

The Business of Adoption: Past Practices at the Royal Women's Hospital, Melbourne

Abstract

In the period 1945-1975, over 45,000 adoptions were legalised in Victoria. With the demand for adoptable babies at its peak across Australia, up to 68 per cent of ex-nuptial births resulted in adoption. It was argued that adoption guaranteed the moral and social redemption of mother and child, with adoptive parents cast as benevolent and sympathetic. Professionals who facilitated adoption perpetuated the stigma attached to single motherhood by encouraging silence, secrecy and relinquishment. Drawing on economic and business concepts to emphasise the incentive-driven, transactional nature of the adoption industry in this period, this paper examines past adoption practices at the Royal Women's Hospital (RWH) in Melbourne. This analysis reveals the persistence of market-like transactions, notwithstanding legislation that was introduced in the early twentieth century which intended to distance adoption practices from past discredited trade in babies.

Sir: For some years past the demand in Australia for babies for adoption has been far greater than the supply. At the same time, politicians have been tearing their thinning hair over the threatened decline in the population. Also, for some years past, babies have been dying like flies all over the rest of the world—chiefly from starvation. In the case of any commercial article we import what we cannot produce locally until the demand is satisfied. Why not do the same with babies?¹

Often referred to as the ‘heyday’ of adoption, a total of 45,458 adoptions were legalised in Victoria in the period 1945-1975.² With the demand for adoptable babies at its peak across Australia, up to 68 per cent of ex-nuptial births resulted in adoption. In finding and deciding ‘the best solution to [the unmarried mother’s] problem’,³ professionals who facilitated adoption perpetuated the stigma attached to single motherhood by encouraging silence, secrecy and relinquishment. Seen as a mutually advantageous solution, it was argued that adoption guaranteed the moral and social redemption of mother and child, with adoptive parents cast as benevolent and sympathetic.⁴ Through these means, such arrangements also functioned to maintain a stratified system of reproduction and family formation. Drawing on economic and business concepts to emphasise the incentive-driven, transactional nature of the adoption industry, this article examines past adoption practices at Victoria’s largest public hospital, the Royal Women’s Hospital (RWH) in Melbourne.⁵ An analysis of the roles played by consumers (adoptive parents), suppliers (birth mothers) and the hospital (management) reveals the persistence of market transactions despite the introduction of legislation that was intended to remove adoption from past discredited trade in babies.⁶ In the process of these dealings, women who did not fit prevailing domestic models and patriarchal ideals of motherhood were exploited in a gendered imbalance of power.⁷

Recent scholarly and government interest in past adoption practices has revealed a history of policies and practices that were unethical, illegal and used undue influence to coerce single mothers to place their babies for adoption. The 2012 report of the Senate Inquiry into Former

Forced Adoption Policies and Practices described the way in which unmarried women were disempowered during their pregnancy,⁸ while earlier government reports described a society whose standards and values ‘placed female virginity before marriage as being of higher value than the bond between mother and baby’.⁹ Recent feminist scholarship on the history of adoption has challenged the notion that birth mothers were complicit in the process whereby their maternity was denied.¹⁰

The idea that a child’s life chances would be improved should they be permanently removed from their parents intensified during the early twentieth century. The 1928 Adoption of Children legislation established the first legal recognition of adoption in Victoria and was firmly centred on the adopters’ right to bestow inheritance and succession on the adopted child. But the legislation also entrenched the ideal of separation and provided greater certainty for prospective adoptive parents. In introducing the bill, Attorney-General Slater argued:

Every member of the legal profession has personal knowledge of hundreds of cases of people who have sought the security of the law in connection with cases when kind-hearted persons have adopted, reared and protected a child, and have found the natural parent of that child coming along and taking it away, the child will be protected from the slur of illegitimacy. A home will be provided for it, and in general, a new vista entirely will be opened ... [As] adoption will apply to at least 90 per cent of illegitimate children ... the State gains in another way ... in that it has its burdens of maintaining destitute persons and children ... lightened.¹¹

While the legislation was slow to take effect, the argument for separation was strengthened by the efforts of F. O. Barnett. After a survey of Melbourne’s inner city slums in 1933, Barnett proposed ‘to remove the children of the slum-minded as soon as possible after birth from their present vicious environment into an atmosphere where they could grow up to be decent

citizens'.¹² His aggressive manipulation of the new legislation helped ease concerns over the genetic inheritance of 'undesirable traits' in adopted babies, which had all but ceased by the post-war period, indicating a shift from hereditarianism to environmentalism.¹³ Amendments in the 1936 Act further entrenched the sense of ownership amongst adopting parents by introducing penalties for stealing or harbouring an adopted child, as well as increasing secrecy provisions through restrictions on the inspection of those entries in the birth registry that had been marked 'Adopted'.¹⁴ These provisions were to become pivotal in the post-war construction of family.

