.[31]

Promotion of breast feeding was an important part of a midwife's work. This helped to ensure the continued health of a normal baby. The New South Wales Royal Commission into the declining birth rate had reported that poor maternal health affected the mother's ability to breast feed the new baby.[32] Observation of maternal health was a routine part of assessment of all labouring women. A comment identifying general health status was made in many of the examined case records.[33] (See Tables 17-26). Anaemia was a common health problem but did not appear to interfere with breast feeding.

During pregnancy the breasts undergo development in preparation for breast feeding. Poorly developed breasts or inverted nipples could create feeding difficulties for the baby. Examination of the breasts at the onset of labour assisted in identifying possible breast feeding problems. This was a routine part of the pupil's assessment of the mother with comments on breast and nipples recorded in the majority of cases. (See Tables 17-26). A few women had inverted nipples.[34] (See Tables 17,19 & 24). Most mothers fully breast fed their baby. Alternately breast milk could be expressed and fed to the baby.[35] Artificial feeding was rare the exception being when the mother was unwell.[36] (See Table 22). Belladonna plasters or a tight binder were used to suppress lactation when

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30 ibid.

31 ibid. See also nurse attending in case records, Appendix 1 and Appendix 2.

32 *NZOYB* , 1905, p. 253, Condition 3.

33 *ABBR*, 6902/1, 1907-1913, WARC.

34 ibid. Cases 175, 178, 199, 504.

35 ibid. Case 178. - this baby was born at 28 week gestation, needed active resuscitation and died at 9 days. Expressed breast milk was given until 9th day and baby was said to be thriving. Case 519. - This baby was premature but healthy and thrived.

36 ibid. Case 347.

the baby was stillborn or too sick to breast feed.[37] (See Table 25). The comments on breast feeding show that pupils had the opportunity to learn management of breast feeding and care of the breasts in a variety of different situations.

Puerperal convulsions were a common cause of maternal mortality associated with kidney disease.[38] A change in urinary output was a recognised sign of this problem. Large quantities of albumen would be detected on testing if the condition was present. Convulsions which resembled epileptic fits, could be averted with preventative treatment or when convulsions developed their effect on the woman could be minimised.[39] Medical assistance was needed in these situations. Written report of urinalysis was made in many of the entries, less than 1% showed the presence of albumin. The records frequently stated 'nil albumin' indicating pupils were alert to the condition.[40] Treatment with daily aperients and diuretic drinks was part of the preventative treatment. [41] A patient with chronic kidney disease who showed 'half albumin' on urinalysis made a good recovery on this treatment.[42] (See Table 18). Curative treatment included administration of sedatives, morphia, chloral or chloroform, and thorough purging of the poisonous substances circulating in the blood. Stimulation of kidney function helped to excrete the poisons from the body.[43] Various ways of achieving this were described. One pupil had the opportunity to care for a woman in eclampsia. (See Table 22). Treatment consisted of applying hot kidney packs two hourly to encourage kidney function. Rectal infusion of a Chloral and Bromide mixture in a saline buffer to sedate the woman was given on three occasions.[44]

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[37] ibid. Cases 157, 182, 196, 277, 278, 347,560.

[38] H. Jellett, 1908, p. 249. *SCNZ 1904*, 1905, p. 41.

[39] H. Jellett, 1908, p. 266.

[40] *ABBR*, 6902/1, 1907-1913, WARC.

[41] ibid. Cases 131-136,

[42] ibid. Case 192.

[43] H. Jellett, 1908, p. 266-267.

[44] *ABBR*, 6902/1, 1907-1913, WARC. Case 347.

Midwives needed to recognise when to manage the labour actively and to call medical help in good time.[45] Traditional practitioners were not good at this often calling medical help as a last resort.[46] Midwives were being educated to recognise the limitations of their abilities in caring for women in labour.[47] Normal labour was determined by the presentation of the foetus, the nature of the pains, and the length of the labour. A vertex presentation with regular contractions and delivery within twenty four hours of the onset of labour was considered normal.[48]

Foetal position in labour assisted in determining the need for intervention in the delivery of the baby and was assessed through abdominal palpation. If this skill was taught it was not demonstrated in the case record until circa 1910 at which time the findings of this assessment skill were hand-written into the formal record.[49] (See Tables 22, 23, & 26). Prior to this time there was rarely indication that pupils understood why delivery was effected through the application of instruments or manipulation to a breech presentation. Records which show evidence of abdominal palpation frequently link an abnormal presentation and instrumental delivery together. The commonest abnormal presentations were sacral and occi'pito posterior.

Intervention in labour commonly preceded puerperal septicaemia which was a leading cause of maternal mortality[50] The infection began in the genital tract.[51] A high temperature and fetid lochia indicated the presence of infection.[52] Dirty

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[45] *NZG*, 1905, pp. 1022-23. Regulation 1 c, 1 d.

[46] J. O. C. Neill, 1961, p. 89.

[47] *NZG*, 1905, pp. 1022-23. Regulation 1 c., & 1 d.

[48] H. Jellett, 1908, p. 148.

[49] *ABBR*, 6902/1, 1907-1913, WARC. Case 558.

[50] *SCNZ 1904*, 1905, p. 41.

[51] H. Jellett, 1908, p. 344.

[52] ibid. pp. 346-47.

hands and instruments were the source of these infections.[53] Assessment skills to detect puerperal sepsis included observation of lochial changes, measuring uterine involution and taking a temperature accurately. The interpretation of the observations incorporated knowledge of the normal physical recovery of the post natal woman and ability to use a clinical thermometer. Pupil nurses demonstrated the ability to make these observations and interpret the findings appropriately.[54] (See Table 20).

Treatment of puerperal sepsis included hot vaginal or uterine douches.[55] These could be administered prophylactically or as treatment when the condition developed. Prophylactic treatment was recommended when delivery had included manipulation or manual removal of placenta.[56] Administering a douche safely required accuracy in positioning of the douching can and an ability to prepare antiseptic solution correctly.[57] As various antiseptics were used each requiring different strengths a good knowledge of each was required. Douching was not specifically a nursing skill. Doctors would administer a douche following a manipulation during delivery or when problems developed in the puerperium.[58] (See Tables 20 & 26). In the post natal period the pupil attending gave the douche. The treatment was effective. Not all patients who were treated prophylactically developed infection.[59] All patients who showed signs of infection recovered after administration of douches.[60] (See Tables 20, 24 & 26).

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[53] ibid. p. 7.

[54] *ABBR*, 6902/1, 1907-1913, WARC. Cases 232, 235, 318, 517, 558.

[55] H. Jellett, 1908, p. 347.

[56] ibid. p. 12.

[57] 'State Examinations of Midwives', *JNNZ*, July, 1913, p. 96.

[58] *ABBR*, 6902/1, 1907-1913, WARC. Case 423

[59] ibid. Case 321, 565, 558.

[60] ibid. Cases 235, 301, 331, 487.

Manipulative delivery was as hazardous for the infant as the mother. Birth injuries were one of the causes of infant death. Midwives were assistants to the doctor in instrumental and manipulative deliveries. In this capacity pupil nurses were exposed to situations where infants were at risk at birth or in the post natal period.[61] (See Tables 23, 24 & 26). There is no evidence that pupil midwives were taught to assess the infant's well-being through auscultation of the foetal heart during labour. Comments on the baby's condition at birth indicate this was the first time assessment was made. Further assessments were made on a daily basis during the first ten days of attendance within the post natal period and on discharge.[62] (See Tables 17-26).

Establishing respirations was the first hurdle for the infant. This could be compromised through hidden cord problems, either compression of the cord from impacted shoulders[63] or due to the cord being wrapped around the baby's neck,[64] sometimes further complicated by the presence of a true knot.[65] The recommended method of resuscitation included immersion alternately in hot and cold water.[66] This method is described as a common occurrence in protracted labours and cases of manipulation or breech. A few pupil nurses had the opportunity to participate in this life saving measure.[67] (See Tables 17 & 23).

Prematurity was a leading cause of infant mortality. Despite this premature infants were born and nursed at home, and in some instances stated to have progressed well.[68] (See Table 26). Others were admitted to hospital for special

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[61] ibid. Cases 140,199, 280, 300, 321, 363, 402, 420, 478, 488, 504, 515, 516, 581.

[62] *NZG,* 1905, pp. 1022-23. Regulation 11. *ABBR*, 6902/1, 1907-1913, WARC.

[63] *ABBR*, 6902/1, 1907-1913, WARC. Case 402.

[64] ibid. Case 420.

[65] ibid. Case 488.

[66] H. Jellett, 1908, pp. 394-398.

[67] *ABBR*, 6902/1, 1907-1913, WARC. Cases 178, 321 and 420.

[68] ibid. Cases 558.

treatment for prematurity.[69] (See Table 24). In one case a premature baby was born before the arrival of St Helen's staff.[70] This baby was cold when the nurses arrived and died six hours after birth due to exposure. In another case a seemingly full term baby was admitted to hospital on the 9th day for care following chilling. This baby died on the 17th day.[71] These cases demonstrate that although prematurity was a leading factor in infant mortality lack of warmth immediately following birth was a contributing factor which did not have to be linked with prematurity.

Although not life threatening, eye infections posed another challenge for pupil nurses. Seven babies in all were treated for purulent opthalmia.[72] The severity of the problem varied. Six of the babies were treated at home with instillation or irrigation of Argyrol, Perchloride or Boracic lotions.[73] The seventh case was aggressively treated with irrigations of Perchloride lotions, Tinct Argyrol m 1/1 am - nocte and occasional hot foments and Boracic irrigation alternating with mercurial lotion. Despite this treatment the baby was referred to the hospital for outside treatment from day ten.[74] (See Table 21).

Safe midwifery care involved care of both the mother and the baby with the aim of reducing both maternal and infant mortality. Within the cases examined effective nursing care of the mother was demonstrated at all stages of the childbirth experience. No maternal deaths were recorded. Containing and reducing infant mortality was less easily managed. Infant mortality within the first ten days occurred in nineteen cases, slightly less than 3.7% of recorded births.

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[69] ibid. Case 140, 300, 478, 504, 515.

[70] ibid. Case 312.

[71] ibid. Case 478.

[72] ibid. Cases 176, 233, 252, 406, 544, 566, 598.

[73] ibid. Cases 176, 233, 406, 544, 566, 598.

[74] ibid. Case 252.

Prematurity or seizures were features of half of these. Manipulation such as would be experienced in podalic version also placed infants at risk of either birth injury which precipitated death or stillbirth. Two cases of podalic version led to infant death.[75]

The situations identified in the outside case records represent learning through clinical experience. It was the St Helens Hospital medical officer's responsibility to provide this experience.[76] In the Wellington area pupil nurses from St Helens Hospital were also involved in cases with other general practitioners. The names of the first and second medical practitioners to the hospital, Dr. Perkins and Dr. Agnes Bennett, are identified in the casebook as are nineteen other medical practitioners.[77] The antagonism between doctors and the St Helens Hospitals was beginning to dissipate as qualified midwives assisted the doctors at deliveries. By 1909 a system had evolved whereby a doctor could apply to St Helens Hospital for the temporary services of a pupil nurse if the nurse engaged did not arrive to attend the birth.[78] The temporary nature of the pupil's services extended over the next ten days at which time the patients were discharged from care.[79] This system of care has been described as an open system.[80] The clinical experience and learning it constituted for individual pupils was an added bonus which contributed to their preparation as qualified midwives.

This glimpse into childbirth experiences in the early years of establishing midwifery training programmes supports the syllabus set out in the Regulations

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[75] ibid. Cases 196 and 336.

[76] *NZG*, 39, April 27, 1905, pp. 1022-1023. Regulation 10.

[77] *ABBR*, 6902/1, Home Delivery Casebook, NA.

[78] *AJHR*, H-22, 1909, p. 10.

[79] *ABBR*, 6902/1, Home Delivery Casebook, NA. Records show that the pupil nurse and sometimes a midwife attended the mother and baby twice daily for three days then daily for seven days following which the patients were discharged from care.

[80] G. Smith, "Essentially a Woman's Question" A Study of Maternity Services in Palmerston North 1915-1945, Research Exercise, BA Honors, Massey University, 1987, p. 34.

set under the Acts of 1904 and 1908. The distribution of normal and abnormal labour and births in which pupils were involved assisted them in meeting the requirements of attending twenty cases of labour and twenty cases of lying-in women during ten days following labour.[81] There is no indication in the regulations that care of a given number of infants is needed before pupils are eligible to sit examination.[82] Nor does the required knowledge appear to include care of a sick or premature infant. It could be assumed that care of the infant would be a normal part of caring for a lying-in woman but this would not be the case if the infant died at birth or soon after. Despite this gap in the requirements the syllabus did require a knowledge of care of the infant during the first ten days.[83] This knowledge was examined either in the written or practical and oral parts of the examination.[84]

The recommended pupil intake of ten registered nurses and ten direct entry pupils was small enough to allow for individual support of the trainees. Initially less than recommended, the intake was not too small as to restrict learning through discussion which may have been generated within the lectures provided and the formal and informal discussion of cases attended by pupils. The nature of general hospital duties is not indicated in the syllabus and so the extra period of six months direct entry pupils needed in order to learn these duties cannot be commented upon.

The introduction of Listerism into midwifery practice was a major feature of the new training programmes. Pupils were to learn the preparation and use of antiseptics in midwifery practice and the elements of house sanitation.[85] The

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[81] *NZG,* 39, April 27, 1905, pp. 1022-1023. Regulation 10.

[82] *NZG,* 39, April 27, 1905, pp. 1022-1023. Regulation 11.

[83] *NZG,* 39, April 27, 1905, pp. 1022-1023. Regulation 1(h).

[84] State Examinations, 1912, *JNNZ,* 6:1, January 1913, 6:1, pp. 32-36. State Examination of Midwives, *JNNZ,* 6:3, July 1913, p. 93-96.

[85] *NZG,* 39, April 27, 1905, pp. 1022-1023. Regulation 1 (f) and 1 (l).

houses rented for use as St Helens Hospitals posed many problems in relation to maintaining aseptic technique and sanitary conditions.[86] The 1908 inspectors report on St Helens Hospitals identified the very primitive conditions under which asepsis was carried out in the Auckland hospital. Thorough disinfection, painting and renovation was to take place to improve the situation, an exercise which would give pupils an opportunity to learn first hand this aspect of their syllabus.[87] In 1909 it was reported that the Dunedin St Helens had been extended and altered including 'hot and cold water to aseptic basins and sinks, which are also supplied with sterilised hot and cold water.' All of these comments and changes in accommodation demonstrate the committment to this aspect of care.