In the years following World War II, government concerns with post-war nation building placed the value of an idealised nuclear family at the forefront of population policy and practice. Families, that is those who were married, white and preferably Christian, were urged to 'Populate or Perish' in the face of fears of invasion and in order to replenish the population after the devastation of war. At this time, Australians were 'constantly reminded by political, commercial and religious leaders of the existence of a population "problem"'.¹⁵ In 1944, Dr Norman Haire expressed these concerns on an ABC radio programme. He proposed an alternative baby bonus to encourage the production of children of 'good stock' and warned of the potential encumbrance of children of 'bad stock':

It is not only the quantity of births that matters. We must also consider the quality of the children born, and the likelihood of their growing up as healthy, happy and useful citizens ... It is obviously stupid to offer the same baby bonus to parents of bad stock to provide us with healthy children ... We should be as careful to dissuade parents of bad stock from producing children who are likely to be a burden on the community as we are to induce parents of good stock to provide healthy children who are likely to be an asset.¹⁶

Despite such misgivings in relation to the quality of the 'stock', fears of genetic inheritance were largely diminished in the post-war period with the belief that 'a good environment will make a better job of bad genes than a bad environment will make of good genes'¹⁷ gaining

scientific support. The adoption market was open to consumers with women's magazines and the press publicising its benefits.¹⁸ Underlying moral assumptions upheld the sanctity of marriage and the nuclear family. Within the discourse, there was no space to question a single mother's desire or willingness to keep her child, but instead a decision was based on her perceived ability to adequately care for it. Throughout the 1950s and into the early 1960s the image of a picture-perfect suburban family continued to be promoted within a framework of a growing population.

But the attainment of this goal was hindered by an increased rate of infertility amongst returning servicemen ready to begin their families.¹⁹ At the same time an increased rate of illegitimacy was perceived to be threatening the moral fabric of society. Adoption appeared to provide a perfect solution to both these social problems.²⁰ Further, this outcome had the benefit of relieving the government of accepting any financial responsibility for the ongoing support of the single mother and her child.²¹ Infertile couples were longing for a newborn baby that they could rear as their own, without the risk of having the child removed. The permanence of an adoptive situation not only provided couples with a sense of security, but adoptive families were not subject to ongoing inspections, thereby offering the illusion of a 'real' family.²² The rising demand for adoptable babies after WWII is but one factor that resulted in increasing pressure for single mothers to choose adoption.

Media campaigns, focusing on promoting the benefits of adoption, coincided with a rise in its popularity after WWII. Women's magazines were particularly vocal in their advocacy of adoption as a solution, both for the infertile couple and the single mother. Adoption was seen to be in everyone's best interest. Indeed, the Social Work Department at the RWH claimed that 'adoption is a service that we render not only to our own obstetrical patients and the many of our gynaecological patients who become adopting applicants, but to the community'. The

RWH was often the first agency to receive requests for assistance when articles appeared in the daily papers. A 1944 piece in the *Herald*, promoting the work of the sterility clinic at the RWH, resulted in ‘a rush of applicants anxious to adopt babies’.²³

The demand from adoptive couples continued to grow throughout the 1950s, with the hospital spending much of this decade trying to supply babies for an ever-increasing number of applicants. In 1953, head almoner Isobel Strahan noted that ‘though there was an increase in the number of adoptions arranged last year, the waiting list is still very long’. By 1955, the almoner was bemoaning a decreasing number of available babies to satisfy the customer base. The problem continued to grow and in 1958, restrictions were imposed: prospective adoptive parents using the adoption service at the RWH must be patients or have been referred by one of the hospital’s honoraries. By 1974, the waiting lists for adoption were closed, reflecting the changing social values and increasing acceptance of the single mother within the community. The supply of infants had indeed dried up, marking the end of ‘the era of the “perfect baby” for the “perfect couple”’²⁴ within the context of White Australia.

The provisions of the 1964 Adoption of Children Act attempted to abolish a growing illegal trade, in part by limiting the arrangement of adoptions to one of the twenty-one registered agencies in Victoria.²⁵ While the ethical implications remain questionable, prior to the introduction of this Act, it was not illegal for an adopting couple to pay the hospital and medical fees of the mother of the child. In their desperation to adopt, affluent couples could take advantage of such an opportunity in order to fulfil their family dream. One honorary recalls the practice in which doctors facilitated the adoption arrangements:

There was a practice in those days by a small number of Obstetricians to take on the antenatal care and the delivery of the single mother in private practice with the financial cost of the hospital at least, being born by the potential adopting parents. What the specific arrangements and details were entered into, I do

not know. I do not believe it was a widespread practice.²⁶

Social worker Isobel Strahan expressed fears that ‘this practice can be very open to abuse, and regarded as an inducement to give up the child even against all her own feelings, because she is under an obligation to do so’.²⁷ Strahan argued that the exploitation of earlier legislation by one or two doctors in the community had created a black market in babies. She claimed that ‘one of them had a large house where he had six to eight pregnant girls staying at any one time’.²⁸

Despite the changes enacted by the 1964 Adoption of Children Act, which intended to eradicate the business of illegal adoptions once and for all, the practice continued. At the seventh conference of Adoption Agencies in February 1969, representatives of fourteen agencies, plus the Family Welfare Advisory Council and Departmental officers, discussed the issue of private adoptions. Mr A.G. Booth, Director of Family Welfare, chaired the meeting. Discussion revolved around the fact that placements were being made ‘for adoption of children with unrelated persons where approved agencies had not participated in the arrangements’.²⁹ No estimate was made of how many unregistered arrangements were occurring on a yearly basis. However, it was requested that in future any knowledge of such placements be brought to the attention of the Department.