Pupils who successfully completed their training programme were required to present for examination before they could seek registration as a midwife. Examinations held between 1912 and 1914 identify the range of written questions to which pupil nurses were required to respond.[88] Oral and practical examination was also conducted.[89] Written questions in each paper do not provide sufficient information to say that each midwifery examination was comprehensive in assessing the range of required knowledge. A longitudinal evaluation of the written papers provides a better idea of the effectiveness of midwifery examinations. The written questions in January 1912 did not identify a full range of required knowledge a midwife should have. The next four written papers were more comprehensive.[90] The absence of questions on labour, the infant and puerperium or the use of antiseptics in a written paper did not indicate

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[86] *AJHR*, H22-1, 1907, pp. 5-6.

[87] *NZG*, 39, April 27, 1905, pp. 1022-1023. Regulation 1(l).

[88] The State Examination of Midwifery Nurses, *JNNZ*, 5:1, January 1912, p. 19. Examination of Midwives, *JNNZ*, 5:3, July 1912, p. 83. State Examinations, 1912, *JNNZ*, 6:1, January 1913, p. 32-36. State Examination of Midwives, *JNNZ*, 6:3, July 1913, pp. 93-96. State Midwifery Examination, *JNNZ*, 7:1, January 1914, pp. 29-34.

[89] *NZG*, 1905, pp. 1022-23. Regulation 1.

[90] The State Examination of Midwifery Nurses, *JNNZ*, 5:1, January 1912, p. 19. Examination of Midwives, *JNNZ*, 5:3, July 1912, p. 83. State Examinations, 1912, *JNNZ*, 6:1, January 1913, p. 32-36. State Examination of Midwives, *JNNZ*, 6:3, July 1913, pp. 93-96. State Midwifery Examination, *JNNZ*, 7:1, January 1914, pp. 29-34.

that this knowledge was not examined. The practical examination may have required the pupil to demonstrate a knowledge of aseptic technique, the oral questioning care of the infant or an aspect of labour. This was demonstrated in the practical examination of July 1913 when trained nurse midwives assisted in the practical examination. A variety of skills was assessed including 'changing, weighing and bathing an infant, mixing lotions and urine testing.'[91] The pupil was required to gain a pass in all three parts of the assessment in order to pass the examination suggesting that different knowledge was assessed in each part of the examination.[92] In 1909 the inspectors report on midwifery examinations indicated that suggestions and criticism from the examiners had helped the midwifery teachers to maintain a high standard of proficiency within the training programmes.[93]

The extent to which antiseptics were used in the provision of midwifery nursing is demonstrated through the published answers to the written papers. The January 1914 paper required detailed information of the treatment in second stage of labour. Although the answer receiving the highest marks was not beyond criticism in the care advocated it was published as an example of the expected response. It is possible to identify the extent to which antiseptics and aseptic technique were applied from this answer.[94] Preparation of the bedroom and lotions is identified along with disinfection of the hands to render them surgically clean.[95] Washing the vulva, commonly called 'parts', was carefully followed by application of hot lysol foments to the area. Strict aseptic precautions throughout the birth process were carried out to prevent the entry of bacilli to the woman's body.[96] This followed the recommendations made in midwifery textbooks

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[91] *JNNZ*, 6:3, July 1913, p. 93.

[92] *JNNZ*, 5:1, January 1912, p. 19.

[93] *AJHR*, H-22, 1909, p. 10.

[94] *JNNZ*, 7:1, January 1914, pp. 29-34.

[95] ibid.

[96] ibid.

published in the early nineteenth century. The first chapter in a midwifery textbook for nurses prepared by Henry Jellett in 1908 places asepsis in midwifery in the first chapter.[97] The importance of continuing aseptic technique in any procedure required during the birth process was reinforced in another question in the same paper, answers to which drew attention to the minimal attention given to hygiene in the pupils' responses.[98]

The possibility that a mother may not survive labour to feed her infant placed a knowledge of artificial feeding in the domain of midwifery knowledge.[99] The expected answer to examination questions on infant feeding indicated that pupil nurses also needed to know how to prepare artificial feeds and calculate the baby's nutritional needs within the first month of life.

Examinations were a formal acknowledgement of a pupil's ability to perform competently as a midwife. Socialisation into the role was equally important and occurred informally during the training period. This included acceptance of the hours of work and the nursing and medical focus adopted within midwifery practice.

Throughout history the clinical hours in midwifery have been antisocial. The good celebratory histories give clear reference to the nocturnal journeys the traditional midwives made in response to the needs of other women in labour.[100] The time spent at a birth could also be long, keeping the midwife, commonly a wife and mother, away from home and family responsibilities.[101]

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[97] H. Jellett, 1908.

[98] *JNNZ,* 7:1, January 1914, pp. 29-34.

[99] *JNNZ,* 6:1, January 1913, pp. 32-36. *JNNZ,* 6:3, July 1913, p. 93.

[100] Anon, *WDNZFU,* 1939, p. 86-91.

[101] J. A. Salmond, 1993, p. 213.

The provision of state midwifery care initiated changes in the working hours of midwives. Pupils were socialised to both hospital and community approaches to care. The two environments were combined within their working day blurring the parameters of each.[102] The community or outpatient cases were responded to when the family called. This could be any time within the day or night.[103] Pupils attended both public and private patients in the community. Guidelines were established requiring pupils to be out for a maximum of eight hours when attending private patients.[104] This arrangement supported the idea that eight hours was a normal working day. This could be wavered in special circumstances when arrangements had to be made with the matron of the St Helens Hospital.

The experience of working in the community also socialised the pupils to adopt a medical and supervisory approach to midwifery practice. After the birth of the baby pupils provided care during daily visits. These were made over a period of ten days at which time the mother was considered well enough to be out of bed.[105] The standard visiting pattern was twice daily for three days then daily until the tenth day, a pattern of attendance recommended to student doctors training in Edinburgh during the 1880s.[106] These recommendations stated that the doctor supervised the care assessing and advising during his daily visits. This form of care was condoned by the regulations under the Midwives Act, 1904 which stated that the medical practitioners should take pupil nurse out to cases of labour.[107] The requirement that the family provide for the care of the mother

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[102] *Health III*, B64, St Helens Hospitals - General 1905-38, WARC, Rules for attendance of Outdoor Cases in Charge of Private Doctor. Clause (a).

[103] *ABBR*, 6902/1, 1907-1913, WARC.

[104] *Health III*, B64, St Helens Hospitals, General 1905 - 38, WARC. Rules for the Attendance of Outdoor Cases in Charge of a Private Doctor. Clause (b).

[105] *ABBR*, 6902/1, 1907-1913, WARC. See case records in appendix 1. The pre printed pages for recording cases had space to record the morning and evening visits made by the attending practitioner during the ten days following the birth.

[106] King, *MS 1121*, 1885, p. 689.

[107] *NZG*, 1905, pp. 1022-23, Regulation 10.2.

in the absence of the attending nurse[108] placed the pupil nurse in a supervisory role with the person engaged.

The formal and informal structures combined to prepare a pupil nurse as an independent midwifery practitioner.[109] The examination confirmed that the pupil had sufficient knowledge to take this responsibility. Successful candidates were entered upon the register of qualified midwives.[110] This carried a responsibility to keep the registering body informed annually of intent to practise midwifery in the following twelve months and of current home address.[111] This kept the register current and enabled the midwife inspectors to attempt to trace midwives who failed to notify intent to practice. Should a midwife prove untraceable she remained on the list with the words 'Not Found' beside her name. Failure to notify intent to practice for two consecutive years could lead to removal of the practitioner's name from the register. Reinstatement was possible upon application and would be made if the practitioner was entitled to be registered.[112]

The Midwives Act of 1904 marked the beginning of state involvement in midwifery practice.[113] It also marked a transition phase in the identification of midwifery as a profession for women. Neill hoped that a growing body of double certificated women would choose to make a career for themselves in nursing or midwifery and work in the senior positions in the hospitals.[114] Direct entry pupils were, however, welcomed into the midwifery training schools in equal numbers

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[108] *Health III*, B64, St Helens Hospitals, General 1905 - 38, WARC. Rules for the Attendance of Outdoor Cases in Charge of a Private Doctor.

[109] ibid. Telegram from the Department of Public Health, Hospitals and Charitable Aid, Wellington, New Zealand. The telegram identifies that midwives registered after a certain date would be qualified to practice on their own account.

[110] The Midwives Act 1904 [4 EDW VII, No. 31] *NZS*, 1904, Clause 14.

[111] *NZG*, 1905, pp. 1022-23. Clause 18. See also the Schedule in the same regulations.

[112] *NZG*, 1905, pp. 1022-1023, Clause 19.1. / 19.2.

[113] *NZPD*, 1904, p. 72.

[114] J. O. C. Neill, 1961, p. 51.

with registered nurses.[115] The former, on successful completion of their course, proved to be equally dedicated to the profession, and gave substantial years of service to the country as efficient midwives. Both untrained women and registered nurses continued to travel overseas for midwifery training and on their return swelled the growing numbers of qualified midwives working throughout New Zealand. Their careers were a mark of the success of their dedication to study, and the faith the state placed in the training and education of midwives as a means of reducing maternal and infant mortality.[116] It was believed that traditional midwives, now called Class B midwives, would quickly disappear from practice. Until this happened they were to be inspected and their practice improved through simple instructions, mainly in the use of antiseptics in practice. How effective the new midwifery service was in bringing the expected changes into reality and in creating a new career option for women is examined in chapter six.

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[115] *NZG,* 1905, pp. 1022-23, Clause 9. *NZG,* 1914, pp. 2534-35, Clause 9.

[116] C. J. Maggs, 1983, p. 127. Maggs states that the worth of the long years of nurse training can be judged by what happens to the practitioners following qualification.

Chapter Six

New Zealand European Midwifery post 1904: The Effects of Formalisation-A Professional Career for Women.

The introduction of midwifery training programmes opened new career directions for women, particularly professional nurses. Grace Neill believed that women who made nursing their lifetime career needed to hold certificates in both nursing and midwifery.[1] These women were to fill positions as hospital matrons, deputy matrons and ward sisters. To ensure this happened in midwifery the regulations supporting The Midwives Act, 1904 specified that the matron of the state maternity hospitals should be registered under both the Nurses Registration Act, 1901 and the Midwives Act, 1904.[2] The establishment of registers naming nurses and midwives entitled to register under both Acts was an important step in the process of developing the available midwifery services. It was expected that trained midwives would quickly replace the traditional midwives and that this would have a positive effect on the maternal and infant mortality rates.[3] This chapter examines the early midwives registers and inspectors reports for the clues they provide of the new professional midwifery services and the characteristics of those midwives who worked within the service following 1904.

Registration has been considered an important step in the professionalisation process demonstrating completion of a training programme and acquisition of a distinct body of knowledge proven through examination. This was so for newly qualifying nurses and midwives when the establishment of registers was linked with the passing of legislation such as 'The Nurses Registration Act, 1901', and 'The

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1 J. O. C. Neill, 1961, p. 51.

2 *NZG*, 1905, pp. 1022-1023, Clause 6.2.

3 Premiere Richard Seddon, *NZPD*, 1904. *Health III*, B64, St Helens Hospitals-General, NA, Letter from Grace Neill to the *Evening Post* dated May 1912. J. O. C. Neill, 1961, p. 89.

Midwives Act, 1904'.[4] Although this was true for Class A registered midwives those entered on the Class B portion of the midwives register were a mixture of trained and untrained women. Traditional midwives whose knowledge had been demonstrated to be unreliable did not fit comfortably into this characteristic of a professional although many did undertake and benefit from simple lectures.[5] However those who delayed their registration until after the 1st January 1906 could claim to have demonstrated their mastery of lectures, principally covering aseptic technique, which prepared them for a simple exam.[6] Successful candidates were entered on the Class B portion of the register. Another group of Class B midwives were entered on the general nurses' register having completed three year programmes in a general hospital.[7] It is possible that many others had failed to take advantage of the concessionary clause in the Nurses Registration Act, 1902[8] and had not taken general nursing registration when they were entitled to. If they were working as midwives when The Midwives Act, 1904 was passed they had a second chance to gain some recognition for their knowledge and expertise. For all of these women registration signified the right to practice midwifery.

Registers of New Zealand midwives also attested to the good moral character of the individuals named.[9] As a document the register of midwives was a means of maintaining contact with qualified practitioners. Over time it recorded their working life and marital status and presents a valuable tool in examining the career path of selected women. The probability is that very few of these women selectively planned their careers despite the changed career structure midwifery

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4 The Nurses Registration Act, 1901 [1 EDW, VII, No. 12] *NZS,* 1901. The Midwives Act, 1904 [4 EDW VII, No. 31] *NZS,* 1904.

5 *AJHR*, H-22, 1908, p. 9. C. & C. Manion, 1960, p. 54.

6 *AJHR*, H-22, 1907, pp. 3-5.

7 Class B Midwives Registered Under the Midwives Act, 1904, *NZG,* 30, April 28, pp. 1095-1097.

8 S. Wallace, BA thesis, University of Otago, 1987, p. 17.

9 The Midwives Act, 1904 [4 EDW VII, No. 31] *NZS,* 1904. Clause 4a, Clause 11a, 11b, 11c, Clause 12.

offered to women.[10] Notwithstanding this lack of career planning many women remained in midwifery for many years following registration as midwives. This is identifiable by tracing the career paths of a group of fifty seven women who trained in Wellington St Helens Hospital between 1907 and 1913.[11]

Until the passing of the Midwives Act in 1904 midwifery had traditionally been almost exclusively the domain of married women.[12] Both married and single women were admitted to the new training programmes, but few married women took advantage of this opportunity. Of those married women who did complete midwifery programmes retention over time was greater than fifty percent.[13] Three married women entered Wellington St Helens Hospital for training between 1907 and 1913. Two of the three women continued in practice in 1921. One of these women had at this time practised for nine years, the other for eight. The third woman had practised for six years before failing to notify intent to practice.

The marital status of fifteen women who trained during this period is unknown. At no stage during the period examined do their surnames change. Although a change of surname alone is no indication that a woman has married, linked with the title, Mrs, this assumption has been made throughout the investigation. All those women considered to have married following midwifery training have this title. Their single name is also given in brackets next to their marital name. (See Table 12 and Appendix 2).

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[10] C. J. Maggs, 1983, p.135. Maggs indicates that few women entered general nursing with a clear idea of making nursing their career.