ADOPTIVE PARENTS AS CUSTOMERS

Unlike a natural birth, adoptive parents were afforded choice in their prospective child: health was guaranteed, physical characteristics were carefully matched, and gender preferences catered for. By the late 1960s, as the supply of babies failed to equal the growing demand, it was argued that adopting parents should be prepared to take a gamble and accept the risks normally accepted by natural parents. But in the world of supply and demand, parents were not only offered choice, they had come to expect it. Senior social worker at the Psychiatric

Centre in North Ryde NSW, Miss M. Mills, claimed that ‘freedom of choice, whether the choice be based on the appearance of the infant or on the result of medical and biochemical examination, remains the prerogative of the adopting parents’.³⁰

Children were handpicked for adoption. The physical and intellectual qualities of the mother were indicators of the child’s potential. Despite the basis for the promotion of adoption being grounded in environmentalism, the quality of the product was still bound by fears of hereditarianism. Social worker and adoption researcher John Triseliotis describes the ideal baby of the time:

Although this was a period when nurture was supposed to rule over nature, this optimism was not reflected in the practices of adoption agencies in the way they selected children for placement ... An ‘adoptable’ infant was, generally speaking, white, healthy, with an acceptable background and developing normally (or at an above average pace).³¹

Babies who did not fit this ideal were harder to place. Although the supply of babies was a pressing issue given the high demand, not all adoptive babies were perfect substitutes for the biological child parents could not conceive: imperfection was not tolerated by most consumers. By the late 1960s concerted efforts were being made by social workers to place the less-than-perfect child. Miss B. Vaughan of the NSW Department of Child and Social Welfare claimed that ‘theoretically the unadoptable baby does not exist. All babies are adoptable if we can find adopting parents willing to accept them with whatever handicap or potential handicap they possess.’³² To Vaughan, the social worker had the responsibility to find a match for the baby who had been classified as unfit for adoption. In other words, social workers were arguing for a broadening of the notion of the adoptable child in order to satisfy the ever-growing demand from their clients.

At the RWH, efforts to regulate the demand from infertile couples centred on professional

judgments of their fitness to adopt and to parent. A large proportion of adoptive parents were private patients of the hospital's honorary doctors. Nonetheless, applicants were vetted through the Social Work Department and the procedure that followed included an investigation into the couple's motivations and circumstances, as prescribed by law:

When they apply officially, a full study would ensue. The principal officer or other adoption officer authorised by him is required by the Regulations 'to determine the suitability of applicants to adopt, having regard to their age, marital status, state of health, educational background, religious upbringing or convictions (if any), personality, physical and racial characteristics, reason for seeking to adopt the child, general stability of character and employment, financial conditions and the accommodation they have available.'³³

However, while hospital social workers prided themselves on the thorough investigation of prospective adoptive parents, honorary medical staff (the only people who were able to refer such parents) considered their own opinions on matters of selection to be superior to those of the social workers involved. The consequent conflict was brought to a head in an incident in 1967. An honorary doctor had referred a private patient to the social work department in order to procure an adoption subsequent to a diagnosis of infertility. As part of the mandatory procedure, a social worker interviewed the applicants, questioning the medical factors that had motivated their decision to adopt—to which the doctor took great offence. The Board of Management was called to intervene and implemented the recommendation that 'a medical certificate need only state that the adoptive parents were medically fit to adopt a child' and any questions relating to the certificate be referred to the Medical Superintendent.³⁴ From this perspective, the customer was always right.

SINGLE MOTHERS AS SUPPLIERS

In the 1980s, an emergent discourse portrayed adoption as an 'exploitative system in which the

“rich and powerful” took advantage of the “poor and vulnerable”.³⁵ Within this context, it is easy to view adoption arrangements as a business transaction, with single mothers supplying a market demand for adoptable babies. In hindsight, the mechanics of this arrangement were obvious to one mother:

So, what I felt was—this was what I suspected was happening, there was a huge mass of people, wealthy people, that couldn't have children or only had one or two and wanted more so you've got all these wealthy, powerful people—people with some power and all this pool of women with no power, that you know we were just like a labour force of people to donate their children to all the wealthier people, and there was a big demand. They were the demand and we were the supply.³⁶

The service provided at the RWH specifically catered for single mothers—excluding married mothers wishing to place their children for adoption until 1972.³⁷ When adoption was requested by married patients, the Chief Almoner argued that it was her duty to convince them that ‘this is no real solution to their problem’.³⁸ Amid legal concerns, problems of overcrowding, and the continued financial feasibility of the adoption service, married women who insisted on adoption were routinely referred to other agencies for assistance in making the necessary arrangements. While the Adoption Sub-Committee had theoretically approved the arrangement of adoptions for married women in 1966, the increasing number of single women meant that they continued to be referred to other the agencies.³⁹ Only when the number of babies available for adoption began to decrease did the RWH adoption agency cease to prioritise the arrangement of adoptions for the children of single mothers.

In 1958, the Almoner Department admitted that the outcomes for adopted children were unknown, adding that ‘it is a very debatable point as to whether adoption is the best course for the baby or not’.⁴⁰ Despite such misgivings, the service continued. The social workers at the RWH supported the early adoption of the infant: that is, the placement of newborn babies. That the single mother should be given the opportunity to care for own child was never

considered a viable option. Eventually, it was assumed, she would find it too demanding, and subsequently relinquish the child, which would then be harder to place.

But far more often, according to every social worker who deals with them, it is exactly the mothers least able to cope who are most likely to keep their babies ... Many struggle on for two or three years, but eventually the knowledge that they will never get out of the trap of living on welfare and being alone with the baby—now a demanding toddler—causes the whole situation to break down. The child is now hard-to-place, and everyone would have been better off if he had been adopted soon after the birth.⁴¹

The popular rhetoric of social workers had been effectively ingrained in the women themselves who were now cited as making the claim: ‘I want my baby to have a father as well as a mother and all the things which I think he should have, but which I cannot give him.’⁴² Social workers argued that they did not have to convert the converted. Women were depicted as willingly lining up to place their child for adoption, in accordance with the social values of the community. However, in the limited allocated time in which the single mother could consult the social worker, she was provided with few alternatives. An undated pamphlet (c. late 1960s) recommended that the single mother consider the feelings of the adoptive parents above her own. Despite her right to revoke consent up to thirty days after the birth, the single mother was advised that ‘it is extremely upsetting emotionally for adoptive parents, if the baby they have at last been able to get, is removed from their care’.⁴³

With an increasing supply from unmarried mothers, it was necessary to refer women to other organisations, placing the hospital in the desirable position of being able to select the adoptions it would arrange. By 1968, six women per month were being routinely referred to the Victorian Children’s Welfare Department (VCWD).⁴⁴ The reasons for referral varied. For example, in 1951 an unmarried mother presented for her third confinement and requested to have the baby placed for adoption. In response, the Almoner explained that ‘such a thing was out of the question’ in the light of her health.⁴⁵ The woman was described as dull and

unattractive. The hospital subsequently applied to the VCWD and the baby was made a ward of the state. In another instance an 'attractive and intelligent girl' from interstate was accommodated at St Joseph's and the adoption was arranged by the hospital. However, another woman, who was married, but carrying the child of another man, was advised to contact the CWD or the Catholic Family Welfare Bureau (CFWB). Such referrals suggest a pattern of choosing healthy and attractive young women for hospital arranged adoptions, while others were actively discouraged from adoption—or simply sent elsewhere for arrangements. These actions to manage supply mirrored the demand for babies (outlined previously) where only some babies were viewed as 'suitable' and therefore easy to place.

In the three-month period April to June 1969, Dr Nan Johns recorded single mothers' stated intentions made to the registration clerk within twenty-four hours of the birth. Of these, 35 per cent intended to keep; 58.8 per cent intended to adopt; and 6.1 per cent were uncertain as to intent.⁴⁶ Although the final outcomes are unknown, these statistics, combined with raw adoption numbers, indicate that roughly 35 per cent of single women who gave birth at the RWH were having their adoptions arranged elsewhere.⁴⁷ These numbers are also indicative of the extent of choice enjoyed by the hospital with regard to the arrangement of adoptions. It must also be noted that these numbers are much higher than those recorded in the *Victorian Year Book*, indicating that only 39.9 per cent of ex-nuptial births resulted in adoption in 1969.

HOSPITAL AS MANAGEMENT

While the role of the hospital in regulating both demand and supply of babies is evident, it is most important to understand that it was budgetary considerations, more than any other factor, which drove decision making within the hospital. By considering the perspective of hospital administrators, it is possible to better understand the outcomes and experiences of the hospital's

patients. Running a hospital was no different from running a business; at the end of the day, the budget has to balance. Even public hospitals need to try and recoup some of the costs of the care provided. And while some may have been covered by private health insurance, most patients of the RWH were not protected by these benefits. The hospital's fees were calculated on a rate scale based on the family's financial situation. Single mothers were not routinely charged any fees for attending the ante-natal clinic, but single women attending the gynaecological clinics were charged according to their income if they were working. With the opening of Frances Perry House, the hospital was able to cater for public, intermediate and private patients. While private patients (or their insurance provider) were responsible for the payment of full fees, an additional fee of \$10 per day '[was] charged the natural mother for babies held in Frances Perry House whilst waiting adoption'.⁴⁸ In response to debate surrounding the cost of running the adoption service, the Manager/Secretary commissioned a cost analysis from the hospital accountant.⁴⁹

As a business, the hospital collected monies in a number of novel ways. While the Board of Management ruled that babies of public patients held in the hospital for adoption should not be charged for, they did advocate voluntary donations. The hospital received many 'donations' from people who had adopted babies.⁵⁰ A 1958 administrative order stated that 'if either the parent or the foster parents care to make a donation this should be encouraged and added to the funds labelled "Patients' Fees"'.⁵¹ It is unclear if this was directed towards recuperating fees from the biological or adoptive parents—or both. Prior to 1964, arrangements for adoptive parents to make such payments were perfectly legal, albeit potentially coercive. But ongoing policies 'encouraging' donations have been viewed as clear evidence that 'babies were "bought and sold" in an era when thousands of single women were forced to give them up'.⁵²