[11] *ABBR*, 6902/1, 1907-1913, WRAC. Of this group 1 woman whose name appears in the Casebook in 1911 is difficult to decipher and no match is identifiable in the register of midwives published following this date. See also case records Appendix 1. The nurse attending each case is identified within the records.

[12] The Gazetted lists of untrained but registered midwives who appear in the Class B list of practising midwives is made up almost exclusively of married women. See New Zealand Gazettes between 1906 and 1933.

[13] ibid. This figure is obtained by examining the career paths of 57 women whose names appear in the Home Delivery Casebook as pupil nurses attending the recorded outside cases.

Table 12: Spread of single and married women entering midwifery training in Wellington, St Helens Hospital between 1907-1914.

YEAR	SINGLE	MARRIED	UNKNOWN
1907 FIGURES INCOMPLETE	3	0	0
1908	3	0	0
1909	5	0	1
1910	9	0	2
1911	3	0	3
1912	8	1	0
1913	7	2	8
1914- FIGURES INCOMPLETE	1	0	1
TOTAL	39	3	15

Source: *ABBR*, 6902/1, Home Delivery Casebook - 1907 - 1913, WARC.

Concern was expressed that single women who undertook midwifery training would be lost to the profession if they married.[14] However some believed that the knowledge and skills they gained would benefit them in any situation they faced in the future, particularly motherhood.[15] Single women did make up the larger proportion of New Zealand trained midwives, many entering into marriage after qualifying. Despite this their contribution to the new midwifery service was equal to that of women who entered programmes as married women.[16] Of the identified group 39 were single at the commencement of their training. Fifteen of this group married following registration and before 1921 by which time two were still in practice as midwives.[17] One had been in practice for 12 years and one for eight years. Five others in this group had practised for six years or longer. These women could still have been practising in 1921 although they had failed to notify their intent to practice during that year.

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[14] *NZPD*, 1904, pp. 70-91.

[15] Premier Richard Seddon, *NZPD*, 1904, p. 71. C. J. Maggs, 1983, p.134-5. The belief that nursing training helped to prepare a young girl for marriage and motherhood was held by individuals in Britain around 1905.

[16] *ABBR*, 6902/1, 1907-1913, WRAC., Lists of Practising Midwives, Class A, *NZG*, 1907 - 1921. See also Appendix 2.

[17] ibid.

The women who entered midwifery practice as single women and remained single had the greater input into midwifery services during the period under examination.[18] Eleven were still in practice in 1921, six had been in practice the previous year but had not notified intent to practice during 1921. Of this last group one had given 12 years of service as a midwife before failing to notify intent to practice. This woman was listed as 'not found' in 1921. The average length of service in this group was between nine and 11 years with 14 years being the longest period of practice.

A group of women whose marital status was unknown followed a similar pattern of service to that of the single women who married. One of this group practised for 11 years, two for ten years. Three practised for eight years whilst three more served for six years. Two others contributed seven years, and one gave three years. Six of these women were still in practice in 1921, one had failed to notify intent to practice in 1921 and had been practising as a Plunket Nurse during the previous year.

The graph below shows the career length of all women in the group. The average length of service within all groups was between eight and nine years.[19] One woman provided a service of at least 14 years within the period examined. This woman's career continued beyond this point and constituted undoubted value for the expenditure invested in her training. The fears of politicians concerning post marital retention and the cost of training single women proved groundless within the examined group.[20]

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[18] ibid.

[19] Lists of Practising Midwives, Class A, *NZG,* 1907 - 1921. Figures for this graph were collated from the Gazetted lists of Class A midwives which show current practising status and marital status. The group of women whose marital status is unknown is comprised largely of a group trained between July 1913 and January 1914.

[20] *NZPD*, 1904, pp. 70-71.

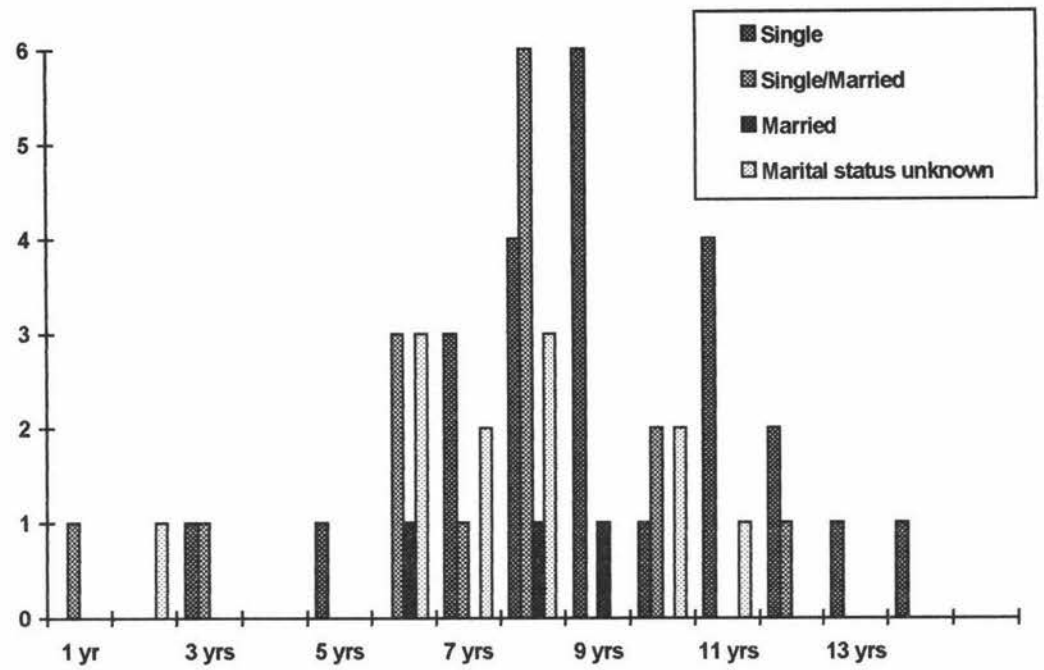

Figure 4: Midwives trained at St Helens Hospital, Wellington, between 1907 - 1913 showing length of years in practice in relation to marital status at time of training.

Sources: *ABBR*, 6902/1, 1907-1913, WARC. Lists of registered nurses and midwives, *NZG*, 1907-1921.

Dual registration as both a nurse and midwife was considered necessary before taking senior positions[21] yet many women trained in only the one discipline of midwifery.[22] Direct entrants to St Helens Hospital programmes outnumbered those who entered with general registration by more than two thirds. Similar trends were evident in other New Zealand midwifery training schools and in overseas programmes as is demonstrated in Table 20 below.

The single certificated women proved equally dedicated to this profession as those with dual certification. Of the 57 midwives represented in figure six 16 were dual certificated, 40 were single certificated, that is direct entry midwives.[23] Although it was popular for women to complete nursing training first occasionally a woman

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[21] J. O. C. Neill, 1961, p. 51.

[22] Lists of midwives entitled to be registered under 'The Midwives Act, 1904", *NZG*, 1905-1920. See also Table 12 in text.

[23] See Appendix 2.

Table 13: Midwives registered in New Zealand 1905-1920 showing differentiation between direct entry midwives and registered nurses with midwifery registration.

Place of Training	Direct Entry RM	RN. RM.
St Helens Hospitals	487	143
Other N. Z. Hospitals.	178	70
Australia/Tasmania	62	29
Central Midwives Board (CMB)	65	36
London Obstetrical Society (LOS)	13	5
CMB/LOS	13	9
Other	66	25
Total	884	317

Sources: Lists of midwives registered under 'The Midwives Act, 1904', *NZG*, 1907-1920.

would move in the other direction and seek general registration after completing midwifery training.[24] The amount of postgraduate nursing experience general nurses undertook before entering midwifery varied between one and ten years with the mode being 3·33 years.[25] This enabled the nurse to develop a degree of expertise in her nursing practice before choosing to train as a midwife. Over time the retention in midwifery practice of general trained nurses who undertook midwifery training was not good. In 1923 it was reported that many registered nurses saw midwifery training as an extension of their nursing qualification and did not intend to practice as midwives on completing their training.[26]

The concept of 'practice' was defined as being engaged in midwifery work. Midwives who were employed in the Government service or in public or private hospitals where midwifery work was not performed were considered not to be in

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[24] ibid. See Mrs. Neilsene Chappell, nee Jensen who registered as a midwife in January 1909 and as a general nurse in June 1914.

[25] C. J. Maggs, 1983, p. 145. Maggs believes that postgraduate training frequently took place immediately after completing general training and that those who then took senior positions had very little expertise to support their practice.

[26] *AJHR*, 1923, p. 32.

practice.[27] These people were exempt from the need to notify intent to practice. The St Helens Hospitals were government institutions and staff were included in the exemption of notifying intent to practice.

Owning and running a private hospital was a possible career option for many midwives. In 1910 a list of people who were applying for licences to run private hospitals was published in the New Zealand Gazette.[28] This list held 202 names and addresses. Almost half of these, 97 in total, were Class B midwives.[29] Two of this group were also registered nurses whilst one had a relative working with her who was a Class A midwife.[30] Approximately a sixth, 36 in total, were registered either as single certificated midwives or registered nurses with additional midwifery qualifications. Within this group 28 women had trained overseas either in England or Australia. Two double certificated midwives from the previously identified group worked in private hospitals following their training. Both were single women who had worked as midwives for 13 and 14 years respectively in 1921.[31] Although other women in the group worked for short periods in private hospitals they were in the minority as owners of registered private hospitals.

When the new midwifery training was introduced it was believed that the traditional midwives would very quickly disappear from practice.[32] Many women who worked as traditional midwives in all probability did cease to practice when the Act came into force. Women like Sarah Higgins who delivered her last baby

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27 *NZG,* 1905, pp. 1022-1023, Clause 20.

28 List of Private-Hospital Licensees as at 1st April, 1910, *NZG,* 33, April 14, 1910, pp. 1168-1169. See also appendix 3 for identification of Class B midwives within this list

29 *NZG,* 1910, pp. 1168-1169. See also appendix 3.

30 See Mrs. Mrs. L. King, Misses Margetts and E. Nicholson, appendix 3.

31 Miss Linton trained in 1908 and ran a private hospital in Palmerston. In 1921 she had worked for over thirteen years as a midwife. Miss Neale also trained in 1908. She ran a private hospital in Wellington and worked as midwife for eleven years before failing to notify intent to practice.

32 *AJHR*, H22, 1909. P. 10.

in 1906 at the age of 74 did not bother to take out registration.[33] Others like Granny Harrold (1830/31? - 1903) a seemingly exemplary practitioner, predeceased the Act by a year.[34] The lists for both Class A and Class B midwives were very short in the first year of publication, 1905, containing only seven names on the list of Class A midwives and thirty five names on the list of Class B midwives.[35] A ratio of 1 Class A midwife to every five with Class B registration. The list of Class B registered midwives had grown to 662 in 1906. The numbers continued to grow as traditional midwives took advantage of their opportunities to gain registration and by the time the register was closed to them in 1907, 905 women were named on the Class B list At this time the list of midwives with Class A registration had grown to 176, that is one Class A midwife to every 5.14 Class B midwives. Ten years after the Midwives Act, 1904 was passed the number of both Class A and Class B midwives was relatively equal and from this point onwards the Class B list slowly dropped whilst the Class A list continued to grow. (See Table 14). By 1933 when the last Gazetted lists were published only 249 names remained on the Class B list, 219 being in practice.[36]

The requirement was that women had to have been in practice for three years in order to register as Class B midwives. This ensured some degree of expertise could have been developed.[37] The three year requirement was a departure from the imperial requirement that midwives should have been in practice for one year in order to qualify for registration as a bona fide midwife.[38] England however did have existing programmes and therefore a pool of trained midwives to provide care. Even so they also had a shortage of midwives and accepted the traditional

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[33] Sarah Higgins, *MS Papers 1146,* WTU, Sarah's name does not appear on the early lists of Class B registered midwives.

[34] B. Harper, 1980, pp. 94-97.

[35] List of midwives registered under 'The Midwives Act, 1904', *NZG,* 1905, p. 937.

[36] *NZG, 1933,* p. 1393.

[37] The Midwives Act 1904 [4 EDW VII, No. 31] *NZS,* 1904, Clause 6.

[38] The Midwives Act, 1902 [2 EDW VII, CAP 17] *BPS,* 1902, Clause 2.

Table 14: Midwives registered in New Zealand in 1905/06/07/08/10/15/20/20/30 showing ratio between Class A and Class B in practice.

Key: * = This official figure differs from the total number of names which appears in the *NZG* list of midwives registered under the 1904 Act.

¤ = Although 'bona fide' midwives continued to practice for similar lengths of time in England following the Midwives Act, 1902 nine years later larger numbers of trained midwives were in practice in England than for the same period in New Zealand.

Year → Type of registration ↓	1905	1906	1907	1908	1910	1915	1920	1924	1930
Class B	35	662 698*	850	905	748	658	411	241	249
Class A	7	63	114	176	284	681	1085	1688	2613
Number of Class A midwives to Class B midwives registered.¤	1 in 5	1 in 10.50	1 in 7.45	1 in 5.14	1 in 2.63	1 in 0.95	1 in 0.37	1 in 0.14	1 in 0.08

Sources: List of midwives registered under 'The Midwives Act, 1904', *NZG,* 1905, p. 937, *NZG,* 1906, p. 1126-1130, *AJHR*, H-22, 1907, p. 4. *AJHR*, H1-N23, 1909, p. 10. List of Midwives registered under 'The Midwives Act, 1908', *NZG,* 1910, pp. 1170-1180. *NZG,* 1915, pp. 1217-1235. *NZG,* 1920, pp. 1269-1294. *NZG,*1924, pp. 762-798. *NZG,* 1930, pp. 1341-1393.

* = *AJHR*, H-22, 1906, p. 3.

¤ = C. Webster, 1993, p. 76.

midwives as a temporary measure until sufficient trained midwives registered.[39] New Zealand traditional midwives had until the 1st January 1906 to apply for admittance to the register.[40] Many did not take this opportunity to legalise their practice and were given a second opportunity provided they were able to pass a simple examination which was introduced following the closing of the Class B register.[41] For a small group of Class B midwives this meant two attempts at sitting the examination after a petition was made to parliament on their behalf.[42]

Attempts were made to inspect as many Class B midwives as possible during a year. This identified a variety of knowledge and abilities within their practices.[43] Those who worked well and safely had integrated the knowledge they had acquired through practice into each new situation they faced. Others demonstrated poor skills and knowledge and needed instruction to improve their practice. Attempts were made to link them into the St Helens Hospital lectures. This was unsuccessful as Hester Maclean considered that theoretical training should be combined with the practical component which should be supervised by a 'well-trained matron'.[44] Further justification for refusing their admission to the lectures supported the requirement that pupil nurses should have received an elementary education.[45] Lectures were above the comprehension of the traditional midwives who were stated to be mostly uneducated and therefore ineligible to train for the certificate of midwifery. Bringing the lectures down to their level of understanding would have defeated the purpose of The Midwives Act, 1904 which was to remove these women from practice. A more effective way of improving their knowledge and practice was to develop a course of simple instruction at their level of

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[39] N. Leap, B. Hunter, 1993, p. 4.

[40] The Midwives Act, 1904 [4 EDW. II, No. 31] *NZS,* 1904, Clause 4a.

[41] *AJHR*, H-22-1, 1907, Report on Private Hospitals, pp. 3-5.

[42] *AJHR*, H-22, 1908, p. 8.

[43] *AJHR*, H-22, 1909, p. 10.

[44] *AJHR*, H-22, 5, 1908, p. 9.

[45] *NZG,* 1905, pp. 1022-1023, Regulation 2.

understanding. Linked with inspection of their work this would assist in improving their practice.[46] Those traditional midwives who attended the lectures provided in their areas found them helpful.[47]

Dr Agnes Bennett was involved in examining many of the traditional midwives for placement on the Class B register of midwives. This responsibility confirmed Dr. Bennett's belief that these women had difficulty in understanding Listerism, and in applying this in their work. Their attitude to the birth process was however far more disturbing. They considered this part of their work unenjoyable and dirty, preferring to have a doctor conduct the birth[48] with themselves taking the role of a monthly nurse.[49] When they attended births they were dressed in dirty clothes, an action which scientific research had proved responsible for the spread of infections in the past[50] This action was considered by the nurse inspectors to be part of the reason their patients had developed puerperal infections.[51]

Some of the traditional midwives had a very different understanding of how their patients contracted puerperal infections. This did not change over time and was articulated by two midwives struck off the Class B register in 1924. The first midwife did not understand the principles of aseptic technique. She had dirty hands and had manually removed the placenta in a patient she attended for delivery. The patient had developed puerperal sepsis in the post natal period.[52] The midwife had not detected the development of puerperal sepsis in her patient and did not have a

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[46] *AJHR*, H-22, 5, 1908, p. 9.

[47] ibid. p. 10. *Report of the Female Sanitary Inspectors 1902-11,* Wm. Byles & Sons Limited, Printers, Piccadilly/Tapp & Toothill Ltd., Printers, Bradford, This report identifies similar arrangements in England. See also chapter 1 of this thesis.

[48] C. & C. Manion, *Dr. Agnes Bennett,* London, Michael Joseph, 1960, p. 54.

[49] M. Chenery, *Pocket Handbook for Monthly Nurses,* Lowestoft, W. Gwynn, London, Simpkin and Co., c1910.

[50] King, *MS 1119,* 1992, pp. 65-66.

[51] C. & C. Manion, 1960, p. 54. H. Maclean, *Nursing in New Zealand: History and Reminiscences,* Wellington, Tolan Printing Company, 1932, p. 60.

[52] *Health I,* 21/29, Removal of registered midwives from register, WARC.

thermometer.[53] She thought the patient's husband was to blame for the infection. He worked in the drains at the Glaxo factory and had slept with his wife in the underwear he wore to work.

The second Class B midwife inspected at the same time made a similar statement about one of her clients who became ill with puerperal sepsis. She had also failed to detect the development of puerperal fever in her client and lied about taking a temperature when she was unable to recognise a thermometer or to read one when asked to do so.[54] This midwife believed the husband had caused the infection. He had slept in the same room as his wife and had a cough which produced blood and sputum. He had since been hospitalised with tuberculosis.

These two scenarios and the discoveries made by Dr Bennett illustrate the very real danger some traditional midwives posed to their patients. This did not change over time. In 1924 the regulations set in 1914 to support the Midwives Act, 1908, an Act which revoked the 1904 Midwives Act, were replaced. The new regulations were very explicit in describing how midwives were to apply the aseptic technique in their practice and in what situations medical help should be sought.[55] The midwifery bag and its contents were equally explicitly described. Despite these instructions the Class B midwives who were illiterate[56] would have been unable to read and make use of the information in their practice.

Compulsory midwifery training and registration did not act as a deterrent to those who had a desire to become midwives. It did open up a new career opportunity for all women, married and single. The length of time many practised ensured a degree of expertise was gained following registration. These factors led to a better co-

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[53] ibid

[54] ibid.

[55] *NZG*, 1905, pp. 2207-2213.

[56] *Health I*, 21/29, Removal of registered midwives from register, WARC. C. I. Baldwin, 1996, p. 246-47.

ordinated midwifery service which displayed the characteristics of a profession the public should have had confidence in. The maternal and infant mortality statistics were a criterion against which the new service could be measured.

Despite the improvements in care the changes had minimal effect on maternal mortality figures between 1904 and 1907 when midwifery training schools were being established. Several issues can influence the interpretation of the statistics between 1904 and 1920. The birth rate increased from 1902 until 1909 after which time it fluctuated before dropping dramatically in 1918. The First World War between 1914 and 1918 is believed to have influenced the birth rate.[57] The introduction of The Bertillon Index of Diseases (TBID) as a framework for measuring mortality also influenced the interpretation of maternal mortality statistics from 1908.[58] This was the framework used in other Commonwealth countries.[59] The introduction of this system in New Zealand was expected to assist in the accuracy of statistical comparisons between countries. The main change within this framework was the inclusion of deaths from puerperal septicaemia alongside other maternal deaths. Previously it had been listed as a condition under the septic order of zymotic diseases.[60] Despite this listing format it was recognised as early as 1886 that deaths from puerperal septic conditions should be added to the total number of maternal deaths. Other changes included separation of accidents occurring at the different stages of pregnancy and new categories for puerperal deaths. The old category of 'other accidents of childbirth' made up by far the largest group of maternal deaths and included those occurring during childbirth and the puerperium. Accidents of pregnancy appears to replace in TBID and to include placenta previa (flooding). These deaths appear to have doubled between 1908 and 1909 and to have risen further until 1912 when they dropped again by almost half with the exception of 1915

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[57] *NZYB*, 1920, p. 22.

[58] ibid. p. 43.

[59] *NZOYB*, 1920. P. 43.

[60] Report of the Registrar General, Statistics of New Zealand 1886, Wellington, Government Printer, 1887. p. xxiv.

Table 15: Maternal Mortality 1904 - 1920.

Year → Cause of Death ↓	1904	1905	1906	1907	1908	1909	1910	1911	1912	1913	1914	1915	1916	1917	1918	1919	1920
Abortion/Miscarriage	19	20	11	13	-	-	-	-	-	-	-	-	-	-	-	-	-
Puerperal Mania	2	1	1	1	-	-	-	-	-	-	-	-	-	-	-	-	-
Puerperal Metritis	-	-	-	1	-	-	-	-	-	-	-	-	-	-	-	-	-
Puerperal Albuminuria Eclampsia	-	-	-	-	10	16	11	8	16	10	18	32	24	37	30	36	37
Puerperal Convulsions	19	9	10	13	-	-	-	-	-	-	-	-	-	-	-	-	-
Puerperal Haemorrhage	-	-	-	-	1	2	13	11	13	14	17	14	20	18	11	10	40
Placenta Previa [flooding]	11	17	19	15	-	-	-	-	-	-	-	-	-	-	-	-	-
Phlegmesia Dolens	-	1	1	-	-	-	-	-	-	-	-	-	-	-	-	-	-
Other Accidents of Childbirth and Labour	-	-	-	-	42	19	4	5	28	17	19	18	26	16	19	11	12
Other accidents of childbirth	34	31	34	44	-	-	-	-	-	-	-	-	-	-	-	-	-
Accidents of Pregnancy	-	-	-	-	18	31	35	43	22	25	21	38	27	27	15	9	26
Other Puerperal Accidents	-	-	-	-	2	34	19	20	2	5	8	7	10	8	11	6	12
Puerperal Septicaemia, Puerperal fever, Pyaemia, Septicaemia	28	21	18	29	-	-	-	-	-	-	-	-	-	-	-	-	-
Puerperal Septicaemia	-	-	-	-	46	33	35	27	19	29	35	22	60	59	48	52	67
Total Maternal Deaths	85+28 = 113	79+21 = 100	86+18 = 104	87+29 = 116	119	135	117	114	100	99	118	131	167	165	134	124	194
% Of Total Births	0.49%	0.42%	0.42%	0.46%	0.45%	0.50%	0.45%	0.43%	0.36%	0.35%	0.41%	0.47%	0.58%	0.58%	0.51%	0.50%	0.64%
Total Births	22,766	23,682	24,252	25,094	25,940	26,524	25,984	26,354	27,508	27,935	28,338	27,850	28,509	28,239	25,860	24,483	29,921

Source: Statistics of the Colony of New Zealand for the years 1904-1906, Wellington, Government Printer. Statistics for the Dominion of New Zealand for the years 1907-1920, Wellington, Government Printer.

when there was a steep rise to 38 of the total 131 maternal deaths. A category for other puerperal accidents as separate from puerperal septicaemia embraced phlegmesia dolens, puerperal mania and puerperal metritis whilst puerperal haemorrhage was listed separately. Puerperal convulsions replaces the old puerperal albuminuria and eclampsia. The remaining section of other accidents of childbirth was changed to embrace accidents of childbirth and labour.[61] These changes are demonstrated on Table 16 below and in Table 15 above.

Table 16: Correlation between categories for maternal deaths following introduction of The Bertillon Index of Diseases in 1908 and categories used prior to this date.

Old category	New category
Abortion/miscarriage	Accidents of pregnancy
Placenta previa (flooding)	Accidents of pregnancy
Other accidents of childbirth	Other accidents of childbirth and labour
Puerperal albuminuria, Eclampsia	Puerperal convulsions
Phlegmesia dolens	Other puerperal accidents
Puerperal mania	Other puerperal accidents
Puerperal metritis	Other puerperal accidents
	Puerperal haemorrhage
	Puerperal septicaemia

Sources: *SCNZ 1907*, Wellington, Government Printer. *SDNZ 1908*, Wellington, Government Printer.

Two major areas of concern in the statistics, accidents in labour and childbirth and puerperal sepsis, were specifically addressed in the syllabus for midwifery training programmes. The introduction of Listerism was to reduce the incidence of puerperal sepsis.[62] Knowledge of the management of natural labour[63] and the signs of an abnormal labour was to reduce the other accidents of childbirth and labour by

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[61] SCNZ, 1886 - 1906. *SDNZ*, 1907 - 1920.

[62] *NZG*, 1905, pp. 1022-1023, Regulation 1 (f), 1(g), 1(k), 1(l).

[63] ibid. Regulation 1(c).

alerting the midwife to changes which required the assistance of a medical doctor.[64]

Infant mortality statistics were reduced by the development of the Plunket Society which had been introduced initially in Dunedin in 1907.[65] The effect this had on infant mortality was to reduce the deaths that occurred following the first month of life.[66] This was attributed to the improvement in sanitary conditions and to the care and education on infant welfare, including feeding, provided by the Plunket Society. This work has been identified as a factor in reducing the infant deaths from diarrhoea and respiratory diseases both of which were prominent causes of infant death following the first month of life.[67] Improvements in female literacy have also been linked with changes in infant mortality.[68] The change to TBID as a statistical framework in 1908 also affects the interpretation of infant mortality figures. The terms zymotic and miasmatic were replaced by specific infectious diseases.[69]

Deaths that occurred in the first month of life were closely associated with maternal mortality and the mother's experience of pregnancy. Prematurity, birth injury and congenital malformations were main causes of this group of infant deaths.[70] These three causes could also be factors in the stillbirth rate which was not officially recognised until 1913. Reduction of these causes lay in the development of ante natal care which was closely addressed in 1924 with the

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[64] ibid. Regulation 1(d).

[65] F. S. Maclean, 1964, p. 177-178. Maclean states that there was no interest in reducing the infant mortality figures when the Plunket Society was introduced and that nothing was done to reduce maternal mortality until 1923. (p. 177) .

[66] ibid. p. 178.

[67] ibid. p. 178.

[68] C. Webster, 1993. p. 12.

[69] G. W. Rice, in L. Bryder, editor, 1991, p. 94.

[70] F. S. Maclean, 1964. p. 177.

introduction of ante natal clinics.[71] At the same time lectures on ante natal care were introduced into the midwifery training programmes. These actions were seen as a direct approach to the continuing problem of maternal mortality and to the still-birth rate and infant mortality occurring in the first month of life.

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[71] *AJHR*, 1925, p. 32.

Conclusion

The Impact of Formalisation on Midwifery Practice in New Zealand.

The introduction of 'The Midwives Act, 1904' was a direct action to change the structure of New Zealand midwifery practice then in existence.[1] The changes this meant for society, for women collectively and individually, and for midwifery as a profession were far greater than the debate on the Bill indicated. At the time this act of formalisation was considered important to the continued well-being and strength of the European people resident in New Zealand. That the expected improvements in health and national strength would not happen within the then foreseeable future was only apparent as time evolved.[2] However eight years after the Act was passed those women practising Midwifery were of the opinion that the expected outcome had been achieved.[3] That politicians, doctors and midwives continued to have concerns related to the same issues twenty years later raises questions as to why the Act was passed and how this had affected the practice of midwifery in the following decades.[4]

The dominant concern raised during the debate on the Midwives Bill was the number of maternal and infant deaths that occurred during and immediately after childbirth. The fear and anxiety this caused to individuals facing confinement was apparent in the discussion that occurred.[5] Although Seddon acknowledged that government had at that time done nothing to relieve this apprehension he nevertheless claimed that midwives were to blame for the situation. Their lack of

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1 Premier Richard Seddon, *NZPD*, pp. 70-90.

2 C. Webster, 1993, p. 6-7.

3 Valedictory, *JNNZ*, April, 1912, p. 23.

4 P. M. Smith, 1986. Smith provides a classic study of the disputes and issues present in midwifery between 1920 and 1939.