Child endowment was also paid to the institution. Initially, women were not eligible to receive child endowment for their first child, resulting in the exclusion of most single mothers. Amending legislation passed in June 1950 awarded endowment for the first child under sixteen years of age at the rate of 5/- per week.⁵³ The *Victorian Year Book* states that in the case of institutionalisation, the endowment was payable directly to the institution in question.⁵⁴ This payment was applicable to babies awaiting adoption and was paid directly to the RWH. And while the payment was not initially granted to foster families caring for babies awaiting adoption, the Minister for Social Services approved Cunningham's requests in 1970, at which point the payment was made directly to the families in question.⁵⁵ A final avenue for the recuperation of the costs of providing the adoption service was a Ministerial suggestion that agencies charge a \$30 fee for the arrangement of an adoption. The 1964 Adoption of Children Act allowed the Minister to approve fees collected for the purpose of 'administration costs'. However, a conference of Victorian Adoption Agencies unanimously decided to oppose the proposal for the charging of fees.⁵⁶ Eventually, the Minister capitulated and granted a state subsidy of \$30 to be paid to the agency for each adoption arranged.⁵⁷

Another consideration of running the business of adoption was the hospital's ability to house and care for the mothers, and especially the babies. Hospital facilities are by nature long-term investments. At the time, these facilities were constrained and could not easily or quickly be expanded. The increasing number of ex-nuptial births raised serious concerns for the Board of Management. Coupled with the effects of the 1964 Adoption of Children Act, hospital facilities were under enormous pressure. The introduction of a thirty-day revocation period meant that babies had to be held for an extended period, particularly in the case of undecided mothers, straining available resources. Hospital nurseries were overflowing with babies awaiting adoption, and the associated expense was becoming a major financial burden for the hospital. It is very likely that the constraints on existing facilities had a driving influence on

hospital polices.

The suggestion to reduce the time granted for revocation, as the solution to constrained facilities, was first canvassed by doctors. Those who supported this idea believed that ‘the trouble seems to begin when the unmarried mother has not consented to adoption before the baby is born’; doctors were equally concerned about ‘deprivation syndrome’ suffered by the new baby.⁵⁸ It was the post-war work of psychiatrist Dr John Bowlby that popularised the hypothesis that maternal deprivation in infants could have serious mental health consequences for the child.⁵⁹ Midwives at the RWH had also been voicing concerns with regard to the care and attention of babies since the early 1960s, particularly with respect to those awaiting adoption who were failing to thrive.⁶⁰ Social workers defended the mother’s right to a full thirty-day period of revocation, and for consent to be taken after birth.⁶¹ In late 1967, Cunningham was notified by Sir Henry Winnecke that a Committee of Judges of the Supreme Court were reconsidering the existing procedures. Cunningham had argued that the problem was not exclusive to the RWH:

Nearly all of the Voluntary Adoption Agencies are experiencing great difficulty with insufficient facilities and staff; consequently, there is a tendency for the babies for adoption banking up in our nurseries causing extreme over-crowding which is concerning our Paediatricians, so that any method of speeding up adoptions lessens the possibility of out-breaks in the nursery.⁶²

The revocation period was upheld and debate over the holding of babies awaiting adoption intensified. In May of 1968, the Medical Superintendent wrote to the Manager/Secretary expressing his concerns for the health of these babies, as well as the financial administration of the hospital. The Medical Superintendent’s recommendations were focused on downsizing the rapidly growing adoption service. This cost-cutting measure would also regulate the ‘expensive empire building up’ in the Medical Social Work Department, specifically in relation to their work in adoptions.⁶³ Ultimately, nothing changed and the number of adoptions arranged

by the hospital continued to increase.

In the interim the hospital also considered restricting its adoption services to single women, who were unlikely to revoke consent.⁶⁴ Social workers estimated that there was a revocation rate of 17 to 20 per cent among undecided single mothers. In an attempt to minimise the risk of being left holding the baby, social workers tried to establish the intent of the mother prior to the birth.⁶⁵ When the intent to relinquish the child for adoption had been established in this way (with consent officially obtained on the sixth day after birth), babies were immediately placed with their new families. However, the babies of undecided mothers were legally required to be held for the thirty-day revocation period. One midwife remembers: ‘Some of [the babies] would go out to the adopting mothers the day after their mother went home, if they were a hospital adoption, but later on some of them had to stay thirty days.’⁶⁶

In order to cope with the overcrowding, several agencies pledged assistance. The Berry Street Babies’ Home agreed to take on the arrangements of two ‘single girl’ adoptions per month.⁶⁷ However, while the Queen Elizabeth Hospital for Mothers and Babies had taken an undisclosed number of babies pending adoption, the relationship seems to have soured over the issue of payment.⁶⁸ Similar issues arose with the Social Welfare Department. Despite an agreement to accept the referral of six mothers per month, the Department continued to fail in its responsibility to care for these babies—who remained unclaimed in the nurseries at the RWH.