5 *NZPD*, 1904, pp. 70-90.

formal preparation as practitioners,[6] and failure to incorporate new knowledge of the containment of disease into practice were the root of the problem. Enforcing change in the teaching of midwives through statute was the mission and duty of the government. It was believed this education would reduce the mortality statistics of both mothers and infants thus making childbirth safer.[7]

The official characterisation of the traditional New Zealand midwife pre 1904 was of an elderly woman, educationally and professionally disadvantaged, who carried death and disease with her to all cases of childbirth she attended.[8] This description replicates that found in England and other parts of the world.[9] This portrait of the midwife was implicated within the decision to formalise midwifery in England and New Zealand. The unofficial New Zealand vision of the same person identifies her as a stalwart individual who brought comfort by her very presence to all she attended.[10] The latter individual was officially recognised in her community for her services as a midwife and received remuneration, often in kind, for the care she provided.[11] These attributes identify her as a professional of the old order,[12] a position also described as sub-professional.[13] At the same time these virtues place her in disharmony with the newly emerging image of professionalism[14] that midwives in other parts of the world were developing

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6 Premier Richard Seddon, *NZPD,* 1904, p. 70.

7 Seddon, *MS 1619,* WTU.

8 *NZPD,* 1904, pp. 70-1.

9 A. R. Ward, 1981, pp. 190-194, & pp. 237-242. I. Loudon, 1992.

10 Anon, *WDNZFU,* 1939.

11 *Health I,* Hester Mclean - Midwives Registration, WARC. Letter from a Mr. Cooper of Waihow which details his perspective of the differences in payment for midwifery services pre and post The Midwives Act, 1904. C. Webster, 1993. p. 30.

12 R. Marshall, NM, 1983, pp. I-vi.

13 T. W. H. Brooking, 1980, p. 21.

14 S. Wallace, BA thesis, University of Otago, 1987, pp. 66.

through formalisation which embraced legislation and specified standards of practice.[15]

The move to formalise New Zealand midwifery practice in 1904 was a pro active action on the part of Grace Neill and Alice Holford aimed at changing the public image of midwives and providing a safe environment in which the working class woman could give birth.[16] The interest of Premier Richard Seddon was ensured as he believed the experiences at maternity were directly influencing the rate of natural increase and the health of the European New Zealand population.[17] The task of effecting a change was enormous, but not impossible. The impact of the change could only be measured over time.

As a venture into reform the process was part of a much wider movement to improve public health which followed in the wake of four major developments in public health care. These were vaccination, anaesthesia, antiseptic surgery and knowledge of the causation of infectious diseases.[18] This movement of reform originated in England and was widely believed to be the answer to pressing issues of mortality which had become associated with ignorant traditional practitioners. In fact the changes which took place constituted the separation of a multifaceted health consortium of lay and formal care providers into individual professional groups with competing rivalries for the right to provide care to the public at large.[19] As time evolved and the sense of professionalism within work groups emerged this early change became visible as a phase in the progressive development of professions.

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[15] The Midwifery Nurses Act, 1902 [I EDW VII, No. 24] *Tasmanian Statutes,* 1901. The Midwives Act, 1902 [2 EDW VII, CAP 17] *BPS,* 1902.

[16] J. O. C. Neill, 1961, 55. B. Salmon, 1991, 305-07.

[17] Seddon, *MS 1619,* WTU, See Seddon memorandum on Child Life Preservation in New Zealand, May 7, 1904.

[18] C. Webster, 1993. p. 6.

[19] C. Webster, 1993. pp. 22-30. T. W. H. Brooking, 1980, p. M. Belgrave in L. Bryder, 1991, pp. 9-12 & 16-20.

The world view of both Neill and Holford was influenced by experiences of midwifery practice outside New Zealand.[20] Each held strong beliefs regarding the impact changes could have on both practitioners and patients. The most effective way of enforcing change on all existing practitioners was to set standards supported by statute. This would enable formalisation of practices embracing new scientific methods to become a standard part of midwifery care. Such care would be supported by a greater depth of knowledge regarding the process of pregnancy, labour and post natal care of the mother and baby. In short the midwife would become a knowledgeable and safe practitioner able to work autonomously in the social environment of the time.

Previous Health Acts passed in New Zealand had been adaptations of existing English statutes and had been considered to be compatible with the developing public health services in New Zealand.[21] The expectation that the English Midwives Act could be similarly utilised was a reasonable assumption. This Act had been designed to eliminate from practice those who were unable to work safely and knowledgeably as midwives.[22] The component clauses which made up the Act were considered effective in their purpose within the English midwifery system.[23] Adapting this Act to achieve the same changes in New Zealand made the preliminary work in drafting the Bill much easier to accomplish, and, as existing conditions in both countries were not dissimilar such a move was also considered appropriate. The acceptance of the Bill in parliament set in place new

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[20] J. O. C. Neill, 1961, 55. B. Salmon, 1991, 305-07. Neill had trained as a general nurse and midwife in England. Holford had traveled to Australia to train as a midwife.

[21] F. S. Maclean, 1964, pp. 11 & 419.

[22] *BPS*, 1902.

[23] C. Webster, 1993. P. 6-7. Webster states that this belief constitutes a 'triumphalist fallacy' which did not bear fruit over time as the expected results were impossible to achieve. In fact the English Midwives Act had only been operative for two years when New Zealand adapted it for use in the Colony.

professional expectations incorporating scientific developments considered to be effective in reducing maternal mortality.[24]

The formalisation of midwifery practice through The Midwives Act, 1904 clearly set in place the characteristics considered to be displayed within a profession at that time.[25] Although this did not bring immediate changes within the midwifery services it was a positive step taken to bring about improvements. The trained midwives practising in 1912 believed they had successfully brought about the demise of the traditional midwife in New Zealand.[26] Although they were not entirely correct in their belief the standards set in place following the Act did provide a check on the inappropriate and often dangerous practices some traditional midwives demonstrated.

The most significant aspect of the changed midwifery service was the behaviour of the practitioners. New recruits to the service were taught to incorporate the new medical approaches to midwifery into their practice. Listerism was all important to the issue of safety for the mother. Aseptically clean hands and instruments, clean clothes worn at each new case, ensured this. A clean environment within which to practice completed the approach. These aspects of care, considered to be beneficial to the health recipient, were the consequences of the formalisation of health care provision.[27] In time they were also instrumental in swinging midwifery care in the direction of medical control and out of the hands of midwives, a factor which created rivalry between doctors and midwives[28] and changed the experience of childbirth for many women.[29]

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[24] J. O. C. Neill, 1961, p. 89. Formal statement by Seddon indicating that 'The Colony must keep abreast of the times and the introduction of Listerism into Midwifery practice has brought about a tremendous diminution in what once occasioned an appalling mortality.[24]

[25] S. Wallace, BA thesis, University of Otago, 1987, p.66.

[26] Valedictory, *JNNZ*, V:II, April, 1912, p. 23.

[27] C. Webster, 1993. p. 12.

[28] P. M. Smith, 1986.

[29] C. M. Parkes in L. Bryder, 1991, pp. 165-180.

The systematic development of theoretical knowledge leading to qualification as a midwife is clearly identifiable within the course prescription sanctioned by the New Zealand Midwives Act, 1904.[30] Knowledge of female anatomy and reproduction, the normal and abnormal progression of labour, post natal care of mother and baby were embraced within the curriculum.[31] The concept of Listerism was central to this learning[32] and, as a universal precaution used to prevent infection,[33] was shared across disciplines including medicine, nursing and midwifery. Of these three professions medicine was dominant. Medicine was also the discipline in which Joseph Lister, the person credited with researching the effectiveness of antiseptics against pathogenic organisms, was qualified. The universal aseptic technique, central to later developments in New Zealand midwifery,[34] was linked with the process of change from home births to hospitalised births.[35]

A belief by medical personnel that the application of Listerism in the home environment and in private maternity hospitals was not possible has been implicated within the move to transfer all births into a hospital environment where aseptic technique could be achieved.[36] Support for this belief is seen in the maternal mortality statistics for puerperal sepsis following the introduction of midwifery training schools and the application of Listerism in 1904.[37] (See Table 15, p. 103). These statistics do not show a national reduction in the septic condition. However the outside cases attended by pupil nurses at Wellington St Helens Hospital between 1907 and 1913 show a regional containment and

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[30] *NZG,* 1905, pp. 1022-23.

[31] *NZG,* 1905, pp. 1022-23.

[32] J. O. C. Neill, 1961, p. 89.

[33] H. Morten, 1900, p. 82.

[34] J. Donley, 1986, pp. 43-45.

[35] P. M. Smith, 1986, pp. 64-66, G. Smith, B A Honours, Massey University, 1987, p. 4.

[36] G. Smith, B A Honours, Massey University, 1987, p. 5-6.

[37] *SCNZ,* 1904-1906. SDNZ 1907-1920.

reduction in puerperal sepsis through the use of antiseptics, particularly when these are administered in vaginal and uterine douches.[38] These cases demonstrate that an understanding of, and committment to the use of Listerism within practice, regardless of where that practice takes place, could contain and reduce the incidence of puerperal sepsis.

The Midwives Act, 1904 was instituted to remove from practice the traditional midwives whose knowledge and application of Listerism was limited and misguided.[39] Despite this move the traditional midwives continued in practice post 1904 in numbers greater than those of qualified registered midwives for the next ten years.[40] These midwives, vital to the continuance of a maternity service, were largely involved in running private maternity homes.[41] Establishments which proved in time to be unsatisfactory situations for the practice of aseptic technique, yet were allowed to remain open in many instances due to the lack of other available facilities. These two variables, instrumental in future fatalities,[42] could be the link with the continued problems with puerperal sepsis which formed a large proportion of maternal mortality statistics in the two decades following The Midwives Act, 1904 and led to the eventual closure of 'twenty-one maternity hospitals of the smaller class' due to the low standard of efficiency particularly in regard to the practice of asepsis.[43]

The statistics used to measure the success of the changes to the service were themselves undergoing changes. The introduction of TBID changed the focus of

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[38] *ABBR*, 6902/1, Home Delivery Casebook - 1907-1913, WARC.

[39] *NZPD*, 1904, pp. 70-91. *Health I*, 21/29, Removal of registered midwives from register, WARC. C. & C. Manion, 1960, p. 54.

[40] List of registered midwives under the Midwives Act, 1904, p. 937, *AJHR*, H-22, 1907, p. 4, *AJHR*, H-22, 1909, p. 10, G. Smith, B A Honours, Massey University, 1987, p. 12.

[41] *NZG*, 1910, pp. 1168-1169, G. Smith, B A Honours, Massey University, 1987, p. 12-13. See also Appendix 3.

[42] P. M. Smith, 1986. G. Smith, B. A. Honours, Massey University, 1987.

[43] *AJHR*, H-31, 1930, p. 52.

maternal mortality towards puerperal sepsis which had until then been consumed under the figures for general septic conditions. Despite these changes it is evident that an immediate change in the statistics was not achieved by the introduction of specialised training for midwives. Indeed it would have been unrealistic to expect significant changes immediately in either maternal or infant deaths[44]. The initial small numbers of specially trained midwives were not sufficient to either provide a service nationally or to have any significant impact on existing services. The continuing large numbers of traditional midwives who remained in practice were required to maintain the service. The new legislation was needed to change the practice of, but not remove from practice, the traditional midwives unless they were proven to be unsuitable practitioners.

Until legislation was introduced midwifery had been largely the domain of married women who frequently combined the calling with other domestic responsibilities, sometimes under the title 'monthly nurse'. This placed midwifery alongside nursing and firmly in the realm of womens' work. Legislation took midwifery out of this environment and placed it alongside nursing as a professional career choice for women. The admission of single women to the training schools had been challenged during the debate on the Midwifery Bill. If the Bill was passed training of midwives would be funded by the state. The biggest fear was that on marriage these women would cease to practice midwifery therefore reducing the expected return for the monetary investment in their training. This did not happen. Single women outnumbered married women in the new midwifery environment. Whilst many did marry following completion of their training this did not impinge greatly on the contribution they made to the re-shaped midwifery services.

The Midwives Act of 1904 represented a change in society's understanding of a professional midwife and was an integral aspect of the formalisation process. Three definitions of a professional in relation to health professions have been

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[44] The reduction in infant deaths has been attributed to the work of Truby King and the Plunket Society rather than to the introduction of 'The Midwives' Act, 1904'.

identified. (See Tables 2, p. 7, 4 & 5, p.17). Each definition reflects the period in which the health professional practised. The definitions also demonstrate the changes seen within the four identifiable phases of professional development. (See Table 3, p. 8). Only the first two phases, the sub-professional and semi-professional phases are relevant to midwifery within the period between 1840 and 1904.

Although professionalism is a nebulous and indefinable concept five distinct features of the second or semi-professional phase have previously been described.[45] These included systematic development of theoretical knowledge leading to a qualification, a distinctive culture, service orientation, ethical codes and autonomous practice.[46] These characteristics support the conceptualisation of a professional midwife in and following the semi-professional phase but challenge the midwife in the sub-professional phase. This person was recognised in the community, midwifery being their usual occupation followed for payment.[47] Although these practitioners had no formal qualification they can, however haphazardly developed, be credited with having developed some knowledge related to their occupation. They were service orientated according to popular accounts of history and practised autonomously. They had their own ethical codes many being acutely aware of the contribution their practice might make to the mortality statistics.[48]

As an integral part of formalisation legislation provided an overt code of ethical conduct which set a standard for midwifery practice. This code identified misconduct related to practice as well as other activities defined as indictable offences that the midwives might engage in as appropriate reasons for

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[45] S. Wallace, BA thesis, University of Otago, 1987, p. 66.

[46] ibid. P. 66.

[47] R. Marshall, NM, 1983, pp. i-vi. C. Webster, 1993. p. 30.

[48] Higgins, Sarah, *MS Papers 1146,* WTU.

suspending midwives from practice.[49] With puerperal sepsis identifiable as a major cause of maternal mortality midwives likely to spread this infection between their patients were also to be suspended from practice. This applied to midwives who ran maternity homes, as well as those in community practice, and to the running of the St Helens Hospitals. Return to practice was not allowed until the danger of infection had passed. This included the terminal disinfection of the home or maternity hospital if applicable. One proprietor of a private maternity hospital was suspended and the home closed due to infection. The midwife made application for inspection in order to have the ban on her practice lifted.[50]

Clear parameters were placed upon the midwives' practice. Midwives were directed within the Act not to represent themselves as doctors.[51] This clause originated from the old definition of a medical practitioner which embraced all practitioners of health care.[52] Malpractice was also clearly identified within the regulations.[53] The use of instruments to assist delivery was considered in this section. Administration of chloroform was also outside the realms of the midwives' practice.[54] Eight years later the regulations relating to administration of chloroform were changed and matrons of State Maternity Hospitals and other

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[49] *NZS,* 1904. Clause 11.

[50] *Health I,* Hester Mclean - Midwives Registration, WARC. Telegram to Health Department from midwife involved.

[51] *NZS,* 1904, Clause 17.

[52] C. Webster, 1993. p. 25.

[53] *NZG,* 1905, pp. 1022-23.

[54] *Health I,* Hester Mclean - Midwives Registration, WARC. Memo for the District Health Officer, Auckland dealing with issues of malpractice. The former offence may never have been committed the latter was an issue on several occasions. In one instance the breach was committed by a Class B midwife who collaborated with a doctor's wishes that chloroform be administered to his patient.

approved hospitals were authorised to administer chloroform with permission of the medical officer in charge.[55]

Evidence of philosophical beliefs as a guide to practice do not feature in the documents and historical writings related to midwifery in the 1890's and early 1900's. The evidence however points towards an illness orientation. The choice to formalise midwifery training, although a positive step, was precipitated by rising mortality figures. The language used in debating the Midwives' Bill also supports this philosophy. The fear and anxiety associated with childbirth was considered to be precipitated by the practices of ignorant traditional midwives which could lead to illnes and/or death. The programme established following formalisation required pupil nurses to have a knowledge and ability to manage both normal and abnormal situations. The incidence of abnormal situations described in the Home Delivery Casebook, whilst not outnumbering the normal situations, occurs with sufficient regularity to warrant including this knowledge. The continuing rise in mortality rates could be considered to justify the continuance of the move towards medical management of labour and birth.

The midwifery practitioner who emerged from the St Helens training schools conveyed a completely different image to society than did the two old images of the traditional midwife portrayed in the celebratory and Dicksonian literature. This new midwife and the training she received provided the platform from which the changing approach to midwifery practice could develop. The Midwives Act, 1904 was the catalyst from which this change took place. The programme of instruction which shaped the understanding, thinking, and practice of the new professional midwife was integral to the Act. Checks and balances on the practice and character of both the traditional and newly emerging midwives were made through the Act which was designed to remove unsuitable individuals from practice and control the activities of the practising midwives. Although these variables did not have any immediate effect on the statistical outcome of

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[55] *Health I,* 111/2/4, St. Helens General - Patients. Use of Anesthetic, WARC. Extract from *NZG* of 25 June 1914 signed by Hester Mclean.

mortality rates they did constitute a turning point in the professional development of midwives. Prior to the Act midwives had operated in the sub-professional phase of professionalism. Following the Act midwives functioned in the semi-professional phase. (See Table 3, p. 8). This Act also placed in existence public records which assist in tracing these early changes and are more reliable than the subjective data which popular and celebratory histories portray.

This thesis covers a period of eighty years yet represents only a small portion of midwifery history. Had the study concluded immediately following inception of the Midwives' Act, 1904 a successful conclusion would not have been out of place. Incorporation of a detailed examination of statistical evidence of unchanged maternal and infant mortality rates negates this conclusion. The Act did effectively place some control on midwifery practice and practitioners which theoretically made childbirth safer. However a triumphant outcome to the Act was not identified. This would only have been possible if an immediate and dramatic change in mortality figures had been recorded.

A limitation of this study is that it does not extend to examine the effect later legislation had on the practice of the prodigies of the Midwives Act, 1904 and the rising problem of puerperal sepsis.[56] This limitation notwithstanding, the answers to the research questions have been identified within the present study. Firstly New Zealand midwifery formalised to provide a training programme for midwives. Secondly this created a safe and affordable venue where the wives of working men could give birth to their babies. Thirdly formalisation created structure from which practice could proceed. This included strict ethical codes controlling poor practices and inclusion of modern scientific approaches to care of the parturient woman. Fourthly midwifery was placed alongside other professional groups advancing the occupation as a profession. The Midwives Act, 1904 was a positive step for New Zealand women who no longer had to

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[56] Nurses and Midwives Registration Act, 1925 [16 GEO V, No. 10] *NZS,* 1925. Regulations under the Nurses and Midwives Act, 1925, *NZG,* 1925, pp. 3442-3449. Regulations under the Nurses and Midwives Act, 1925, amended, *NZG,* 1926, p. 2796. B. M. Chalmers, *MSX 3510,* Obstetrical Case Book, WTU.

seek midwifery training overseas. New career opportunities were created for both single and married women, and for registered nurses interested in advancing their nursing practice. Finally the practice of traditional midwives was circumscribed by their lack of knowledge and training and they were required to meet the new standards set down to control practice.

Appendix 1.

Tables 17-26

Table 17:

OUTDOOR

Case No. *178*

Nurse present: *Jensen* *Dr. Cameron.*

Date: *21st October 1908.*

Name: ********[1]

Address: *********

Hour called: *8.15 am*

Hour of delivery: *8.30 am*

Hour of departure: *10 am*

Notes at time: *On arrival found patient in the second stage of labour. One nipple much inverted. General varicosed condition. Baby born at the 28th week. Badly asphyxiated, artificially restored, wrapped in swaddling and given daily unction of oil. Stimulant and medicine prescribed by Dr. Cameron given 4 hrly. Powders given TDS for Icterus. The milk was drawn off and given to the child who appeared to thrive until the ninth day having gained 6 ozs. The child began to have convulsions at 8 am and died at 12.5 pm. Weight at birth 3 lbs 2 ozs. Third day 3 lbs 4 ozs. 7th day 3 lbs 6 ozs. Patient made an excellent recovery.*

Puerperium

Time Visits					
Day		AM		PM	Nurse attending
21st October		Arr	Dep	Arr Dep	*Nurse Jensen*
22nd	1	*The case visited 4 hrly*			"
23rd	2	*during the nine days*			"
24th	3				"
25th	4				"
26th	5				"
27th	6				"
28th	7				"
29th	8				"
30th	9				"
31st	10	*11*		*11 40*	"

Discharged *Dr. Cameron.*

[1] Names and addresses have been omitted in all case records to prevent identification of patients.

Table 18:

OUTDOOR
Case No: 192

Nurse present: Jensen Dr. Curtis

Date: 24.12.08.

Name: *********

Address: *********

Hour called: 11 pm December 24th 1908

Hour of delivery: 2 am December 1908

Hour of departure: 3.30 am " " "

Notes at time On arrival found patient in labour. Also having a history of Chronic Kidney disease. The urine at the time of labour being one half albumin. Diuretic drinks and daily aperients were ordered by Dr. Curtis. Patient made an excellent recovery. Baby gained 7½ oZs.

Puerperium

Time visits						
Day		AM		PM		Nurse attending
24th Dec		Arr	Dep	Arr	Dep	Jensen
25th	1	10	11	6.30	7	"
26th	2	10	11	7	7.30	"
27th	3	9	10	6	6.30	"
28th	4	8	9			"
29th	5	8	9			"
30th	6	9	10			"
31st	7	9	10			"
Jan 1st	8	8	9			"
Jan 2nd	9	10	11			"
3rd	10	10	11			"

Discharged Dr. Curtis

Table 19:

OUTDOOR

Case No: 199

Nurse present: *O'Hagan*

Date: *Jan. 22nd 1909*

Name: **********

Address: **********

Hour called: *8 pm January 22nd 1909*

Hour of delivery: *9.55 pm January 22nd 1909*

Hour of departure: *11 pm*

Notes at time: *On arrived found patient in labour. Appeared delicate. Two previous pregnancies instrumental. Present pregnancy - patient exhausted. Had copious loss. Eruution*[2] *given. Patient complained of pain. Expressed large clot on 2nd morning. No further pain. Breasts well developed. Nipples inverted. Child impacted shoulders. Slightly asphyxiated. Patient made excellent recovery. Baby gained 6ozs.*

Puerperium

Time visits						
Day		AM		PM		Nurse attending
1909		Arr	Dep	Arr	Dep	
Jan 22nd	1			*8*	*11*	*Nurse Jensen & O'Hagan*
" 23rd	2	*9*	*10. 10*	*7.10*	*7.30*	*Nurse O'Hagan*
" 24th	3	*9*	*10*	*6*	*6.30*	*"*
" 25th	4	*8*	*9*			*"*
" 26th	5	*8*	*9*			*"*
" 27th	6	*9*	*10*			*"*
" 28th	7	*9*	*10*			*"*
" 29th	8	*8*	*9*			*"*
" 30th	9	*10*	*11*			*"*
" 31st	10	*10*	*11*			*"*

Discharged *Dr. Agnes Bennett*

[2] This word is indecipherable.

Table 20:

OUTDOOR

Case No: *206*

Nurse present: *Sextont* *Sister Clark*

Date: *February 21st 1909*

Name: *********

Address: *********

Hour called: *3.5 am Feb 21st 1909*

Hour of delivery: *4.50 am*

Hour of departure: *6.5 am*

Notes at time: *On arrival patient in strong labour. Breasts well developed. Appearance delicate. Patient has a cough 3rd day Temp & Pulse 102.6 ℉ Pulse 112. 4th day intra uterine douche given by Dr. Bennett. 5th day vaginal douches creolin twice daily. Temp falling 7th day normal Douches continued. Patient much improved. Discharged Baby healthy.*

Puerperium

Time Visits						
Day		AM		PM		Nurse attending
		Arr	Dep	Arr	Dep	
Feb 21s	1	*3.5*	*6.5*	*4.30*	*6 -*	
	2	*8.45*	*9.45*	*4.30*	*5*	
	3	*9*	*10.30*	*6*	*6.30*	
	4	*9*	*10.30*	*6.30*	*7*	
	5	*9*	*10.30*	*7*	*8*	
	6	*9.5*	*10.5*	*6.30*	*7*	
	7	*9.5*	*10.5*			
	8	*1pm*	*2pm*			
1st	9	*8.45*	*9.45*			
2nd	10	*8.45*	*9.45*			

Discharged: _____

Table 21:

OUTDOOR
Case No 252

Nurse present: Melville Sister .

Date: 20-12-09

Name: **********

Address: **********

Hour called: 10.45 pm 19-9-09

Hour of delivery: 1 am 20-9-09

Hour of departure: 2 am 20-9-09

Notes at time: On arrival found patient in labour, ill nourished looking woman. Breasts and nipples well developed, labour normal, puerperium normal. Baby's eyes affected with purulent opthalmia which first appeared 36 hours after birth. Eyelids much swollen and a secretion of a thick ropy yellow pus. Treatment :- Perchloride (irrigation) lotion 1-6000 for a few days also tinct Argyrle m ·/1 inserted night and morning. Occasional hot foments which relieved eyelids and Boracic irrigation alternately with mercurial lotion. Treatment was given every two hours from time infection started. Eyes were very much improved by the 10th day when the mother was taught to bathe them herself and directed to take baby for outdoor treatment to the public Hospital. Child was then attended by the district nurse.

Puerperium

Time Visits						
Day		AM		PM		Nurse attending
September		Arr	Dep	Arr	Dep	Melville
" 20th	1	9	10	4	5	"
" 21st	2	9.30	10.30	7	8	"
" 22nd	3	9	10	7	7.20	"
" 23rd	4	9	10.15	10.30		"
" 24th	5	8.15	9.45	one ho	urly	"
" 25th	6	11 8	11.30 8.30	Two h	ourly	"
" 26th	7	8	8.30	"	"	"
" 27th	8	8	8.20	"	"	"
" 28th	9	8	8.30	"	"	"
" 29th	10	7.55	8.30	"	"	"

Discharged: 30-9-09

Table 22:

OUTDOOR

Case No 347

Nurse present: Honeyfield Dr. Hogg

Date: November 13th

Name: *********

Address: *********

Hour called: 5 am

Hour of delivery: 8 am

Hour of departure: 9-5 am

Pres. Vertex
Pos. L.O.A.
Sex. Female

Notes at time: On arrival found patient in labour. Anaemic and unhealthy. During labour patient had an eclamptic fit 6 hours later patient had another fit followed by a more severe one 2 hours later. Hot kidney packs applied every 2 hrs up to midnight. Chloral & Bromide mixture with saline were injected per rectum 3 times. Mixture prescribed and taken after food. Patient made good progress. Three months before pregnancy patient was an inmate at Porirua. Owing to mothers condition baby was artificially fed on Allenbury's food No. 1. Made good progress and gained in weight. Weight when born 8½ lbs. Weight on 10th day 9 lbs.

Puerperium

Time Visits					
Day	AM		PM		Nurse attending
	Arr	Dep	Arr	Dep	Honeyfield
1	5.30	9-10	4.30	1.20	
2	5.5	9.55	6.50	7.30	
3	9.30	10.30	6.50	7.30	
4	9.30	10.30			
5	9.30	10.30			
6	9.30	10.30			
7	9.30	10.30			
8	9.30	10.20			
9	9.30	10.30			
10	9.30	10.30			

Discharged

Table 23:

OUTDOOR

Case No: 420

Nurse present: *Allan* *Dr Perkins*

Date: *13.10.11*

Name: **********

Address: **********

Hour called: *7.45 pm*

Hour of delivery: *1.30 am*

Hour of departure: *2.45 am*

Pres. Vertex

Pos. ROP

Sex Male

Notes at time: *On arrival found patient in first stage of labour. Appearance healthy & breasts well developed. On account of position of child labour was rather prolonged. Dr. Delivered with instruments. Puerperium normal and patient was allowed up on 10th day and made good recovery. Baby was asphyxiated at birth, on account of short cord and twisted twice round neck. Treated with hot and cold water alternately & artificial respiration. Made good recovery and gained in weight. Entirely breastfed.*

Puerperium

Time Visits					
Day	AM		PM		Nurse attending
Oct. 14th 1911	Arr	Dep	Arr	Dep	*Allan*
1	*9.15*	*10.15*	*7*	*7.30*	
2	*9.20*	*10.30*	*7*	*7.30*	
3	*9.25*	*10.30*	*7*	*7.30*	
4	*9.20*	*10.40*			
5	*9.20*	*10.30*			
6	*9.30*	*10.35*			*Stenburg*
7	*9.40*	*10.50*			
8	*9.15*	*10.10*			
9	*9.20*	*10.30*			
10	*11.15*	*12*			

Discharged

Table 24:

OUTDOOR

Case No 504

Nurse present: MacLean Dr Hogg

Date: 3.11.1912

Name: *********

Address: *********

Hour called: 6. 30 am 3. 11. 12

Hour of delivery: 9. 40 am 3. 11. 12

Hour of departure: 12. 20 pm 3. 11. 12

Notes at time On arrival found patient in second stage of labour. Membranes had ruptured 2am (3.11.12) Dr Hogg delivered patient (instrumentally) at 9.40 am. Patient healthy. Breasts well developed. Nipples inverted. Baby was 2 months premature. Transferred to St Helens Hospital Nov. 5th. Patient made good recovery. Had one vaginal douche on the 9th day of puerperium. Stitches (2) removed from perineum Nov. 11th

Puerperium

Time Visits						
Day		AM		PM		Nurse attending
1912		Arr	Dep	Arr	Dep	Vida MacLean
Nov 3rd	1	7.30			12.20	
" 4th	2	8.20	10.15	2.15	2.45	Baby was badly
" 5th	3	9.35	9.55	7	9	bruised about the head
" 6th	4	10	10.45			during delivery & on
" 7th	5	9.30	1.10			admission to Hospital
" 8th	6	9.30	10.10			was very oedematous.
" 9th	7	9.45	10.30			Condition improved by
" 10th	8	8.50	10			10th day. Weight
" 11th	9	9.45	10.15			4 lbs.
" 12th	10	9.35	10			

Discharged: Nov. 12th 1912

Table 25:

OUTDOOR

Case No: 515

Nurse present: Start Dr Keep

Date: DEC 9th 1912

Name: 'em

Address: 'em

Hour called: 1 am

Hour of delivery: 12.30 am

Hour of departure: 2.40 am

Notes at time: Called to case at 1 am Baby born before arrival 12.30 am (Premature). Patients appearance healthy. Breasts & nipples well developed. Puerperium normal. Patient up on 10th day. Baby brought into hospital 11 am for treatment it being necessary to suppress lactation - Saline purgatives given and firm bandage applied to breasts. fluids restricted. Breasts caused no trouble.