In 1968, a formal system of fostering babies was initiated by Valerie Douglas, in order to care for both medically deferred babies, and the children of undecided mothers.⁶⁹ This arrangement offered the most immediate relief to the problem of overcrowding. During the first year of operation, the programme cared for seventy-one babies for an average of fourteen days each. It

was estimated that the use of foster care had saved a total of 3,980 nursing hours. While cost cutting measures topped the list of foster care's achievements, the programme was equally congratulated for its value to the babies involved, which was reflected 'in their obvious physical and emotional development with their foster family'.⁷⁰ The hospital claimed that their foster mothers were not paid for the care of the baby, and encouraged the single mother to contribute to its upkeep: the foster parents would appreciate 'anything from 50¢ to \$5.00 a week'.⁷¹ It is more likely that this was insisted upon, as historically, such payments were common.⁷² At a Social Work Committee meeting it was noted that it was 'normal to require the mother to undertake the financial costs through such fostering'.⁷³ By 1978, the programme was being funded by the newly established Foster Fund, which sourced its income from the adoption subsidy,⁷⁴ by specific donations from outside organisations, as well as by ongoing contributions made by natural mothers.⁷⁵

By the 1970s, community attitudes to extra-marital intercourse had begun to relax, and the supply of adoptable babies decreased. Single mothers became more visible, suggesting that they and their families had become less concerned with the disgrace previously associated with illegitimacy. Between 1969 and 1975, the proportion of single mothers who kept their babies increased dramatically: by 1970, it had risen to 50 per cent, and by 1975 it had further increased to 80 per cent.⁷⁶ No single factor can adequately explain the dramatic decrease in babies available for adoption that began in 1971-1972. Certainly the introduction of the Supporting Mothers Benefit in 1973 eased financial impediments and provided income security for single mothers, and the Victorian Status of Children Act removed the legal disabilities of ex-nuptial children. Other changes that improved the sexual freedom of single women were the increased availability of contraception and abortion.

Between the 1940s and the early 1970s, the adoption industry in Australia took on the form of a

standard supply and demand driven market, where newborn babies became a valuable commodity. During this time, demand increased rapidly, driven by an increase in the number of adoptive parents in the post WWII period and an increased belief in nurture over nature. Supply arrived in the form of young, never-married mothers. Social pressures, including the promotion of the idealised 'nuclear family' stigmatised and shamed the single mother, encouraging relinquishment as the only path to salvation. The RWH was pivotal in facilitating and influencing the outcomes of these adoptive transactions, incentivised through its budget requirements to match wealthy couples with desirable babies. Constrained facilities drove policy that encouraged the quick and complete removal of children to new parents, which was further facilitated through legislation.

It has been claimed that the service provided by the RWH was one that benefitted its patients (both adoptive parents and single mothers), as well as the wider community. These provisions were underpinned by a belief that the life chances of illegitimate children would be improved by removing them from their mothers and placing them with respectable, middle-class, married couples. Adoption professionals, particularly the Principal Officer, played an instrumental role in matching supply and demand for babies, acting on behalf of all members of the adoption triangle. Health workers, including doctors and social workers, were in a position to apply pressure to the mothers of potentially desirable babies, while also dealing with the growing demand for babies from infertile couples; the potential conflict that this situation entailed was especially apparent when anxieties increased over the decreasing supply.

¹ Letter to the Editor, 'Import Babies,' *Argus*, 29 March 1947.

² *Victorian Year Book*, (1942-1994). This total includes 8794 legitimations, but does not provide any information on adoptions by relatives, nor does it consider private adoptions that were not sanctioned by the court.

³ Victorian Council of Social Service (VCOSS), 'The Service of Adoption,' pamphlet, (Melbourne: VCOSS, c.1960).

⁴ Shurlee Swain and Renate Howe, *Single Mothers and Their Children: Disposal, Punishment and Survival in Australia*, (Melbourne: Cambridge University Press), 140.

⁵ This paper is based on research funded by the Royal Women's Hospital (RWH). The RWH was responsible for the arrangement of over 5000 adoptions between 1940 and 1987, at which point its involvement in adoption ceased.

⁶ The author acknowledges the problematic nature of terminology in adoption discourse and has chosen 'adoptive' and 'birth' as the least problematic and providing the most clarity. See Christine Cole, 'Language' in *Releasing the Past: Mothers' Stories of their Stole Babies* (2008), 248, and Christin Quirk, 'Separated at Birth: Adoption Practices in Relation to Single Women Confined at the Royal Women's Hospital 1945-1975', MPhil thesis, Australian Catholic University, 2012, pp.23-26.

⁷ The author acknowledges feminist tensions in counter-positioning birth and adoptive mothers in binary opposition and essentialised views of motherhood. For further discussion on this debate, see Denise Cuthbert, Kate Murphy and Marian Quartly, 'Adoption and Feminism', *Australian Feminist Studies*, Vol. 24, No.62, (2009): 395-419.

⁸ Senate Community Affairs References Committee, 'Commonwealth Contribution to Former Forced Adoption Policies and Practices'.

www.aph.gov.au/senate/committee/clac_ctte/comm_contrib_former_forced_adoption/index.htm

. (hereafter Senate Inquiry).