Puerperium

Time Visits						
Day		AM		PM		Nurse attending
December		Arr	Dep	Arr	Dep	
" 9th	1	9.15	11 am	7pm	7.30pm	Stuart
" 10th	2	9.30am	10.30am	7pm	7.35pm	"
" 11th	3	9.30am	10.30am	7pm	7.40pm	"
" 12th	4	9am	10am			"
" 13th	5	9.15am	10am			"
" 14th	6	9.30am	10.30			"
" 15th	7	9.15am	10.15			"
" 16th	8	11am	11.30am			"
" 17th	9	11.45am	12.30am			"
" 18th	10	12nd	1.15pm			"

Discharged: last visit Dec. 18th

Table 26:

OUTDOOR
Case No 558

Nurse present: Curlett Dr. Bowerbank

Date 10.6.13.

Sex Female
Pres. Vertex
Pos L. O. A.

Name: *********

Address: *********

Hour called: 5.30 pm June 10th

Hour of delivery: 7.30 pm " " "

Hour of departure: 10 pm " " "

Notes at time: On arrival found patient in strong labour. Health history good. appearance healthy. breasts nipples well developed. Placenta removed by Dr. Bowerbank. Puerperium douches given on 1st & 2nd day & Intrauterine on 3rd day for retained fragments of placenta and fetid lochia. Condition clearing on 6th day. Baby: Premature 8th month Entirely breastfed & lost 1 lb in weight. Weight at birth 5 lbs. When discharged 4 lbs.

Puerperium

Time Visits						
Day		AM		PM		Nurse attending
1913		Arr	Dep	Arr	Dep	Curlett
June 11th	1	10	11.30	5	6	"
	2	10	11.30	5.30	6.30	"
	3	10.15	11.45	6	6.30	"
	4	10.15	11.45			"
	5	10.15	11.45			"
	6	10.15	11.45			"
	7	10.10	11.30			"
	8	10.10	11.30			"
	9	10.10	11.30			"
	10	10.10	11.45			"

Discharged: June 20th 1913

Appendix 2

Pupil nurses identified inWellington St Helens outside casebook with year of registration, other qualifications and postgraduate workplace. [1]

Key: * - Has not notified intent to practice in current year (1921) . ¤ - Has not notified intent to practice for two years. May be struck off the register .

Name	Year/Month Registered	Practising Status 1913	Practising Status 1915	Practising Status 1921
Fisher, Miss Mary.	RN. December 1903 RM. January 1907	Raetahi	Private Hospital, Abel Smith Street, Wellington.	Private Hospital, Abel Smith Street, Wellington.
[Hall], Mrs. Lucy McLachlan	RM. December 1907	Blenheim	Blenheim. Not Practising.	Seddon. ¤
McKenzie, Miss Edith M.	RM. December 1907	7 Elizabeth Street, Wellington	7 Elizabeth Street, Wellington	Wellington. Not Practising
Linton, Miss Muriel	RN. December 1902 RM. June 1908	Private Hospital 137 Broad Street, Palmerston.	Private Hospital 137 Broad Street, Palmerston.	Private Hospital, 137 Broad Street, Palmerston.
Barnard, Miss Dora	RM. July 1908	34 Nairn Street, Wellington	34 Nairn Street, Wellington	Owaka. Not Found 1921 *
Neale, Miss E.	RM. July 1908	Wellington	61A Broughton Street, Wellington	Not Found 1921 ¤
[Ansell], Mrs. Louisa Crooper	RM. Janaury 1909	61A Broughton Street, Wellington	61A Broughton Street, Wellington	c/- W. Neil, Ohaupo Road, Hamilton ¤
[Jensen], Mrs. Neilsene Chappell	RN. June 1914 RM. January 1909	Hospital Christchurch	Hospital, Christchurch.	Southsea Private Hospital, Cameron Road, Tauranga.
Whitehouse, Edith	RM. January 1909	Ashburton	Ashburton.	Not Found 1921 ¤
Sexton, Miss Jessie	RN. June 1907 RM. June 1909	Home of Compassion, Island Bay.	Gladstone, via Manukau.	Home of Compassion, Island Bay.
O'Hagan, Miss Katherine	RM. August 1909	61A Broughton Street, Wellington	18 Austin Street, Wellington.	121 Tasman Sstreet, Wellington. *
Wilson, Miss I. G.	RM. September 1909	St Mary's Home, Otahuhu.	Cloubern Road, Remuera, Auckland.	36 Wickstead Street, Wanganui. *
Darvall, Miss Florence	RM. January 1910	Daniel Road, Ngaio	Daniel Road, Ngaio.	c/- Rev. W. A. Evans, 19 Hiropi Street, Newtown.
Dustow, Ellen	RM. January 1910	10 Duke Street, Palmerston North.	Auckland. Not Practising.	Auckland. ¤

[1] ABBR 6902/1, Home Delivery Casebook 1907-1913. Lists of Nurses and Midwives, *NZG*, 1907-1921.

McIwrick, Miss Ellen C.	RM. January 1910	61A Broughton Street, Wellington	61A Broughton Street, Wellington.	"Wairongomai" Featherston.
Mulville, Miss Esther	RN. December 1907 RM. January 1910	Johannesburgh	Johannesburgh.	Johannesburg. ¤
Peacock, Eva Elizabeth	RM. January 1910	Lighthouse Road, Napier	Lighthouse Road, Napier.	"Waipukurau"
Rockstrow, Miss Nellie	RM. January 1910	59 Cuba Street, Palmerston North.	59 Cuba Street, Palmerston North.	Not Found 1921. ¤
[Whangaperita] Heni Reedy	RN. June 1908 RM. January 1910	Tuaparoa, East Coast.	Tuaparoa, East Coast.	Tuaparoa, East Coast. *
Reynolds, Miss Evlyn	RM. June 1910	Gordon Street, Dannevirk.	Gordon Street, Dannevirk.	"Wairongomai" Featherston. *
Kimber, Miss Ada	RM. August 1910	"Grafton". Greenpark.	Gordon Street, Dannevirk.	Not Found 1921. ¤
Spurdle, Miss Margaret	RM. August 1910	74 Boulcott Street, Wellington	74 Boulcott Street, Wellington.	18 Aurora Terrace, Wellington. ¤
Warnock, Miss Sarah	RN. May 1905 RM. August 1910	Geraldine.	Greytown.	Not Found 1921
Cawthron,	RM. 1911	Not Listed	Not Listed	Not Listed
Honeyfield, Clara	RM. March 1911	12 The Terrace.	231 The Terrace, Wellington.	27 Arlington Street, Wellington.
[Cooper] Mrs McClusky.	RM. July 1911.	Wellington	5 Adrian Terrace, Brooklyn.	5 Adams Street, Brooklyn. ¤
Whishaw, Miss Mabel H.	RN. January 1910 RM. July 1911	Dannevirke.	Edunburgh Street, Dannevirke. *	Not Listed
[Scott] Mrs M. Hatalie Drysdale	RM. July 1911	The Hospital, Picton.	The Hospital, Picton.	32 Shands Track, Hornaby, Canterbury. ¤
[Fissenden] Alice Richards	RM. September 1911	Raetihi.	Raetihi.	Matamata. ¤

[Allan], Mrs. Ruth Derrett [1915] also identified as Durett [1921]	RN. May 1902 RM. January 1912	c/- Mrs. Richardson, Roseneath, Wellington.	Auckland. Not Practising.	Cairn Jill. Mangare Bridge, Auckland. ¤
Jenkins, Miss Constance	RN. January 1911 RM. January 1912	Wellington	Wellington.	Native Health Nurse. Te Kaha.
Kingaby, Miss Annie	RM. January 1912	"Rahiri", Kimbolton, Fielding.	"Rahiri", Kimbolton, Fielding.	Longbush, Masterton.
[Stenberg], Mrs. Hannah S. Johansen	RM. January 1912	Makareto, Hawkes Bay.	Denbigh Street, Fielding.	"Tiraki", Dannevirke. *
Hulme, Mrs. Ruby W.	RM. July 1912	Waterloo Road, Lower Hutt.	Private Hspital, Lower Hutt.	"Raheny", Princess Street, Cambridge.
Kummer, Miss Gertrude	RN. July 1909 RM. July 1912	23 Liverpool Street, Wellington.	87 Wickstead Street, Wanganui.	c/- C. Holmewood Esq. Bushcroft, Masterton.
Miller, Margaret Jessie	RN. June 1911 RM. July 1913		14A Kelburn Parade, Wellington.	c/- F. S. Greenshields. 9 Glen Road, Kelburn.
[Stronach], Mrs. Muriel E. Smith	RM. July 1912	St. Helens Hospital, Wellington.	Te Harakeke.	Taihape. Not Practising
[Tennant], Mrs. Dorothy I. Oliver	RM. July 1912	Hull Street, Oamaru.	6 Mathieson Street, Wanganui.	Maternity Hospital, Blenheim. *
Cole, Mrs. Jeanie	RM. January 1913	Picton.	96 South Road, Masterton.	17 First Street, Lansdowne, Masterton. ¤
Hamilton, Miss Gwendoline M.*	RM. January 1913	26 Hawker Street, Wellington.	Ewington Avenue, Auckland.	4 Oakland Road, Mount Eden, Auckland. *
MacLean, Vida M. K.	RN. January 1909 RM. January 1913	Bird Grove, Hunterville.	Active Service.	290 Willis Street, Wellington.
Nisbet, Miss Margaret	RM. January 1913	Waterloo Road, Lower Hutt.	Opotiki.	Private Hospital, Wellington Street, Opotiki.
Perrott, Miss Mabel E.	RM. January 1913	285 Worcester Street Christchurch.	173 Riddiford Street, Wellington South.	173 Riddiford Street, Wellington South.
[Stuart], Mrs. M. M. Donnelly	RN. January 1909 RM. January 1913	Picton.	Wierou Street, Hawera.	"Glaxo" Nurse, Ponsonby Road, Auckland.

[Tuohy], Mrs. Margaret Flynn	RM. January 1913	Sydney Street, Wellington.	Stratford.	Martinborough. ¤
Cowles, Charlotte E.	RM. July 1913	-	Khandallah.	Lochiel Road, Khandallah, Wellington. ¤
Cunningham, Mrs. Angelina	RM. July 1913	-	Emerson Street, Napier.	Nurse Bureau, Battery Road, Napier.
Curlett, Ilma M.	RM. July 1913	-	Christchurch. *	22 Kent Terrace, Wellington. ¤
Flemming, Elizabeth	RM. July 1913	-	Christchurch. *	Christchurch. ¤
Jackson, Catherine E.	RM. July 1913	-	District Nurse, Marton.	Te Kuiti.
Mitchell, Esther A.	RM. July 1913	-	St. Helens Hospital, Wellington.	Plunket Nurse, Wellington. *
[Vosper], Mrs. Annie Turvey	RM. July 1913	-	Motueka, Nelson.	24 Nen Street, Oamaru. *
Wells, Eliza Eleanor	RM. July 1913	-	Hospital, Picton.	8 Campbell Street, Wanganui.
Wilson, Miss Mary E.	RM. July 1913	-	c/- Mr. Crichton, 9 Everton Terrace, Wellington.	9 Everton Terrace, Wellington. *
Wix, Elizabeth	RN. December 1911 RM. January 1914	-	Te Karaka, Gisborne. Not Practising.	Plunket Nurses Office, Nelson.
[Metze], Mrs. Amy J. Falconer	RN. December 1911 RM. March 1914	-	Wanganui.	Northcote. *

Appendix 3.