⁹ Joint Select Committee, *Adoption and Related Services 1950-1988* (Hobart: Parliament of Tasmania, 1999), 3.

¹⁰ See for example Ann Fessler, *The Girls Who Went Away : The Hidden History of Women Who Surrendered Children for Adoption in the Decades before Roe V. Wade*. New York: Penguin Press, 2007; Shurlee Swain, 'Adoption, Secrecy and the Spectre of the True Mother in Twentieth-century Australia', *Australian Feminist Studies*, Vol.26, No. 68, June 2011, pp.193-205.

¹¹ Attorney-General Slater quoted in Swain and Howe, 137.

¹² F. Oswald Barnett, *The Unsuspected Slums* (Melbourne: Herald Press, 1933), 28.

¹³ Janet McCalman, *Sex and Suffering: Women's Health and a Women's Hospital*, (Baltimore: John Hopkins Paperbacks edition), 271.

¹⁴ Adoption of Children Act 1936, Act no 4381 (1936).

¹⁵ W. D. Borrie, *Population Trends and Policies: A Study in Australian and World Demography*, (Sydney: Australasian Pub. Co., 1948), xiii.

¹⁶ Dr Norman Haire (sexologist), 'Population Unlimited?' *The Nation's Forum of the Air*, vol.1, no.2, Australian Broadcasting Commission, 23 August 1944, in Katie Holmes and Marilyn Lake, eds., *Freedom Bound II: Documents on Women in Modern Australia* (St. Leonards, NSW, Australia: Allen & Unwin, 1995), 104.

¹⁷ McCalman, 273.

¹⁸ See Swain and Howe, 138-142; and Shurlee Swain, 'Dear Problem Page, I'm Single, Pregnant And...' *Lilith*, (1991).

¹⁹ See 'Melbourne Sterility Clinic,' *Townsville Daily Bulletin*, 9 January 1945, 3.

²⁰ Audrey Marshall and Margaret McDonald, *The Many-Sided Triangle: Adoption in Australia*, (Melbourne University Press, 2001), 1-17; Swain and Howe, 1-11; T. R. Frame, *Binding Ties:*

An Experience of Adoption and Reunion in Australia (Sydney: Hale and Iremonger, 1999), 7-8.

²¹ Either by financially supporting the mother to keep the child or through a financial commitment for the care of greater numbers of institutionalised children.

²² A 1953 public appeal for foster-parents to care for state wards commented that people ‘didn’t want a child unless they could adopt him,’ see Lawrence Kerr, ‘Children Must Have Homes: Don’t Let Miss X Miss out in Life,’ *Argus*, 4 September 1953.

²³ Almoner Department, ‘Almoner’s Report,’ 16 March 1945, RWHA, Melbourne.

²⁴ J.P. Triseliotis, Joan F. Shireman, and Marion Hundleby, *Adoption: Theory, Policy, and Practice*, (London: Cassell, 1997), 7.

²⁵ The Adoption of Children Act 1964, Act no 7147 (1964), s.17.

²⁶ Interview with WC, 1 June 2010.

²⁷ Nurses’ Lecture, c.1963, RWHA, Melbourne.

²⁸ Isabel Strahan, ‘Looking Back: 25 Years of Social Work at the RWH,’ 1966, RWHA, Melbourne.

²⁹ Victorian Social Welfare Department, ‘Seventh Conference of Adoption Agencies,’ 18 February 1969, RWHA, Melbourne.

³⁰ M. Mills, ‘2. Who is the Unadoptable Child?,’ *Australian Journal of Social Work*, 20, no. 1 (1967): 18.

³¹ Triseliotis, Shireman, and Hundleby, 7.

³² B. Vaughan, ‘3. Placing the Unadoptable Child,’ *Australian Journal of Social Work*, 20, no. 1 (1967): 21.

³³ Conference of Approved Adoption Agencies, *Notes on Adoption for Distribution to Doctors, Solicitors, Nurses, Ministers and Other Professional Groups*, (North Melbourne: Family Welfare Division, Social Welfare Department, 1968), which in turn cites *Adoption of Children Regulations*, Victoria, 1965, Regulation 31.

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- ³⁴ Letter to Miss V. Douglas, Medical Social Worker from A.J. Cunningham, 1 September 1967, RWHA, Melbourne.
- ³⁵ Judith Schacter Modell, “‘How Do You Introduce Yourself as a Childless Mother?’” Birthparent Interpretations of Parenthood,’ in *Storied Lives: the Cultural Politics of Self-Understanding*, George C. Rosenwald and Richard L. Ochberg (eds) (New Haven: Yale University Press, 1992), 78-79.
- ³⁶ Interview with DG, 31 August 2010.
- ³⁷ Medical Social Work Department, ‘General Report’, March 1972, RWHA, Melbourne.
- ³⁸ *Annual Report* (1961), 28.
- ³⁹ Medical Social Work Department, ‘General Report’, July 1969, RWHA, Melbourne.
- ⁴⁰ ‘Almoner’s Report’, 25 July 1958, RWHA, Melbourne.
- ⁴¹ Mary Kathleen Benét, *The Politics of Adoption* (New York: The Free Press, 1976), 177.
- ⁴² *Annual Report* (1960).
- ⁴³ Information for Women Considering Adoption, Social Work Department, (c. late 1960s), RWHA, Melbourne.
- ⁴⁴ Report Prepared for Medical Social Work Sub-Committee, 20 September 1968, RWHA, Melbourne.
- ⁴⁵ While all adoption records were transferred to Community Services Victoria (CSV) in 1987, two boxes of social work department records remain in the RWH archives. These are not restricted to adoption records, but include a full alphabetical range of social work clients prior to 1965.
- ⁴⁶ Dr Nan Johns, statistics for April - June 1969, in ‘General Report’, July 1969, RWHA, Melbourne.
- ⁴⁷ Using Johns’ data and those reported in the *Annual Report* 1969.
- ⁴⁸ Intra-Hospital Memo Re: Frances Perry House Adoption Babies, 3 March 1971, RWHA,

Melbourne.

⁴⁹ Cost Study of Cost Operating Adoption Agency, by A.F. Campbell, 22 May 1968, RWHA, Melbourne.

⁵⁰ ‘Almoner’s Report’, 7 November 1957, RWHA, Melbourne.

⁵¹ ‘Administrative Order No.194’, 26 February 1958, RWHA, Melbourne.

⁵² Opposition family services spokeswoman Christine Campbell quoted in Cheryl Critchley, ‘Adopt Families Urged to Pay,’ *Herald Sun*, 16 February 1998.

⁵³ *Victorian Year Book 1954-58*.

⁵⁴ Ibid.

⁵⁵ Letter from W.C. Wentworth, Minister for Social Services to A.J. Cunningham, Manager and Secretary Royal Women’s Hospital, Re: Procedures for Claiming Endowment, 1970, RWHA, Melbourne.

⁵⁶ Social Welfare Department, ‘Seventh Conference of Adoption Agencies,’ 18 February 1969, RWHA, Melbourne.

⁵⁷ Hospital correspondence indicates that the hospital received a state subsidy of \$30 for each adoption finalised. See Submission to Mr A.J. Cunningham, Manager/Secretary and Dr G. Trevaks, Medical Director, from Valerie Douglas, (c. 1971-1978), RWHA, Melbourne; See also Finance Committee Minutes, June 1971, RWHA, Melbourne.

⁵⁸ L. Howard Whitaker, Memorandum Re: (a) Babies for Adoption (b) Adoptive Parents, 10 October 1968, RWHA, Melbourne.

⁵⁹ Dr John Bowlby, ‘Maternal Care and Mental Health,’ World Health Organization, 1951. For the Australian media representation of his theories see, ‘Grandmother Was Right About “Mother Love”’, *Women’s Interests, Brisbane Courier-Mail*, 28 March 1952; ‘Children need affection to develop normally,’ *Women’s Interests, Brisbane Courier-Mail*, 4 April 1952; and ‘Should The Adoption Law Be Changed?’ *Sydney Morning Herald*, 1 October 1953.

⁶⁰ ‘Letter to Medical Superintendent, Re: Adoption Babies from Betty Lawson,’ 9 July 1971, RWHA, Melbourne. Lawson makes reference to earlier complaints and claims that ‘Until there is some resolution of the matter the hospital is at a disadvantage financially, the babies are at a disadvantage as entities, and the nursing staff is burdened with baby care which it knows falls far short of proper care.’

⁶¹ Report Prepared for Medical Social Work Sub-Committee, February 1969, RWHA, Melbourne.

⁶² Letter to Chief Justice, Sir Henry Winneke from A.J. Cunningham, 22 December 1967, RWHA, Melbourne.

⁶³ Memorandum to Manager/Secretary from Medical Superintendent: ‘Adoptions’, 20 May 1968, RWHA, Melbourne.

⁶⁴ Ibid.

⁶⁵ Adoption Sub-Committee, Minutes of Meeting Held on 4 November 1966, RWHA, Melbourne.

⁶⁶ Interview with MJ, 4 August 2010.

⁶⁷ Letter to Mrs J. Kwiatek, Manager/Secretary, Berry Street Babies’ Home and Hospital, 20 August 1968, RWHA, Melbourne.

⁶⁸ Letter to A.J. Cunningham from the Victorian Baby Health Centre Association, 6 November 1968, RWHA, Melbourne.

⁶⁹ The fostering system began informally in August 1967.

⁷⁰ *Annual Report 1969.*

⁷¹ Information for Women Considering Adoption, updated, March 1976, RWHA, Melbourne.

⁷² See for example Swain and Howe, 124

⁷³ Social Work Committee Minutes of Meeting No.14, 15 November 1968, RWHA, Melbourne.

⁷⁴ While the exact date for the introduction of the subsidy is unclear, there is reference to its

receipt in the Finance Committee Minutes of Meeting, June 1971, RWHA, Melbourne.

⁷⁵ Memo from Deputy Business Manager to Acting Chief Executive Officer, Re: Foster Fund, 1 March 1978, RWHA, Melbourne.

⁷⁶ *Annual Report* (1970) and (1975).