List of Private-Hospital Licensees 1910 showing name and qualifcations of midwives running a Private-Hospital.[1]
Key: RN - Registered Nurse. RM - Registered Midwife. LOS - London Obstetrical Society. CMB - Central Midwives Board.. * - Class B midwife Licensee of Hospital has a Class A midwife working with her.
Sources: List of Privte-Hospital Licensees as at 1st April, 1910, *NZG*, 1910, pp. 1168-1169. Lists of nurses and Midwives

Name	Qualifications of Licencee	Address
Mrs H. Ainsworth	Class B midwife	Eton Street, Ashburton
Mrs M. Andrew	No details found	Park Avenue, Auckland
Miss Arnaboldi	Class B midwife	Regent Street, Waihi
Nurses Babington and Wood	Babington. RM. - CMB. /LOS Wood. RM. - CMB	George Street, Napier
Mrs. E. Baillie	RM. - Sydney	1 Pitt Street, Palmerston North
Miss L. R. Baker	RN.	Liardet Street, New Plymouth
Mrs E. Bamforth	Class B midwife	King Street, Hastings
Dr. Barclay	Medical Practitioner	Shearman Street, Waimate
Mrs R. Barker	Class B midwife	Riverbank, Hamilton
Nurses Beck and Wellsman	RN, RM. - Melbourne	70 Gloucester Street, Christchurch
Mrs Bell	Class B midwife	80 Thames Street, Oamaru
Miss I. Bennett	No details found	Crummer Road, Grey Lynn
Mrs L. Bethune	RM. St. Helens. Christchurch	91 Cashel Street, Christchurch
Miss E. Bishop	RN. RM. - Melbourne	Greymouth
Mrs K. Blanchard	No details found	Fitzroy, New Plymouth
G. A. Brandstater	No details found	Papanui Sanitorium, Christchurch
Mrs Breach	Class B midwife	Rakaia
Mrs Brew	RM. St Helens. Dunedin	211 Castle Street, Dunedin
Dr Brewis	Medical Practitioner	"Opoia", Hamilton
Miss Brookes	RN. RM. - Melbourne	1 Bell Street, Wanganui
Miss F. Brown	Class B midwife	Elgin Street, Grey Lynn
Mrs M. D. Brown	Class B midwife	Burnett Street, W., Ashburton
Nurses Bulkley, Kohn, Spilman	Buckley. RN. RM. Kohn. RN. Spilman. RN.	8 Davis Street, Wellington
Mrs J. Bullick	Class B midwife	Hastings Street, Hastings
Mrs M. Burke	No details found	Hutchison Street, Blenheim
Nurses Burnett and Hunt	RN, RM.	High Street, Hawera
Mrs. I. Burn	Class B midwife	40 Hereford Street, Christchurch
Mrs K. Burn	No details found	1 Montpellier, Dunedin
Mrs. M. J. Burns	Class B midwife	Percy Street, Blenheim
Mrs Burrows	Class B midwife	Clyde Quay, Wellington
Mrs. M. B. Cameron	Class B midwife	Church Street, Ponsonby
Mrs R. Caston	Class B midwife	Mangawhau Road, Kyber Pass, Auckland
Mrs Chamberlain	No details found	Vogel Street, Woodville
Mrs I. Chapman	Class B midwife	King Street, Temuka
Mrs M. Chappell	Class B midwife	Cameron Road, Tauranga
Miss J. Clarke	RN.	57 Campbell Street, Tauranga
Miss I. Clayton	Class B midwife	188 Queen Street, Dunedin
Mrs Clerkin	Class B midwife	Hall Street, Hokitika
Miss C. Collins	No details found	Worcester Street, Christchurch
Mrs E. Counsel	Class B midwife	26 Gloucester Street, Linwood

[1] List of Private-Hospital Licensees as at 1st April, 1910, *NZG*, 1910, pp. 1168-1169.

Miss Cowper	RM. St. Helens. Christchurch	Rugby Street, Merivale
Drs. Crawshaw and Davies	Medical Practitioners	Cass Street, Kaiapoi
Mrs S. G. Cunningham	Class B midwife	Catherine Street, Onehunga
Miss B. Clyne	RM. - Sydney	Ure Street, Oamaru
Mrs L. F. Denbee	RN. RM. - LOS	Cornwall Street, Masterton
Mrs K. Dender	Class B midwife	Church Street, Palmerston North
Mrs A. Dew	Class B midwife	Daisy Bank. Dee Street, Timaru
Miss C. Doig	RN.	Pleasant Point
Mrs B. Donald	Class B midwife	Herbert Street, Mount Roskill
Mrs J. Dudley	No details found	Main South Road, Opunake
Mrs T. A. Dudley	Class B midwife	Te Aroha
Mrs A. Dufty	Class B midwife	Rotorua
Mrs Dunstone	No details found	Newman, Eketahuna
Miss M. Early	Class B midwife	63 Bealey Avenue, Christchurch
Mrs Edmondstone	Class B midwife	Bell Street, Wanganui
Mrs Ellis	Class B midwife	Church Street, Reefton
Miss L. R. Fergusson	RN. RM. - LOS	Ruanui, Taihape
Mrs C. Fiskin	Class B midwife	Dundas Street, East Gore
Mrs Flanagan	Class B midwife	Kawakawa
Mrs Flewellyn	Class B midwife	Surrey Crescent, Grey Lynn
Mrs Fogarty	Class B midwife	Brentwood Avenue, Mount Eden
Miss Foote	Class B midwife	Grafton Road, Auckland
Mrs Forrest	Class B midwife	Carlyle Street, Napier
Mrs Freeman	No details found	Grey Street, Palmerston North
Mrs F. Gapper	No details found	Grey Street, Fielding
Nurses Garrett and Jackson	Garrett. RN. Jackson. RN.	13 Kensington Street, Wellington
Mrs Gill	No details found	Apiti
Mrs Goodison	Class B midwife	Collingwood Street, Ponsonby
Mrs Grammer	Class B midwife	Fielding Street, Ashhurst
Miss A. E. Green	RN.	Mount Pleasant, Wakefield Street, Auckland
Mrs A. Grengor	Class B midwife	High Street, Carterton
Mrs H. Haig	RM. - Launceston	Wilson Street, Geraldine
Dr Hamilton	Medical Practitioner	Richmond, Nelson
Mrs A. E. Hamilton	Class B midwife	Main Street, Greytown
Mrs Hanwell	Class B midwife	May's Road, Papanui
Miss S. Harkness	RN. RM. St. Helens. Dunedin	Manuka Street, Nelson
Mrs Harney	No details found	Palmerston Road, Gisborne
Dr Harrison	Medical Practitioner	Mountain Road, Eltham
Mrs K. Harvey	RM. - LOS. / CMB.	Victoria Street, Hawera
Mrs Hassall	Class B midwife	Miranda Street, Stratford
Miss E. Hattaway	RN. RM.- Auckland Hospital	Taupiri Street, TeKuiti
Mrs Havers	RN. RM. - Melbourne	Lytton Street, Gisborne
Mrs Hayman	RN.	Willis Street, Wellington
Nurses Henderson and Rule	Henderson. Class B Midwife Rule. No details found.	Tanerod Street, Ashburton
Mrs Henderson	RN.	Leonard Street, Waimate
Mrs E. Henderson	Class B midwife	Dundas Street, East Gore
Mrs Holgate	RN. RM. - LOS.	Macdonald Crescent, Wellington
Mrs M. J. Hughes	Class B midwife	Cameron Street, Ashburton

Mrs J. B. Humphreys	Class B midwife	Childers Road, Gisborne
Mrs L. Humphries	RM. - LOS. /CMB.	35 Church Street, Palmerston North
Mrs E. Hutchins	No details found	Ross Street, Woodville
Miss T. Impey	RM. - Sydney	Mairtown, Whangerei
Miss J. A. Jackson	No details found	Maungakawa Road, Cambridge
Mrs Jellyman	Class B midwife	Grove Road, Blenheim
Mrs Hughes Jones	No details found	Arawa Street, Rotorua
Mrs Jordan	Class B midwife	Gill Street, New Plymouth
Mrs Kearse	Class B midwife	53 Dublin Street, Wanganui
Mrs Kelly	No details found	33 Hansen Street, Wellington
Mrs M. Kemp	Class B midwife	George Street, Mount Albert, Auckland
Mrs L. King	RN. Class B midwife	151 Salisbury Street, Christchurch
Nurses King and White	RM. St. Helens. Dunedin	Wai-iti Road, Timaru
Miss Klem	RN. RM. - Adelaide	Ellice Street, Wellington
Mrs Kristensen	RM. - Copenhagen	Fergusson Street, Fielding
Mrs Langford	Class B midwife	Aberdeen Road, Gisborne
Mrs Lawrie	Class B midwife	Elizabeth Street, Timaru
Mrs Law	No details found	Waikawa Road, Picton
Sister G. Leahy	No details found	"Mater Miseriecordiae", Mountain Road. Mount Eden
Mrs N. Leitch	Class B midwife	Inkerman Street, Wnndham
Nurse E. M. Leslie	RM. - Sydney	"Awhina", Hamilton East
Mrs I. D. Lever	RN.	18 Symonds Street, Auckland
Nurse Linton	RN. RM. St. Helens. Wellington	Broad Street, Palmerston North
Mrs Lovell	RM. - LOS. / CMB.	6 Francis Street, Richmond, Auckland
Miss Lucas	No details found	Willis Street, Wellington
Mrs J. Ludlow	No details found	Renfrew Street, Balclutha
Miss C. Ludwig	RN. RM. - LOS. /CMB.	Downtown, Tauranga
Mrs E. Luff	Class B midwife	Nine-mile Road, Westport
Mrs E. McFarlane	Class B midiwfe	Main Road South, Temuka
Mrs McHugh	Class B midwife	Mania
Mrs McLaren	Class B midwife	Dargaville
Mrs A. Major	Class B midwife	29 Marion Street, Wellington
Mrs Malyon	Class B midwife	Te Puke
Misses Margetts	RN's. Class B midwives	Park Road, Auckland
Mrs L. Marriott	Class B midwife	Wilson Street, Sydenham
Miss M. Massey	RN.	Hardy Street, Nelson
Dr Meinhold	Medical Practitioner	Helensville
Mrs Merrie	Class B midwife	Tainui Street, Greymouth
Miss Miller	RN.	Cambridge Street, Paihiatua
Mrs Mills	Class B midwife	Union Street, Auckland
Mrs Missig	Class B midwife	Warkworth
Miss E. Morris	No details found	Walter Street, Blenheim
Miss C. Morris	No details found	Theodosia Street, Timaru
Miss A. Morrison	RN. RM. - LOS.	Burleigh Street, Auckland
Mrs M. Mullin	No details found	Darfield
Miss Murphy	RN. RM. Brighton Hospital for Women and Children	128 Abel Smith Street, Wellington
Miss F. Nairn	RN.	Southampton Street, Hastings
Miss Neale	RM. St. Helens. Wellington	18 Austin Street, Wellington
Dr Newell	Medical Practitioner	Oxford Street, Lyttelton
Mrs E. Nicholson*	Class B midwife	Winton

Miss F. M. B. Nutt	Class B midwife	266 George Street, Dunedin
Mrs F. Osborn	Class B midwife	Elizabeth Street, Timaru
Dr O'Brien	Medical Practitioner	Duke Street, Palmerston North
Mrs L. Olsen	Class B midwife	West Lyttleton
Miss Overton	Class B midwife	197 Peterborough Street, Christchurch
Mrs Partington	Class B midwife	Gill Street, New Plymouth
Mrs Paton	Class B midwife	Carlyle Street, Napier
Mrs Patterson	Class B midwife	Devon Street West, New Plymouth
Miss A. Pay	Class B midwife	Nith Street, Invercargill
Mrs G. Perry	Class B midwife	63 Spencer Street, Addington
Mrs E. Phillips	Class B midwife	Lavander Street, Akaroa
Miss M. N. Pike	RM. St. Helens. Wellington	Courtney Street, New Plymouth
Mrs Pocock	No details found	Gordon Street, Dargaville
Mrs J. Pope	Class B midwife	Bay View Cottage, Havelock, Marleborough
Mrs Ralston	Class B midwife	Orepuki
Miss Rathborne	RM. - Sydney	Victoria Road, Devonport
Miss F. Renouf	RN.	Waipawa
Mrs Rickleben	Class B midwife	Broadway, Stratford
Mrs Robinson	Class B midwife	Makino Road, Fielding
Mrs Rogers	Class B midwife	Nelson Street, Hastings
Mrs Rushbrook	Class B midwife	Inkerman Street, Onehunga
Mrs Russ	No details found	Wakefield, Nelson
Miss Russel	Class B midwife	Victoria House, Cambridge
Mrs Sands	Class B midwife	Ellison Street, Hastings
Miss E. Seales	No details found	Tay Street, Invercargill
Mrs Scherer	No details found	Gillies Avenue, Epson
Mrs Schmoll	Class B midwife	Adelaide Road, Wellington
Dr Scott	Medical Practitioner	Whataupoko, Gisborne
Mrs Sinclair	Class B midwife	17 Union Street, Auckland
Mrs Sisley	Class B midwife	Mount Edgecombe Road, Neww Plymouth
Mrs I. Smith	Class B midwife	Karaka Creek, Thames
Mrs M. Smith	Class B midwife	Cox Street Ashburton
Mrs I. Stuart	RN.	Manse Street, Whangerei
Dr Smyth	Medical Practitioner	High Street, Carterton
Mrs Sommerville	RN. RM. Glasgow West Simpson Memorial, Edinburgh.	Invercargill
Miss B. Spellman	RM. St. Helens. Wellington	Kirton Street, Masterton
Miss Sproull	RN.	Forth Street, Invercargill
Dr Stopford	Medical Practitioner	Kyber Pass, Auckland
Mrs F. Storey	Class B midwife	Innes Street, Waimate
Mrs Stratford	Class B midwife	24 Cambridge Terrace, Wellington
Miss F. Stronach	No details found	Nen Street, Oamaru
Miss J. Sutherland	No details found	High Street, Dunedin
Mrs Taylor	Class B midwife	Kawakawa
Miss A. Thompson	Class B midwife	Brentwood Avenu, Mount Eden
Miss A. Thomson	No details found	Stafford Street, Dunedin
Mrs E. Thomson	Class B midwife	Castle Street, Dunedin
Mrs G. Thomson	Class B midwife?	Temuka
Miss Tombe	RN.	St. David Street, Dunedin
Mrs Tombs	No details found	King Street, Rangiora
Miss K. Turner	RN.	"The Limes", Victoria Square, Christchurch

Mrs Vincent	Class B midwife	Amesbury Street, Palmerston North
Nurses Wade and Wilbow	RM. - Sydney	Riverside Road, Gisborne
Dr Wadmore	Medical Practitioner	Whakatane
Dr H. Wake	Medical Practitioner	Pukekohe
Mrs Waldin	No details found	Victoria Street, Hawera
Mrs Wallace	RN.	Symonds Street, Auckland
Mrs A. M. Watson	RM. - LOS.	Richmond, Christchurch
Mrs S. A. Watson	Class B midwife	Main Road, Winton
Miss Waymouth	Class B midwife	Sherborne Street, Mount Eden
Miss W. White	RN.	Sussex Street, Masterton
Mrs Annie Whiting. Mrs Caroline Whiting	Class B midwives.	South Road, Hawera
Miss Wiseman	RN.	33 Brougham Street, Wellington
Mrs K. C. Wright	No details found	87 Guyton Street, Wanganui
Misses Yates	RM. - Sydney.	Aberdeen Road, Gisborne

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